



## A Call to Address the Gaps in our Care:

### **A scoping review to determine the extent to which spiritual care is incorporated into the education of Healthcare Support Workers in Scottish Further Education Colleges.**

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Running a race requires commitment, discipline, training, and hard work. But the rewards are phenomenal – not only personally in terms of self-esteem, confidence, and health, but also a sense of fellowship amongst the team, togetherness, and mutual respect for one another. In relay races there is no-one better than the other, each person is running for the team and passing on the baton to win the race. Spiritual care for one another

can be likened to a life race that takes account of the rest of 'the team'. Each team member notices when one becomes tired or drops the baton. There is no blame, but a feeling of pride in one another's attributes and a sense of responsibility when one needs holding up. There are many 'teams' in our lives made up of different colours, cultures and creeds, but each one is of equal value and each one needs the baton you are holding; it is your legacy and their inheritance.

Photo attributed to Dan Reiland Executive Pastor of 12Stone Church in Georgia.

It is the overriding passion of the authors that all people be given permission to speak about the meaning of life and death. Somehow, we have taken that permission away in the last twenty years and instead created for ourselves a platform of fear and retribution if we so much as mention the words death, faith, religion, or spirituality. It is time to address this gap in our conversation for the sake of those who are reaching the end of life or want to find meaning in life. We can do this by

empowering universities and further education colleges to teach the next generation what we ourselves have failed to do.

*‘Human beings, among all living organisms, are most aware of occupying a place within the reality of existence. We are aware of the past. We have an expectation of a future. We recognise the finite nature of our lives. It is how we cope...Something inside prompts us to ask questions and search for an answer’ Spiritual Care Matters 2009(p19).*

### Abstract

This scoping review challenges the dissonance between policies and guidance on the delivery of spiritual care to clients and residents in institutions and the education required to perform that delivery. The authors discovered a paucity of literature regarding healthcare support workers spiritual care education or a common thread describing the need for spiritual care knowledge amongst a significant workforce delivering care particularly to an ageing generation. Various gaps in understanding of spiritual care; resources for education; providence in the curriculum for spiritual care and subsequent learning by students; perceptions and assumptions made by students and lecturers were all observed during discussions with Further Education Colleges in Scotland. The conclusion of this paper is that the educational and professional governing bodies are responsible for ensuring that spiritual care features in all healthcare support workers training and that specialist knowledge should either be available in the colleges or brought in to deliver that education. Spiritual care assessment, as a way of learning and endorsing knowledge, should also feature in the curriculum whether as a specific subject or threaded through existing modules.

*Keywords:* Spiritual Care Education; Healthcare support workers; Further Education Colleges.

*Glossary:* Continuing Professional development – CPD; Faith in Older People – FiOP; Further Education Colleges – FECs; Healthcare Support Workers – HCSWs; Multi-Disciplinary Teams – MDTs; National Health Education for Scotland - NES; Person Centred Care – PCC; Scottish Vocational Qualifications – SVQs; Social, Physical, Emotional, Cognitive, Cultural and Spiritual – SPECCS; Spiritual Care – SC; Spiritual Care Education – SCE; Values Based Reflective Practice – VBRP

### Introduction

This scoping review reinforces and completes previous studies undertaken (Aird and O’Neill 2018; Aird and O’Neill 2020), strengthening the need for inclusion of spiritual care education (SCE) in higher education institutions for health and social care. Spiritual care (SC) aims to sustain individuals, building resilience to cope with challenging and changing circumstances and is as important for staff as it is for residents and patients. We acknowledge that the

methodology of this scoping review (Arksey, O'Malley 2005) is that used in the previous study (Aird and O'Neill 2020) having proved a successful model and enables comparisons to be made of the findings and the potential to share learning frameworks.

Spiritual care enhances the essence of humanness, adding a deeper dimension to the clinical actions necessary to caring. In this study there was a misperception about 'spirituality' and 'spiritual care' which this paper seeks in part to address. For the purposes of this study, spiritual care as defined by Puchalski and Ferrell (2010) describe spirituality in six domains of care: Essence, meaning, transcendence, relationship, values, and rituals. The distillation of these domains defines spirituality as the essence and meaning in life which transcends oneself making a connection to self and others through values and rituals that guide one in life. The juxtaposition between understanding the theory and delivering spiritual care is found in the following definition: 'Spirituality is the practice of loving kindness, empathy and tolerance in daily life; a feeling of solidarity with our fellow humans while helping to alleviate their suffering' (Spiritual Care Matters 2009 p19).

The benefits of 'spiritual well-being enhances and integrates all other dimensions of health, including the physical, mental, emotional and social' (Spiritual Care Matters 2009 p20). It is within this enhancement that SC is required to be given and therefore taught as recommended by the Scottish Government (2008) who 'acknowledge that spiritual care in the NHS is given by all members of staff and by carers and patients, as well as by staff specially appointed for that purpose.' The root meaning of compassion is to share another's pain and it is within this sharing of living that we find the basis of SC when together. The mutual respect that one human has for another affects the way in which pain, trauma, life changing circumstances and even death can become a valuable experience for both parties. While the clinical actions of a carer might save a life, that is no help if the life saved does not feel it was worth saving. To enable and empower another person to feel that there is hope in life despite the circumstances, is to enrich not just that life, but the lives of all those who surround that person. This is the essence of spiritual care which is 'behind all moral values and virtues such as benevolence, compassion, honesty, sympathy, respect, forgiveness, integrity, loving kindness towards strangers, and respect for nature' (Spiritual Care Matters 2009 p19).

It was with this dissonance between recommendations from Scottish Government and delivery of SC within the care sector that Faith in Older People (FiOP) recently completed a scoping review of SC nurse education in Scottish Universities. This recognised that nurses should have a significant component of SCE as it is integral to the Scottish Government Health and Social Care Standards (2017). With the emphasis on the integration of health and social care it is important that the education potential embraces all staff groups, acknowledging the recommendation in the Scottish Government paper (2008) that SC should be delivered by all members of staff. It was therefore deemed appropriate to continue the work of the previous scoping review into the SCE of health and social care workers.

The Scottish Government (2017) places great importance on the human right to respect a person's faith and compassion from others to discuss significant changes in life including death. Health and Social care staff deliver care in various institutions which provide for dementia; palliative care; addiction services; children and families welfare to name but a few. Older residents in care homes have an average length of stay for around 1.5 – 2 years and end of life care, including palliative care, is an inherent part of the support provided. This raises the importance of difficult conversations both with the resident and relatives about death and dying. Understanding the spiritual needs of each resident so that what matters to them should be enabled by the carers, whether it is a religious need or the wider spiritual dimension of friends and family, nature, music, or creativity.

The current Covid-19 pandemic has highlighted end-of-life matters including loneliness and isolation for all staff working in the care sector who have carried the significant impact of the virus. The scoping review on Nurse Education (Aird and O'Neill, 2020) emphasised the critical nature of end-of-life care which resonates with the need to recognise the value of all care staff wherever they are working. In particular, care home staff are constantly confronted with the diminishment of residents and the need to support end of life matters consistently and with compassion, knowing that a care home is the last home for residents. Problems faced by nurses in the NHS during the pandemic has been equally felt by care home staff who had to face their own mortality, sustaining their own grief and fears to support the residents while both were isolated from family and friends.

The Covid-19 Pandemic has given educators an opportunity to observe SC gaps in the education of health and social care staff. There is a need to equip students with the ability to assess SC needs of residents; enable SC to be delivered and honour those residents who have religious or other emotional needs. Previous research (Aird, O'Neill 2018) has shown that many care home staff deliver SC but do not recognise it or simply dismiss spirituality as religion.

This scoping review has enabled a better understanding of the assumptions made regarding SCE showing that a taught component of SCE as part of the HCSWs curriculum could fit with delivery in practice. Reviewing the curriculum for Scottish Vocational Qualifications (SVQ's) this paper was able to highlight the educational gap in both care homes and the NHS with regard to health and social care understanding and delivery of SC, echoing the recommendations made by Jaquet (2019).

#### *Aims of the Scoping Review*

The overall aim is to ascertain the extent to which SCE is delivered as part of the SVQ curriculum in Further Education Colleges (FECs) in Scotland and to what extent it is mandatory for health and social care students. A consequent aim is to enhance the care of people in the community by investing in the SCE of health care support workers (HCSWs).

#### *The objectives of the scoping review*

- A literature search specific to SVQ modules in FECs on SCE using web-based technology, including papers researching SCE for HCSWs.
- To identify questions enabling discussion with FEC module leaders and their approach to SCE, using an interview approach.
- To identify differences in approach and emphasis of SCE between FECs.
- To analyse those differences and map existing SCE amongst an identified sample of FECs with evidence from literature.
- To make available the SCE resource (2018) developed following the scoping review in Scottish universities (Aird and O'Neill 2020).

## Methodology

The Scoping Review framework (Table 1) set out by Arksey and O'Malley (2005) was loosely adopted, using the optional stage six to consult FECs for expert insight and knowledge on SCE.

*Table 1: Stages of Framework for conducting a scoping study*

<p>Stages of Framework (Arksey and O'Malley 2005) for conducting a scoping study:</p> <ol style="list-style-type: none"> <li>1. Identifying the research question.</li> <li>2. Identifying relevant studies through a web-based literature search.</li> <li>3. Study selection.</li> <li>4. Charting the data.</li> <li>5. Collating, summarising, and reporting results on the literature available.</li> <li>6. Consultation of stakeholders for further references or to provide insights on what literature fails to highlight (optional).</li> </ol>
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A literature search was undertaken to determine the extent of SCE amongst health and social care workers and was collated, summarised and reported as data. This search also examined the SCE modules available in FECs in Scotland. From available literature, questions were identified to present to FEC interviewees using open ended questions in an informal setting on a zoom platform (App 2). Ten geographically spread FECs provided the sample for discussion to determine the definition, extent, and impact of SCE for health and social care students. Thematic analysis of the data was conducted using Braun and Clarke's (2006) framework to map qualitative data from these discussions. An Advisory Group was set up which provided additional advice and support to the researchers.

Data from the interviews was collated into a series of mind maps (App 3) which enabled coding of appropriate information and mapping onto the literature table (Table 3/ App 5). Each interview was recorded, transcribed, and deleted. Sentences from each interview were coded and selected for mapping against the various themes as they emerged. The data was critically analysed through continual discussion, reading and re-reading. Conclusions and recommendations were discussed in consultation with stakeholders.

## Ethical considerations

This work was commissioned by NES and participants for discussion were accessed by email to all FECs in Scotland. Those who agreed to take part in the discussions gave permission to have their interviews used for this paper. In order to protect confidentiality each interview was recorded on zoom, transcribed onto a laptop and the recording then deleted. Each interview was anonymised using codes for every piece of data and all recognisable data removed from the final paper.

### Funding

The study ran for seven and a half months working one day a week, funded by National Health Education for Scotland (NES), delegated to FiOP, with two authors to whom this work is attributed.

### Literature search

Having identified the research question to determine the extent of SCE within FECs in Scotland, a web-based search was undertaken to identify FECs which included SC in any part of their curriculum for health and social care students. The NES Knowledge Network was used to search for papers in English from 2002, apart from a single paper in 1979 which was cited by Norwegian authors when using a spiritual assessment tool.

Words for the search included Spiritual Care Education; health and social care education; religious needs; care homes; meaning and purpose; FEC; SVQ; Vocational education; nursing assistant training; health care assistant training. One of the challenges to this literature search has been finding appropriate words as virtually all papers do not overtly describe spiritual care but couch it in other terms such as 'a troubled conscience'; 'palliative care'; 'dignity'; 'death and dying'; 'positive ageing'; 'person centred care (PCC)'; values and meaning of life. Further literature was gathered through secondary referencing of papers.

### Results

During the reading of these papers emerging themes were noted to use as questions for discussions with interviewees.

The search yielded 37 papers altogether, however only 19 papers were examined in depth as these were written for research. Given the paucity of literature available on this specific subject it is important to note where these papers originate: America = 11; Norway = 3; Sweden = 3; Canada = 1; UK = 1; England 5+1 Guideline; Scottish = 4+Education 3+Guidelines 5.

*Table 2: Concentration of subjects and country of origin for SCE papers*

	SC Education	Pertaining to HCSWs	Palliative SC	Pertaining to undergraduate students
Canada		1	1	1
Norway	1	2	1	2
Scotland	1	1	1	1
Sweden		3	3	
UK	4	2	1	2
USA	5	6	2	4

Table 2 shows the concentration of subject content in four areas of the 19 papers examined, excluding guidelines, books, and reviews. Although all countries used various terms to describe non-university trained and untrained care workers, they are collectively described here for the purposes of data collection as HCSWs, the term generally used in Scotland. The USA, possibly due to a greater numerical and faith-based population, shows more research into the SC aspect of HCSWs with a lesser involvement in palliative care. Sweden on the other hand bases all three of its papers on HCSWs in palliative care. Eleven papers are based on education, but nine of the papers to a lesser or greater degree ascribe SC to end of life. While all the papers include HCSWs, some did not mention them by name but only by virtue of inclusion, ten papers focus on undergraduate students and HCSWs are mentioned as the comparison rather than the focus. It can be seen therefore that most of these papers focus on palliative care and existential ideals are rarely resourced in terms of education for HCSWs. The fact that these papers represent two continents and only five countries is testimony to the little value placed upon the work force that is employed to care for the rising numbers of people with needs in the communities of these countries.

The completed chronologically arranged table of all literature uncovered is found in Appendix 1. Fourteen themes were identified from the literature search, as recorded in Table 3. The complete Table is found in Appendix 5, showing coding of the data as patterns emerged from both literature and interviews.

*Table 3: Themes from literature search*

No.	Theme	Description
1	Use of Assessment tools	How these tools are used in education and research
2	Policies underpin the necessity of SCE	Spiritual care policies assist training and delivery but also highlight the dissonance between theory and practice
3	The 'normalness' of SC	Everyday conversation and the importance of listening
4	Inadequate SC training for HCSWs	Support staff tend not to have SC as part of core training despite having the closest contact with clients. They also lack confidence in answering existential questions because of inadequate training
5	Positive outcomes for teaching HCSWs SC	When experts guide novices, they become more courageous in addressing existential issues with positive outcomes for practitioners and carers
6	Multi-Disciplinary Teams (MDTs) include HCSWs	Policies and guidelines are inclusive of all staff when discussing who should deliver SC
7	Primary definition of SC unavailable in FEC literature and guidelines	SC language is lacking in FEC, replaced by other definitions such as PCC, respect and worth. Without a true definition of SC the theory is unable to be taught and practiced
8	Lack of SCE from the SQA	No evidence of SCE within main modules for caring or within the SSSC Code of Practice



9	SC Definitions	Many definitions of SC in literature but there remains confusion within the FEC fraternity as to what it actually means
10	Challenges to training	Without a specific SC definition both lecturers and students find it difficult to articulate learning, assessment and practical application
11	Paucity of literature	With the bulk of literature focusing on SCE in palliative care it seems that more research should be carried out in order to address the imbalance
12	Gap in National Guidelines	A token gesture in most guidelines refers to religion without describing how SC fits healthcare
13	What Matters to You	This document given to all clients in residential homes does not necessarily address the importance of the spiritual dynamic to students or clients
14	Standards of Care	There appears to be confusion over the inclusion of SC in official documents for registration and if there was, how the lecturers would address the theory

### *Literature search discussion*

As can be seen from Table 3 the results of the literature search were collated and summarised into manageable themes. It was immediately evident that the same challenges were being tabled both sides of the Atlantic and across the European community. SC teaching amongst HCSWs was superficial, despite the recognition that they have limited prerequisites for their role (Beck et al 2014), the shortest education and yet the closest contact with older people's death and dying (Beck et al 2012).

Donald Mackaskill in the Malcolm Goldsmith Lecture (2021) quoted George Macleod, who described the spiritual island of Iona as a 'thin place, where barely a sheet of tissue paper as thin as gossamer' separated the material from the spiritual. It is this definition of SC described variously by FEC interviewees as 'a slippery fish' or 'woolly' that presents a challenge to the literature when finding a single classification for SC. Literature describes it as the need to give and receive love; the need to be understood; the need to be valued as a human being; the need for forgiveness, hope; trust; the need to explore beliefs and values; the need to express feelings honestly; the need to find meaning and purpose in life (Scottish Government 2008). From a client's perspective SC is described variously as meaning; purpose and hope; relationship with God; spiritual practice; religious obligations; interpersonal connection and professional staff interactions, which is the human face of the health care system (Hodge and Horvath 2011).

However, when it comes to teaching SC only some of this language is seen in FECs. One of the Scottish Further Education Unit modules (SQA 2007) for Care Values and Principles uses

the language of respect; worth; dignity; social justice and social welfare. The needs of older clients are assessed using a five pillar model called SPECC (Social, Physical, Emotional, Cognitive and Cultural) to which Spiritual has been added more recently (SPECCS). There was no modular evidence of material for this sixth pillar and if used it was subsumed into religious care without being assessed. Baker and Dinham (2021) when searching for a definition of terms for beliefs and religion in the healthcare system, could find little that would enable theory to turn into practice. Without a specific definition of SC lecturers are left floundering in a sea of enigmatic descriptions based on government guidelines (SGHD 2008) and no academic theory. Levison's (2009) description of meeting the needs of the human spirit when faced with trauma is probably the closest to a SC definition that can be grounded in theory and practice. While each chapter of this resource is embedded in the Knowledge and Skills Framework it was noted that there were no steering group members from FECs.

Literature describes the normality of spirituality in everyday conversations (Wheatley, 2002; Levison, 2009) and it is this that should form the basis of the theory of listening. It is, says Levison (2009 p35) the 'ultimate patient-centred therapeutic activity', which Kuven and Giske (2019) researched amongst their first year student nurses. This qualitative study of 385 students across two universities studied the results of conversations about spirituality in a mandatory assignment. They concluded that despite the student's reluctance to talk of existential matters, they not only had fulfilling conversations but also discovered characteristics about themselves which helped them to understand the theory of listening. Although the subjects in this paper were university students, the study could be replicated across FECs.

Various papers cite inadequate training for HCSWs (Albinsson and Strang 2002; Larimore et al 2002; Meyer 2003; Levison 2009; Holloway et al 2011) despite the fact that they have the closest contact with the clients, limited pre-requisites for their role (Beck et al 2014) and the shortest education (Beck et al 2012). In the USA Hodge and Horvath (2011) showed from a metanalysis of literature that research shows little evidence of SC training for HCSWs, From this they were able to initiate the incorporation of spiritual assessment requirements into its accreditation standards for all healthcare workers. Without the theory of SC, HCSWs lack confidence when talking to clients about end of life issues (Beck et al 2014) and feel inadequately prepared (Roff and Parker 2003). Bulduk et al's (2017) study examined HCSWs as they cared for the elderly and recognised the essential importance of spiritual care and the need to equip them to care in a professional manner. Macer and Simmons (2019) in their Fair Work document cited the challenge that HCSWs have when needing additional training, because 'this undervalued voiceless workforce is unable to articulate' their needs. Part of this results from a lack of funding; working conditions; zero hours contract and low confidence in their own abilities (Feeley Report 2021). Not only that but insufficient training can give rise to retention difficulties and burnout from having to respond to crises for which they are ill prepared (Tornoe et al 2015). Focus groups do enhance care, as Holloway et al

(2011) noted, particularly when experts guide novices. Training results in positive outcomes for patients and empowerment for HCSWs (Lemmer 2010) and when taught with a purpose students respond positively (Kuken and Giske 2019). Larimore et al (2002) found evidence that training is immediately helpful and applicable in the workplace. However it is important that educators give students time for debriefing and reflection in order to be aware of their own well-being and work life boundaries (Levison 2009).

If SC training is a necessity, then assessment of the theory must also follow as generally students choose not to learn subjects which are unassessed. There are many SC educational assessment tools available (Stolle 1979; Levison 2009; Goodchild 2009; Baker and Dinham 2021) however a mechanistic approach can result if no training is given (McSherry and Ross 2002).

Although literature points to the need for training in SCE for HCSWs and its positive outcomes for client care, policies are required to underpin the need for such education. The Scottish Government (2002, 2008) have written guidelines for Spiritual Care in the NHS which assist training and delivery. These guidelines are based on the original paper by Larson (1996) which started the conversation to define a spiritual dimension of health for the World Health Organisation (WHO). Only recently Macaskill, Chief Executive of Scottish Care (2021) in the Malcolm Goldsmith Lecture reiterated the necessity of recognising SC as a human rights issue requiring training at all levels. Baker and Dinham (2021) have highlighted the dissonance between theoretical knowledge and the delivery of such care. But there remains a surprising gap in National Guidelines from the policies written by Government and the outworking of SC. Government policy talk of SC, but by the time the learning frameworks for HCSWs (2016) were written it seems that SC morphed into PCC and values. Health and Social Care standards (2017) again supports basic human rights without using the term SC as does the Feeley Report (2021). The Scottish Social Services Council (SSSC 2020) who set out standards of practice for all employees in social services ensure all employees, clients and employers are treated with respect and individuality, without articulating SC.

It appears that policies exist, and guidelines point towards SC without the articulation, so what constitutes the gap between writing guidelines and students needing to learn the theory enabling them to put it into practice? FECs write modules based on educational needs assessment from the SQA. Social Services Code of practice for HCSWs is the SSSC (2020) which does not describe SC and therefore the SQA has no need to ensure it is present within the curriculum. So, for instance, the SQA 2007 Unit: Understanding the needs of the Older Person which could include SCE does not mention spirituality as an influencing factor on the older person's life. Literature shows that the gap for SCE is between the educational governing body in Scotland [SQA] and the policies and guidance given by the Government. It becomes the responsibility of the SQA to ensure that SCE is embedded in the curriculum in order to address Government guidance.

It is not only the challenge presented by guidelines and consequent teaching. The multiple definitions of spirituality (Lemmer 2010) are confusing and there remains a critical necessity for organisations to define spirituality, SC, faith, and belief in order to deliver appropriate care (Baker, Dinham 2021b). Larimore et al (2002) cites unreliable evidence that decries the need for SC within clinical practice despite robust evidence to the contrary. HCSWs are often put in conflicting situations with client spiritual needs when nurses have little time to deal with deep listening (Meyer 2003), producing a revolving cycle of events: nurses have little time; HCSWs have even less time because of tasks delegated to them; HCSWs are frustrated because of lack of knowledge so return to the nurse in charge. Tools such as Values Based Reflective Practice (VBRP, National Delivery Plan 2016) are free and available to all staff but lack of available time for Continuing Professional Development (CPD) in the Social Services Sector makes this almost impossible to access.

The literature is quick to point out on several occasions, that SC belongs to all members of the MDT. Puchalski et al (2006) describes the need for the whole team to be involved in the SC of a patient receiving palliative care. Levison (2009) states that all staff have a vital role to play in SC, and as such need to receive similar training in order to offer routine SC to their patients. The responsibility for SC rests with every care worker (Holloway et al 2011) and in order to expedite this Chaplains should also form part of that MDT (Scottish Government 2008). In so doing they would be able to offer specialist knowledge to the team as a whole, offering SC to their clients without having to call upon the stretched capacity of the Chaplaincy team.

One very positive note struck by a new project co-funded by Erasmus and the European Union is that the ultimate aim of any human project is not necessarily to cure but always to care (FCTC 2021). With that in mind five universities from Ireland, Spain, Italy, and Poland met in September 2021 with a view to writing an online course on assessment and management of patients religious and spiritual needs. This was in response to the recent situation created by Covid-19 and the recognition that spiritual care needs are as important as physical aid. The paper for this project will be available in February 2022.

The following discussion is taken from mind mapping all eleven interviews from ten FECs over a period of three months during 2021.

#### *Results from interviews held with FEC staff*

While 'gap' appears a negative word to use in education the authors would like to emphasise the positive possibilities that exist to fill this gap thereby honouring what is already present in significantly wide-ranging curriculums. Nineteen sub-themes in all were noted which were condensed into the following five areas:

#### *Curriculum Gap:*

*Curriculum; Euphemisms for SC; Devolved learning of SC to Universities; Palliative care = SC; SPECC; SQA; Subjective approach to teaching; Assessment; Lecturer confidence.*

Interviewees noted inconsistencies between euphemisms used for SC, rare evidence of units which offered either religious or spiritual content and the knowledge that generally it was not part of the learning landscape. Frustration was evident, recognising that while religion in itself was not enough for a single unit, students rarely chose units that had any spiritual component.

*'Spiritual care is not a focus for the course and therefore no one would think of choosing this option. Actually I don't mean it is not a focus, it's just something that no one has thought anything about...apart from religion of course...but that's not enough to spend a unit on.'*

There was a gap in the understanding of SC, acknowledged by the interviewees, and the euphemisms used in the curriculum which described an essence of SC without actually using the word spiritual. These included person-centred care; uniqueness of the individual; holistic care; culture; respect; values; communication skills; subliminal understanding. There was an implicit understanding that spiritual care equalled religion and psychological care, but there was a lack of definition, recognition, and value of SC as a possible subject within the curriculum. One articulated this as:

*'our spiritual care overlaps between what we would do if you were looking at a holistic assessment care, between bringing in the people's personal values and...if they have got specific spiritual beliefs [religion] then to make sure that is catered for...'*

Many interviewees did see SC as a personal philosophy with professional development value particularly with regard to self-evaluation, ethical conversations, morality of care and professional boundaries. There was also a recognition that seeing the bigger picture for the greater good was an important aspect of SC.

It seemed that many of the interviewees devolved both learning of SC and the action of SC to universities and nurses. It was deemed that the higher the qualification award the more knowledge and understanding they would have to deal with such a perceived deep and grave subject. Quite often the interviewees stated that SC is only for skilled practitioners and not health or social care workers.

Palliative care frequently surfaced as holding the monopoly of SC units, but on examination these modules discussed religious rites rather than the underpinning foundations of SC. When thinking about SC one interviewee said:

*'Palliative care is the most obvious place where any of these subjects will be discussed. I don't think we do much of that [SCE] at all.'*

But there was a perception that because our death averse society cannot deal with end of life, neither can students or apparently lecturers.

Most curriculum planners use the model of assessment SPECC (SQA 2007) as described earlier. However, within each college there was a different interpretation of the way in which this model of assessment was used. Consequently, while the cultural component has a subtext of spirituality there appeared to be a default to understanding this as religion. This was shown particularly when case studies were discussed as only occasionally would religion be raised and never in relation to spiritual care. There appeared to be no depth to the spiritual component of SPECCS and although aware of this addition it was often not adopted by the colleges. This was partly due to the SQA who have a dual responsibility with the regulatory bodies as to the subject matter of the curriculum. While they introduced SPECCS there is no articulation of how the spiritual content should be approached and neither are there any proffered resources. It is therefore open to the module leader's interpretation and crucially there is no SC assessment. Without assessment there is no required learning and therefore no time on the curriculum for teaching. It seemed on listening to the interviewees that a top-down approach is required on the part of the recently disbanded SQA.

There is a somewhat subjective approach to SC education which is dependent on the lecturer's interpretation of the curriculum, tolerance, and awareness of the subject. However, it must be said that the module teams regularly discuss the options available and are very much aware of each other's strengths when putting together new units. Needless to say, because of the many options available in FECs a student's education will depend on the units chosen and where the lecturers direct them. Core units are those which surround the euphemisms for SC already mentioned, but SC itself is rarely mentioned and never taught as a subject.

From a student's point of view assessment is key to learning, however some of the lecturers were quick to point out that learning goes much deeper than reading a book. Many do assess SC even if it is not defined as such. While it does not fit the official curriculum, they felt that it was there in essence, such as PCC and valuing the individual. There is another problem with assessing a subject which is not officially taught and that is mentor signoff on placement. Most of the mentors were unaware of the SC content of SPECCS and so had no knowledge themselves of how to assess it, therefore defaulted to religious rites and the necessity of treating each person as an individual within their faith or non-faith needs.

The gap in lecturer's knowledge created an ethical dilemma of confidence, being afraid of personal bias yet not having the understanding to facilitate discussions which might lead to unanswerable questions. As one interviewee put it:

*'I don't know if a person asked me if I knew the meaning to life if I would have the right expertise, I think that questions [like that] would create an ethical dilemma for people.'*

Asking specialist lecturers to fill this gap would in general go against the multidisciplinary team approach adopted by the FECs. Some did suggest that writing SC modules with the SQA might enable lecturers but most felt they did not have this specialist knowledge.

Perception Gap:

*Perceptions; Assumptions.*

The perceptions held by many of the interviewees, the unconscious signals received by students and lecturers, give rise to long held ideas which become markers of learning. In the case of SC there is a perception that it takes too much time; there is a fear of proselytization; SC is only available in hospitals, because of the inference that the lower the academic level the less likely SC will be either taught or understood; and lastly the more task orientated a role the less likely there is a need for SC. Health care is apparently seen as clinical with a more practical element, while social care more holistic and non-physical. Crucially there was a perception that not everyone needed spiritual care, making the distinction a subjective choice on the part of the carer rather than a robust assessment:

*'It is not really needed [in the Drugs and Alcohol services], people access these services because they have reached the place where they want to come off drugs.'*

As a result of these perceptions, both lecturers and students made assumptions, something accepted as true without proof, and as a result learn and teach based on these apparent truths. For instance, it was assumed that younger students sidestep life issues; they might be upset during placement; social care doesn't need SC because of extreme health challenges and dealt more with individual needs: *'spiritual care is not something used on a daily basis'*; historical approach affects teaching *'that was long ago and spirituality wasn't an issue'* and there is a fear of inappropriateness between client and care worker if existential issues are raised. There is an assumption that because students rarely talk about SC, they cannot think deeper than surface reflections. Students build relationships to inform physical care rather than SC and dismiss religion because most in society today *'do not have a faith'*, and *'Scotland is no longer recognised as the Christian country as it once was.'* However, despite the fact that students seem empowered by challenge, lecturers still worry on their behalf that the challenge of death and dying in particular, might be too great for them to bear. Resilience was not a word used during the interviews.

Learning Gap:

*Awareness of existential issues; Challenges of learning; Dissonance between student needs and their learning.*

The interviewees were very aware of the challenges that faced their students in both learning and emotional upheaval of working with clients. Significant support was offered to all students in all of the FECs to enable debriefing and reflection on life changing

experiences that they had observed on placement. While there was a recognition that coping strategies should be taught in the classroom, a greater emphasis was placed on avoidance strategies. One interviewee observed:

*'No one talks about it [SC] – it's a bit like death, no one talks about that either...we are not equipped to deal with death, and I don't think that any of us lecturers have any specialist knowledge either.'*

Interviewees were afraid of the possibility of students being upset so the existential issues were avoided rather than faced in the security of the classroom. Many felt that because of the lack of time required for these discussions it was better left unsaid as no one asks about these deep issues and would probably, at their level of learning, not have the understanding to cope. There was a general feeling that while students were not oblivious to SC issues, social influences were being taught instead and existential questions were being avoided. Many of the interviewees were proactive in teaching emotional issues in a reflective way:

*'you cannot escape having personal reflections as well, so we do ask the students to think about their own emotional attachments to certain situations.'*

In the elderly residential sector, care home beds outnumber hospital beds, yet there is little attention paid to the spiritual care training of care workers who are essentially working with people at the end of their lives. There was consistent observation across the FECs assuming that because students are unlikely to deal with SC, training was not needed. Some interviewees did observe that if the students had more SC training, then they would become more confident and therefore more able to engage with clients at this level. One FEC had designed an innovative App called Care in your pocket, which gave guidelines for all levels of care both practical and psychological. Interestingly, the care organisations had requested that religious rites and routines were included in the App.

It appeared the majority of FECs were able to close this learning gap in terms of religious rites, but the soul needs of a client whether religious or not, were being unmet. Some of the interviewees felt that the Mental Health students were better equipped personally to deal with SC as they were allowed to discuss death and SC appeared to be embedded within the curriculum for Mental Health. However, this appeared to be articulated within a 'them and us' scenario, without recognising the advantages of collaboration.

A stumbling block for students in SC, recognised by the interviewees, was that the depth of this learning does not lend itself to online training when face to face discussion is required in small groups. Not only that, they felt senior workers had more difficulty with online training, and most modules are online – particularly during Covid. Listening skills are core modules, difficult to teach online and key for SC. One interviewee felt that students were taught 'not to' rather than 'how to' and this didactic method of learning meant that when it came to the art of SC students would find it difficult to think on their feet.



Another challenge picked up by one interviewee was that SC requires good mentors in practice and this particular expertise was rare.

*'I always think that is a starting point that marriage of [with] a good mentor, if you get a good person to guide you, like in nursing, you will become a good practitioner.'*

Another mentioned the lack of UK SC research within FECs which would underpin this specialist knowledge. SC research is much more evident in universities, hence the possible reason for lecturers feeling that SC is the domain of degree level students. It was also noted that there is a gap in UK Social and Health care partnerships, where they lag far behind that of the EU and in particular Scandinavia where much of the literature was sourced for this paper.

A final learning challenge for the students was the matter of placements and in particular faith-based organisation placements. Many students did not see the value of a placement in a faith-based organisation allowing their personal opinion to override the work amongst a particular people group. The core module for equality, respect and culture perhaps needed to deal as much with student perceptions as with the respect and value placed upon client's opinions and feelings. This was offset by one FEC who said that they sent students to a placement in a faith-based organisation which worked extremely well, due to that organisation sending workers into the college to give talks on the work they did, so there was a sense of shared learning.

### Resources Gap

None of the FECs had previously seen any of the resources sent to them from this project. As one interviewee said:

*'Noone uses SCE resource material. I don't know of the existence of any.'*

A few had been involved with or thought about the use of Death Cafes but most did not know that any such resources existed. However, there was evidence of significant student support resources in almost all of the FECs some of which was inhouse and others from local support networks. Some used different faiths, accessing community assets. Many said that if the students had any existential questions from the clients needing answered, the mentors would refer them to their employer. Although there was no knowledge of how this would be dealt with by the employer.

The interviewees were very positive about sharing resources with each other and indeed between colleges. However, there was still a very significant gap between the desire to discuss SCE and the lack of resources that were available to them, not including FiOP's own resource list. This was despite the fact that they all used resources from the RCN, NMC, SQA and SSSC.

### Covid Gap

The advent of Covid-19 has brought about scenarios that no-one had ever seen before or had ever imagined. This has impacted people's lives at all levels – as patient, client, student, or relatives. It was impossible to conduct an interview and not mention the impact that Covid-19 has had on both students and lecturers. The changes to learning meant that students were learning online and unable to practice the theory or engage with clients. As one interviewee put it:

*'For us working in health and social care, being hands on, is what makes you a practitioner not through a book.'*

The placements were all halted and without placements teaching remained theoretical based on zoom, reducing any sense of meaningful discussions. There was a lack of relationship building, both between lecturers and students, students and potential employers. In terms of SC there was less access to chaplains and so limited referrals, in fact it was the staff at the coal face, that needed to step up their listening skills and answer the difficult questions. This impact increased the anxiety of the lecturers who were concerned about the emotional coping capacity of their students.

On the positive side, it was found that there was more awareness of death and the existential side of life, normalising grief rather than avoiding or hiding it. One interviewer said that Covid-19 had brought about a new generation of listeners, partly because of more time to listen, but also and somewhat surprisingly because it was easier to talk with a mask on. One interviewee felt that the only difference Covid-19 had made to their teaching was that:

*'students are much more engaged when we talk about viruses and hygiene.'*

Students have also expressed a desire to learn more about Mental Health, despite the fact that an increased number have required in-depth counselling. Perhaps Covid-19 has brought about the natural teaching on SC in a way that the classroom never could.

#### *Proposed Actions from FECs – will there be a gap?*

The majority of FECs expressed a willingness to discuss SCE with their colleagues during curricular multidisciplinary meetings, raising the awareness of such a proved necessary element of care. Without exception all wished to receive the resources list and use it for present modules if appropriate. One interviewee felt that these resources would fit well on the E Portfolio platform. Reading papers to inform practice was a helpful action, although as already noted that there is a scarcity of UK papers on this subject, two of which have been written by the present authors.

Many commented that there should be a recognition of SC right across the curriculum as a subject in its own right with recognisable language. All agreed that there should be an

improved terminology of SC. There was also an understanding that perhaps students should be more directed in their choice of units so that they have a wider view of SC.

Two of the interviewees highlighted the need for more in-depth debriefing after placements which would specifically include the SC aspect and so adhere to the SPECCS assessment. Visiting specialists came up high on the agenda and two interviewees said that they would look carefully at including expert knowledge in the future during the module lectures. It was also suggested that rather than wait for a debriefing, a pre-course or pre-placement questionnaire might enable student reflection to mitigate anxiety or stress of the unknown. Appendix 4 shows a prototype of possible questions.

Looking beyond FECs, one interviewee felt that universities could share more of their resources, particularly in this area where there seemed to be a disparity of knowledge between what was learned in FECs and at Higher Education Institutions.

Finally, almost all the interviewees mentioned the role that the SQA plays in setting the scene for curricular activity. Given that SPECCS is used for most assessment guidelines, and that spirituality is the final component of this, it seems that the SQA should be challenged to write the guidelines for this area and provide the resources to accompany it.

### Conclusion

The conclusion drawn from this paper is the significant disparity between spiritual care guidelines which originate from Scottish Government, Health and Social Care policy makers and the Educational Qualifications agencies that guide the education of health and social care students. Not only does there appear to be a paucity of literature which enables conclusions to be drawn from Scottish SCE but there is also little evidence of SC understanding in FECs. This is in part due to lack of a definitive definition of SC and the education that surrounds it, but also a fear that SCE could become an unwelcome religious platform. Rather than maintaining that fear, education should be able to address it and allow the richness of spirituality to become a mandatory core element of a student's learning experience.

This paper recommends that a body of specialist educators is set up to write a robust training programme which would fit the SQA criteria for Health and Social Care training in spiritual care. As mentioned earlier in the paper there is already new SC training that is coming online in 2022 in five countries in Europe. A possible collaboration with other educational establishments who have already recognised the gap detailed in this paper would go some way towards enabling and empowering both lecturers and students to teach and deliver the essence of spiritual care in all health and social care settings.

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## Appendix 1

## Literature Table

Code	Reference	Discussion
1	<p>Stoll R 1979 Guidelines for Spiritual Assessment <i>American Journal of Nursing</i> Sep 79(9) pp1574-7</p> <p>USA</p>	<p>One photo shot on file of the guidelines. This is attributed to Ruth Stoll's work (1979) and takes the form of direct questioning in four main areas of SC. It is a limited tool in that it reflects a Judeo-Christian approach. However, it was used to good effect in Norway with people of faith and no faith and was found to be of significant help as a way of introducing existential issues and giving permission to speak. In that context it was not used as an assessment tool, but rather for student education in both secular and Judeo-Christian context.</p>
2	<p>Scottish Government HDL (2002) 76 Scottish Executive Spiritual Care in NHS Scotland <a href="https://www.sehd.scot.nhs.uk/mels/hdl2002_76.pdf">https://www.sehd.scot.nhs.uk/mels/hdl2002_76.pdf</a></p> <p>Scotland</p>	<p>Recommended requirement for Scottish Health Boards to develop and implement a spiritual care policy tailored to the needs of the local population. This superseded policies in 1964, 1986 and 1994 and defined chaplaincy as spiritual caregivers but not necessarily religious. The document redefined spirituality to include all religions and none, supporting patients, carers and staff in whatever capacity was required at the time. It advised NHS Boards should provide training for NHS staff in assessing spiritual need and providing spiritual care. There was no definition of the term 'NHS staff,' however the provision of spiritual care is clearly mentioned as integral to healthcare offered (para 20). Para 48 states that staff should meet spiritual needs themselves rather than acquiescing to chaplaincy. Training is seen as a normal part of professional development for clinical and non-clinical staff. Teaching by chaplaincy was given a specific number of hours pro rata from 0.5-5hours.</p>

3	<p>Wheatley M J 2002 <i>Turning to one another: Simple conversations to restore hope in the future</i>. San Francisco: Berrett-Koehler.</p> <p>USA</p>	<p>A secular book on the ideology of changing the world through normal conversations with normal people. The simple chat that starts at the kitchen table can transform a life and how we need to ensure that we engage in these chats. This is a resource for students who are engaging in patient conversations.</p>
4	<p>McSherry W Ross L 2002 Dilemmas of spiritual assessment: considerations for nursing practice <i>Journal of Advanced Nursing</i> 38(5), 479–488 (5) pp 479–488</p> <p>UK</p>	<p>Written in the early days of SC exploration, this is a literature review on SC assessment and use in practice. It states there is no UK nursing research on spirituality and little published research internationally. In the ensuing 25 years the balance has gradually been restored but little has seeped into HCSW SCE. Dilemma associated with SC assessment is definition of spirituality, who undertakes the assessment and who addresses and co-ordinates the outcomes. 30 years ago it was expected that nurses would undertake all assessments, now with reduced clinical professionals and an increased number of HCSW this is not an automatic delegation. In fact, even then the authors suggested that health care professionals should not have the monopoly in the provision and therefore assessment of SC. This article discusses the significant challenges that exist when approaching spiritual assessment and the choice of assessment tools. If indicator based tools are used, then loss of individuality and a mechanistic approach to assessment may ensue.</p>
5	<p>Albinsson L Strang P 2002 A palliative approach to existential issues and death in end-stage dementia care <i>Journal of Palliative Care</i> 18 (3) pp 168–174</p> <p>Sweden</p>	<p>The aim of this phenomenological study was to investigate how, in relation to the palliative philosophy of care, municipal staff caring for patients with dementia deal with existential issues, the dying process, and bereavement follow up with next of kin. 31 interviews showed three different approaches of HCSW to existential issues: minimized or ignored the issue; telling the patient that no one has control over life and death issues; showing affection for the patient. The conclusion drawn by the authors was that municipal care should be improved. There was no evidence of SCE being offered.</p>
5a	<p>Larimore W Parker M Crowther M 2002 Should Clinicians import Positive Spirituality into their Practices? What does the evidence say? <i>The Society of Behavioural Medicine</i> 24 (1) pp69-73</p>	<p>This paper discusses the unreliable evidence that decries SC within clinical practice. It concurs that there is frequently a positive association between SC and wellbeing; the desire of most patients to</p>



	USA	be offered SC by clinicians; the censure that most patients show clinicians for ignoring SC; the lack of training that most clinicians have in SC assessment or care; the gradual move of HEIs to provide that training; evidence that training is found to be immediately helpful and applicable in the workplace. This paper evaluates SC training positively but also shows the concerns that some researchers hold as to the ethical question of providing SC to clients. Clinicians should not, without compelling data to the contrary, “deprive their patients of the spiritual support and comfort upon which their hope, health and wellbeing may hinge”. Koenig HG, McCulloch ME, Larson DB: <i>Handbook of Religion and Health</i> . New York: Oxford University Press, 2001.
6	Meyer C L 2003 How effectively are nurse educators preparing students to provide spiritual care? <i>Nurse Educator</i> 28 pp 185-190  USA	The question the author asked in this paper was how well nurses are prepared to identify spiritual distress and provide spiritual care. One of the reasons cited for nurses unpreparedness was that of the shortfall in professional nurses which delegated personal care to ‘care technicians’ (HCSW). With limited interactions between nurse and patient, there is the need to quickly recognise and diagnose spiritual distress and then put a plan into action. This was a large survey over 12 universities involving 355 students of varying ages but all undergraduates. The questionnaire yielded 79% return resulting in students considering spiritual care to be an essential component of holistic nursing care but felt inadequately prepared, despite many resources and methods of learning available in the HEI. This paper did not include any mention of SCE of carers despite research that discovered delegated nurse care meant carers are put in the firing line of spiritual needs of patients and therefore need composite training.
6a	Roff L Parker M 2003 Spirituality and Alzheimer’s Disease <i>Care Alzheimer’s Care Quarterly</i> 4 (4) p267-270  USA	Spirituality and religiousness enable relatives of those with chronic disease, particularly Alzheimer’s disease, to better adapt to their changing circumstances. This article highlights the need for practitioners to understand the importance of spiritual care amongst

		<p>their clients. The authors point out the limitations of normal assessments which reduce spiritual care to religious rites and affiliations. Active avoidance of a clients' unmet spiritual needs is in fact the natural tendency of assessors. This is in part due to health care workers feeling inadequately prepared for such assessments. However, due to the nature of Alzheimer's disease rituals and music provide a stable memory of the past, comfort and security in a changing landscape. The paper describes a voluntary Care Team, implemented by communities of faith, who provide practical, emotional, and spiritual support to both relatives and clients. The paper recommends specialised SC training of healthcare professionals as well as further research on the building of spiritual resources which provide more effective care.</p>
7	<p>Puchalski C Lunsford B Miller T 2006 Interdisciplinary spiritual care for seriously ill and dying patients: a collaborative model <i>The Cancer Journal</i> 12: 5 pp 398-413</p> <p>USA</p>	<p>Each member of the caring team has a responsibility to provide spiritual care. While this paper specifically describes spiritual care and the palliative patient nonetheless the same principles apply to all healthcare. It stresses the absolute necessity of spiritual care particularly when someone is facing death. Paper not available for general public.</p>
8	<p>Care Values and Principles Module 2007 Scottish Further Education Unit Higher grade</p> <p>Scotland</p>	<p>The outcomes of this module enable the student to examine the caring relationship between carer and those requiring care. The main values examined are respect; worth; dignity; social justice and social welfare. The module uses this as a practical example: So, a value can be defined as 'that which is desirable and worthy for its own sake'. For example, the words of the Declaration of Arbroath, 1320, reflect a number of values.</p> <p>'It is in truth not for glory, nor riches, nor honours that we are fighting, but for freedom – for that alone which no honest man gives up but with life itself'.</p> <p>Good practice in care demonstrates agreed care values. The two core values for care are:</p> <p>the value of respect for the worth and dignity of every individual</p>

		<p>the value of ensuring social justice and promoting the social welfare of every individual (<i>Miller &amp; Gibb 2007</i>).When describing stereotypes, religious beliefs come in the long list of individual differences along with the discrimination that results from stereotyping. A task follows to enable the student to understand this process.</p> <p>The needs of people are based on 5 specific pillars: Social, Physical, Emotional, Cognitive and Cultural (SPECC). Although these are not addressed as core learning in this module.</p> <p>Wide ranging in learning across all areas of communication, values and activities that underpin the learning. Reflective practice is also used as a tool for personal evaluation.</p> <p>This is limited in that many of the Care Acts etc have been superseded by new and updated Acts. Among protected characteristics is 'religion and belief'.</p> <p>This module finishes with a helpful formative assessment.</p>
9	<p>SQA 2007 Unit: Understanding the needs of the Older Person Intermediate Level 2 course: Care Issues for Society: Older people Intermediate 2 SCQF Level 5</p> <p>Scotland</p>	<p>A generation of evidence by the student to cover various aspects of needs of older people. This includes impacting influencing factors and personal qualities used by the carer. A variety of learning methods are advised which could include many of the spiritual care education resources which are presently available in Scotland. SPECC is mentioned within patterns of development. Spirituality does not form part of the list of influencing factors on the older person's life.</p>
10	<p>Scottish Government Health Department CEL (2008) 49 Spiritual Care Spiritual Care and Chaplaincy in the NHS Scotland Published by Scottish Government <a href="https://www.gov.scot/publications/spiritual-care-chaplaincy/pages/4/">https://www.gov.scot/publications/spiritual-care-chaplaincy/pages/4/</a></p> <p>Scotland</p>	<p>Revised guidance of the SG HD CEL Spiritual Care 2002 document. The report commended the work carried out by NHS boards to implement HDL 76 2002 and the chaplaincies that were instated during the past six years. It makes the commitment to spiritual care as: 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</p>

		<p>care should always be spiritual. Spiritual care might be said to be the umbrella term of which religious care is a part. It is the intention of religious care to meet spiritual need. This document asks NHS Boards to promote research for spiritual and religious care and also continue the professional development of chaplaincy in the NHS. They were also encouraged to work with members of the multi professional health care team whenever possible. This did not necessarily include HCSW but did not exclude them as it acknowledged that spiritual care in the NHS is given by all members of staff and carers.</p> <p>7. Among the basic spiritual needs that might be addressed within the normal, daily activity of healthcare are: - the need to give and receive love - the need to be understood - the need to be valued as a human being - the need for forgiveness, hope and trust - the need to explore beliefs and values - the need to express feelings honestly - the need to find meaning and purpose in life.</p>
11	<p>Levison C 2009 <i>Spiritual Care Matters</i> National Health Education for Scotland</p> <p>Scotland</p>	<p>Intended as a resource for all those who want to teach and learn about the subject of SC. It gives a wide range of SCE resources. Quote from the intro 'SC is that care which recognises and responds to the needs of the human spirit when faced with trauma, ill health or sadness and can include the need for meaning, for self-worth, to express oneself, for faith support perhaps for rites or prayer or sacrament, or simply for a sensitive listener. Spiritual care begins with encouraging human contact in compassionate relationship and moves in whatever direction need requires.' The author reiterates that all staff have a vital role to play in SC according to Scottish government 2002, to deliver SC in its broadest sense respecting the wide diversity that exists in Scottish society. This document admits that SC is often implicitly integrated, such as within palliative care, but there is explicit evidence of learning within HEI modules, perhaps not so much in FEC. The author adds that although training is more often mentioned in nurse training 'support staff tends not to have explicit spiritual care as part of core learning.' This document was developed in part, to try and rectify this situation. Carers, he says,</p>

		<p>should be seen as more than their job title, and should be cared for through the stress of dealing with other people's trauma, so that it does not become their own. They should be respected as part of the group bringing care to others. The author advises all NHS staff to receive induction and occasional 'top up' SCE in all settings as their role is to offer routine spiritual care to their patients.</p> <p>NB – there are no steering group members from FEC.</p>
12	<p>Goodchild M 2009 The Meaning of Spirituality and Spiritual Care Within Nursing and Health Care Practice <i>Nursing Standard</i> 23 (30) pp 30</p> <p>England</p>	<p>Book by Wilf McSherry: How to research a subject as ethereal as spirituality. Reflective questions provide an opportunity to question beliefs and assumptions. Helpful when embarking on research using grounded theory and anyone with an interest in the meaning and significance of spirituality in a care environment which makes sense out of a complex and bibulous concept.</p>
13	<p>Lemmer C 2010 Reflections on Teaching Spirituality in the Healthcare Environment <i>Journal of Holistic Nursing American Holistic Nurses Association</i> 28 (2) pp 145-149</p> <p>USA</p>	<p>This paper shows how a short course of Religious Studies and Philosophy which addressed spirituality in the healthcare environment enabled healthcare workers to become empowered in their spiritual care of clients. The author cites Pesut (2003) who proffered two challenges to SCE: 'The multiple definitions of spirituality and the varying spiritual maturity level of students.' Lemmer gives two helpful tables: the Elements of Spiritual Dimension and Course Outcomes. A required reading list accompanies these tables. The course was implemented into the undergraduate programme and did not have any room for those who were of Level 4-8 learning. However, the resources used and the assessment process certainly left room for this level of learning to take place.</p>
14	<p>Puchalski C Ferrell B 2010 <i>Making Health Care Whole: Integrating Spirituality into Patient Care</i> Templeton Press ProQuest eBook Central <a href="http://ebookcentral.proquest.com/lib/nhsscotland-ebooks/detail.action?docID=740309">http://ebookcentral.proquest.com/lib/nhsscotland-ebooks/detail.action?docID=740309</a></p> <p>USA</p>	<p>Appendix A of this book gives key definitions related to Spiritual Care found in literature. Spirituality can be understood in six domains:</p> <p>Essence: The core of one's being, the source of one's humanity</p> <p>Meaning: in life which gives purpose or ultimate meaning, sacred or divine</p> <p>Transcendence: An awareness of something greater than oneself</p> <p>Relationship: Connection to self, others, God, sacred, nature</p>

		<p>Values: Beliefs, morals, standards that guide one in life  Rituals: spiritual practices, external expressions of spirituality.  The second set of definitions are based on Religion.  Thirdly, existential definitions look at relating to one’s existence, purpose, beyond the human self and a philosophical approach to a personal meaning in life.  Fourthly spiritual Well-Being is defined as a realisation of the ultimate purpose and meaning of life.  Fifthly suffering is examined as a state of distress brought about by a threat to the normal existence of the person. Pain + fear = suffering.  Sixthly spiritual care is described as pastoral; intuitive by the nurse reflecting the patient’s reality; interventions that facilitate needs; client care that is intentional in assessment.  Seventh – spiritual values are defined as meaning; hope; faith; purpose; reconciliation; social connectedness; dignity.  Eighth – spiritual distress which is the impaired ability to experience that meaning in life which one once had.  Lastly spiritual community, describing a united group of people who interact and share characteristics with relation to spiritual, cultural, ethnic, or moral values.</p>
<p>15</p>	<p>Holloway M Adamson S McSherry W Swinton J 2011 Spiritual Care at the End of Life: A systematic review of the literature <i>Review Report completed by Universities of Hull, Staffordshire, and Aberdeen to support implementation of the End of Life Care Strategy</i></p> <p>UK</p>	<p>Review covers English language literature from 2000-2010 dealing with SC in end of life care settings. It includes spiritual assessment tools and intervention models. This paper agrees that the responsibility for SC rests with every care worker. However the review did not reveal many papers on education and training of SC within the workforce. There was evidence however for a widespread need for training. SC no longer is the province of Chaplains alone but rather all health and social care providers. Despite this shift of responsibility there is little evidence of when where and how SC should be addressed. The bulk of literature involving SC was to be found within the palliative care setting. When discussing nursing and SC there seemed to be no distinction between trained nurses and HCW. Although the paper set out to make the point that SC rests</p>

		<p>with all care workers, this was not evident in the literature reviewed. The chapter on spiritual need starts discussing the skills of the worker and the carer, but this has not been defined, so it is not possible to distinguish between the nurse and the HCW and their own specific SCE needs. Spiritual needs are to be assessed but there is no guidance as to who or how that assessment is carried out. The authors noted that various practice guide documents had calls for all staff to have basic training in SC. The review showed an emphasis was required on the SCE development of the workforce but with different levels of SC competency – such as those outlined by Marie Curie Cancer Care. Again the end of this para mentioned nurses without making a distinction between HCW and Nurses. There are interdisciplinary models of SC and in particular Puchalski is mentioned. SC training appeared to have a positive effect on patients and carers.</p> <p>One recommendation was to identify gaps and complementary roles as well as an urgent need to develop policy and practice in supporting people dying at home.</p> <p>A very comprehensive guide to SC in the palliative context and with useful replicability.</p>
16	<p>Hodge D Horvath V 2011 Spiritual Needs in Health Care Settings: A Qualitative Meta-Synthesis of Clients' Perspectives <i>National Association of Social Workers</i> 56 (4) pp 306-316</p> <p>USA</p>	<p>A qualitative meta-syntheses of studies identifying and describing client perceptions of their spiritual needs in a healthcare setting. Six themes emerged: meaning; purpose and hope; relationship with God; spiritual practice; religious obligations; interpersonal connection and professional staff interactions. With regard to staff interactions it was noted that staff served as the human face of the health care system and as such clients needed friendly facial expressions, words body language, interactions that communicated dignity and respect; empathy and caring and a willingness to be the authentic facilitator between specialist and client. However, research recognises that most HCSW have little training in spirituality and so while education is key to the needs of clients, so also is the ability to conduct a spiritual assessment and so identify needs. So important</p>

		are these requirements that the American Joint commission has incorporated spiritual assessment requirements into its accreditation standards for healthcare accrediting organization.
17	<p>Beck I Törnquist A Broström L Edberg A 2012 Having to focus on doing rather than being — Nurse assistants' experience of palliative care in municipal residential care settings <i>International Journal of Nursing Studies</i> 49(4) pp 455–64</p> <p>Sweden</p>	<p>This paper is primarily aimed at palliative care HCSW and their care of the dying, making the point that HCSW have the shortest education yet the closest contact with older people's death and dying and consequent challenges concerning ethical and existential issues. The ratio of HCSW: nurses in Sweden in nursing homes is 16:1. Literature showed the discrepancy between the care needing to be delivered and the educational resources given (Albinsson and Strang 2002; Osterlind et al, 2011; Dwyer et al 2009). This also causes moral distress (Lutzen et al 2003) noted in Aird and O'Neill (2019). This was an explorative descriptive study using focus group interviews. 25 participants from three districts were selected on the basis that they had already received education in palliative care: 3x3 hr seminars of which 9 had participated. Overall the findings showed that HCSWs are task orientated, doing rather than being, creating a dilemma when managers expectations differed from their own desire to care as they saw a need. Interestingly the HCSWs felt that during the last few days of a patients' life it was the relatives that needed their support, similar to their care of the patient, but had limited training in how to meet those needs. But again it was more about practical needs rather than existential needs. This was an emotionally demanding task for which they lacked competence. HCSWs did not encourage these conversations and in fact actively discouraged this talk in order to protect themselves. Dealing with their own emotions, recognition and support of their work appeared to give them strength to carry on, yet they all stated that managers never gave them recognition. The paper concluded that more support for HCSWs was needed to provide learning on death and dying.</p>



18	<p>Ødbehr L Kvigne K Hauge S Danbolt L 2014 Nurses' and care workers' experiences of spiritual needs in residents with dementia in nursing homes: a qualitative study <i>BMC Nursing</i> 13(1) p12</p> <p>Norway</p>	<p>Qualitative study using phenomenological-hermeneutic approach in 4 care homes. In discussion it appeared that nurses and care workers needed to recognise SC before being able to know what they were offering. This is particularly evident amongst patients with dementia because of cognitive decline. Focus groups formed the sample between nurses and care workers. There was no discrepancy between nurses and care workers engagement with the focus groups, so it was not possible to surmise the difference between answers. Also nurses and care workers were referred to all as 'nurses'. Physical touch was described as calming; responsiveness and intuition gave greater sensitivity to the residents' needs; togetherness; being present; sensitivity in communication; providing meaningful activities for everyday life; facilitation of daily activities; meeting religious needs were all described as the nurses understanding of spiritual care. The nurses developed an understanding of SC through the focus groups but felt they had little theoretical knowledge. Rather SC was based on intuition and emerging from the interaction between themselves and the person with dementia. 'SC is primarily about nurses encountering a fellow human being and is secondarily influenced by social assumptions and cultural barriers.' The implications for practice: more theoretical knowledge is required, and the focus groups provided positive interdisciplinary learning. However the research did not distinguish between nurses and care workers, so difficult to separate the different levels of learning required between managers, trained nurses, and healthcare workers.</p>
19	<p>Pesut B Sawatzky R Stajduhar K McLeod B Erbacker L Chan E 2014 Educating nurses for palliative care: a scoping review <i>Journal for Hospital Palliative Nursing</i> 16(1) pp 47–54</p> <p>Canada</p>	<p>The authors conducted a scoping review to describe available evidence for providing palliative care education to nurses and nursing care providers. Out of 58 papers (2001-2011) that were reviewed only one came from Scotland and 12 from the UK. 15 of these, that is 26%, specifically described spiritual care as part of the education offered. The paper does not state whether the education offered was to HCSWs or nurses, but the overall focus of the paper is</p>

		<p>on undergraduate nurse students. An aging population requires that nurses in all areas of practice be knowledgeable about high-quality palliative care. Although there appears to be an overall positive effect of palliative education, findings from this scoping review illustrate the diversity of educational approaches and lack of rigorous study designs, making it difficult to make recommendations for an evidence-based approach to educating nurses in palliative care.</p>
20	<p>Beck I Jakobsson U Edberg A 2014 Applying a palliative care approach in residential care: effects on nurse assistants' experiences of care provision and caring climate <i>Scandinavian Journal of Caring Science</i> 28 pp 830–841</p> <p>Sweden</p>	<p>The integration of psychosocial, relationship aspects and existential care approach. The recognition that nursing assistants are the closest to clients but have limited prerequisites for their role. The conclusion was that despite leadership involvement in encouraging nurse assistants to look after their own wellbeing as well as that of the existential needs of their clients, the intervention was not sufficient to change organisational philosophy of care.</p> <p>Primarily a study on the last few days of a residents life and the communication during that time between Nursing care assistants and the client. Previous research showed the desire of clients to have someone to talk to during this time, but also the lack of confidence NCA have in dealing with existential conversations. However, research also shows that the environment of the care home and management needs to be in close alignment with the ideals of such communication in order to make it happen. Interventions provided positive outcomes and this study proposed a management intervention that would encourage and support NAs to be confident in dealing with end of life conversations and care.</p>
21	<p>Leclerc B Lessard S Bechennec C Le Gal E Benoit S Bellerose L 2014 Attitudes toward death, dying, end-of-life palliative care, and interdisciplinary practice in long term care workers <i>Journal of American Medical Directors Association</i> 15(3) pp 207–13.</p> <p>USA</p>	<p>As with many articles on palliative care this does not address spiritual care despite the significant number of participants – 1,170 care workers, clinical managers. It was a cross sectional study using an anonymous 4-point Likert questionnaire. The significant differences between nursing professionals and nursing assistants suggested that HCSWs attitudes should be considered, and that training would benefit their subsequent care. However spiritual care did not show in this study.</p>

22	<p>Tornøe K Danbolt L Kvigne K Sørli V 2015 A mobile hospice nurse teaching team's experience: training care workers in spiritual and existential care for the dying - a qualitative study <i>BMC Palliative Care</i> 14:43</p> <p>Norway</p>	<p>This study is based on research showing that a 'number of dying patients long for spiritual and existential care.' A mobile teaching unit drew alongside care workers in Norway to offer focus group discussion and bedside teaching. As a result the care workers became more courageous in addressing the issues of a dying patient. There is an increased international need to address 'existential suffering' according to these authors and therefore SCE is of prime importance with care workers who spend the greater part of their working life with palliative care patients. The challenges of teaching spiritual and existential end-of-life care are multi-complex because 'providing spiritual care is a process with no fixed answers.' Importantly for this scoping review Pesut conducted a similar scoping review to summarize available evidence concerning palliative care education for nurses and other care providers but none of the references explicitly mention training care workers in this topic. This paper employed a qualitative phenomenological hermeneutical approach, and its sample was the mobile teaching team who formed a focus group. Although this was a small sample size (3) and only used one hospice the authors point out that in qualitative studies quantity does not necessarily mean quality and therefore the richness of the conversation was more important. However, it would enable robustness to replicate this study elsewhere and not just in Norway. Three main themes emerged through structural analysis: Fear and Uncertainty; Bedside teaching; Courage and Competency. This feature of experts guiding novices through challenging existential conversations had positive repercussions on both the care workers and the practitioners.</p>
23	<p>HCSW Learning Framework Healthcare Support Worker's Guide NES 2016 <a href="https://www.supportworkercentral.nes.scot.nhs.uk/media/1044/support-workers-guide-web-2016.pdf">https://www.supportworkercentral.nes.scot.nhs.uk/media/1044/support-workers-guide-web-2016.pdf</a></p> <p>Scotland</p>	<p>Career Framework for HCSW developed by NES. Made up of four parts: Pillars of Practice; qualifications search; KSF and PDP; Induction standards. As with all career frameworks this supports a PDP discussion and so can involve any specific knowledge and skills route that the HCSW wishes to progress on. This could be useful if the HCSW wished to progress along a spiritual care route.</p>

24	<p>The National Delivery Plan for Spiritual Care in Scotland 2016-17 Scottish Government 2016</p> <p>Scotland</p>	<p>This plan revises the SG CEL (2008) 49 implementing the recommendations made in that document. There are six paradigm shifts moving from a current focus in health care to promoting well-being: empowering patient self-management and others. This is moving SC from serving the minority of the population towards serving the majority in both primary care and community settings. While this is primarily written for Spiritual care staff it recognises the need for more trained and skilled volunteers to work under their auspices. It addresses best practice of holistic care and the recognition that in addressing emotional and spiritual needs of all both service users and service providers experience greater resilience in the workplace. VBRP; CCL mentioned are available to all staff. One of the key deliveries promised in this paper is patient and carer engagement; staff care and workforce development. This has been rolled out to all health Boards in Scotland as an assets-based spiritual care service across all patients, service users and staff available 24/7. The role of Spiritual Care staff is to be an accompanying and enabling presence to those within Health and Social Care Scotland.</p> <p>Although the plan is specifically written to underpin the rationale for Healthcare Chaplaincy training it is clear that the consequential availability of spiritual healthcare would be accessible for all staff and in all healthcare settings.</p>
25	<p>End of Life Care – Fundamentals of nursing care at the end of life 2016  <a href="https://rcni.com/hosted-content/rcn/fundamentals-of-end-of-life-care/end-of-life-care-%E2%80%93-fundamentals-of-nursing-care-end-of-life">https://rcni.com/hosted-content/rcn/fundamentals-of-end-of-life-care/end-of-life-care-%E2%80%93-fundamentals-of-nursing-care-end-of-life</a> RCN publication</p> <p>UK</p>	<p>These guidelines have been written for all healthcare workers. Chapter on Culture and Spirituality: main message is communicating with people about what is important to them. The care that is given is shaped by the spiritual and religious beliefs that each person holds dear. Having a conversation with someone enables the carer to understand and support them. Two conversational clips are available about the importance of the spiritual dynamic to the patient in the last weeks of their lives.</p>

26	<p>Person-Centred Approaches: Empowering people in their lives and communities to enable an upgrade in prevention, wellbeing, health, care, and support. A core skills education and training framework 2017 <a href="https://www.skillsforhealth.org.uk/images/pdf/Person-Centred-Approaches-Framework.pdf">https://www.skillsforhealth.org.uk/images/pdf/Person-Centred-Approaches-Framework.pdf</a></p> <p>This framework was upgraded in 2020 with a ten year plan.</p> <p>England</p>	<p>This training framework has been written by Health Education England and has been made widely available to aid workforce development in person centred approaches. There is a section on core communication and conversational listening skills</p> <p>Essentially this is a manual for trainers and could possibly be used in FEC but is more at the professional end of the career structure.</p>
27	<p>Bulduk S Usta E Dinçer Y 2017 The Influence of Skill Development Training Program for Spiritual Care of Elderly Individual on Elderly Care Technician Students' Perception of Spiritual Support <i>Journal of Religious Health</i> 56 pp 852–860</p> <p>USA</p>	<p>Spiritual care means helping an individual protect, maintain, and gain all the dimensions of his/her existence. Elderly care technicians face numerous cases or crisis situations in which elderly individuals from different backgrounds question the meaning and value of life. Elderly care technicians must acknowledge that the spirituality is an important element in the way an elderly individual receives health care, and they must be equipped for this matter. This study was conducted in order to examine the influence of "Skill Development Training Program for Spiritual Care of Elderly Individual," which was carried out with students from an elderly care program, on the perception of spirituality support in a pretest–post-test quasi-experimental study design with control group. The data collection form, "Spiritual Support Perception" (SSP) scale was used. A statistically significant difference was found between the mean scores of the intervention group from the pretest and the post-tests immediately after the training and one month after the training (<math>f = 94.247, p = 0.001</math>). In the control group, however, there was no significant change in the SSP mean scores (<math>f = 0.269, p = 0.77</math>). As a result, this study pointed out the necessity of such training programs for healthcare professionals to make a distinction between their professional duties and their own personalities in order to offer spiritual care to the elderly individual.</p>
28	<p>Health and Social Care Standards My Support My Life 2017 <a href="https://www.gov.scot/publications/health-social-care-standards-support-life/">https://www.gov.scot/publications/health-social-care-standards-support-life/</a></p>	<p>These standards replaced the National Care Standards from 2002 allowing the public to see what to expect when accessing health and social care in Scotland. 'They seek to provide better outcomes for</p>

	<p>Published by Scottish Government</p> <p>Scotland</p>	<p>everyone; to ensure that individuals are treated with respect and dignity, and that the basic human rights we are all entitled to are upheld.’</p> <p>The headline outcomes are: 1: I experience high quality care and support that is right for me. 2: I am fully involved in all decisions about my care and support. 3: I have confidence in the people who support and care for me. 4: I have confidence in the organisation providing my care and support. 5: I experience a high quality environment if the organisation provides the premises</p> <p>The Standards are underpinned by five principles: dignity and respect, compassion, be included, responsive care, and support and wellbeing.</p> <p>In terms of those aspects that apply particularly to spiritual care:</p> <p>Wellbeing • I am asked about my lifestyle preferences and aspirations, and I am supported to achieve these. • I am encouraged and helped to achieve my full potential. • I am supported to make informed choices, even if this means I might be taking personal risks. • I feel safe, and I am protected from neglect, abuse, or avoidable harm.</p> <p>1.1 I am accepted and valued whatever my needs, ability, gender, age, faith, mental health status, race, background, or sexual orientation.</p> <p>1.2 My human rights are protected and promoted, and I experience no discrimination</p> <p>1.12 I am fully involved in assessing my emotional, psychological, social and physical needs at an early stage, regularly and when my needs change.</p> <p>1.23 My needs, as agreed in my personal plan, are fully met, and my wishes and choices are respected</p> <p>1.29 I am supported to be emotionally resilient, have a strong sense of my own identity and wellbeing, and address any experiences of trauma or neglect.</p>
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29	<p>Kuven B Giske T 2019 Talking about spiritual matters: First year nursing students' experiences of an assignment on spiritual conversations <i>Nurse Education Today</i> Vol 75 April pp 53-57</p> <p>Norway</p>	<p>This paper is included as many HNC or HND students take the Access to Nursing course and will become first year student nurses. It also gives a wide overview of the use of SC conversations in practice when giving permission to the client to speak about existential issues. In this paper the authors report that nurses are insufficiently prepared for SC in practice. This qualitative study gave 385 students from two universities in Norway a compulsory assignment to carry out a spiritual conversation, using Stoll's guidelines for spiritual assessment, with another person and reflect on it in relation to nursing. Three main categories emerged: meeting oneself, beyond one's comfort zone and discovering the other. Findings discovered the dichotomy between SCE teaching and SC practice. Further research is needed to raise student awareness of SC however, given the plethora of studies and guidelines that are available, it appears that what is missing is not the research but the act of teaching SC. The main challenge students found was not theory but in the act of the conversation about spiritual matters with another person when they had never considered such matters personally and they also considered the conversation private and personal. This paper is extremely helpful in discovering good conversations regardless of the discipline: One student wrote, 'I also thought it was nice to see how this person brightened up when I asked, almost a bit like: It's going to be so lovely to finally talk deeply with someone, and that made a big impression on me.'</p>

30	<p>Fair Work in Scotland's Social Care Sector 2019 Prepared by the Fair work Convention Co-Chairs Lilian Macer Henry Simmons  <a href="#">Fair-Work-in-Scotland's-Social-Care-Sector-2019.pdf</a></p> <p>Scotland</p>	<p>202,090 WTE staff employed in the social care sector. This report was written to answer some of the concerns raised over the social care workforce and their pay and conditions. The overall findings were that this undervalued voiceless workforce are unable to articulate their own concerns about poor practice and fair work dimensions. The support and development of teams is continually at risk because managers are firefighting unpredictable work schedules and the challenge of zero hours contracts. This means that there is no time for CPD or basic training. Accessing training presents a challenge to a mainly older female population who struggle to obtain the necessary qualifications and so leave. Employers are challenged to find funding for training and when they do workers rarely access it.</p>
31	<p><i>SSSC Codes of Practice for Social Service workers and Employers -</i>  <a href="https://www.sssc.uk.com">https://www.sssc.uk.com</a> accessed 3 March 2021 Scottish Social Services Council 2020  Revised in 2016 republished in 2020</p> <p>Scotland</p>	<p>The Scottish Social Services Council (SSSC known as Triple SC) Codes of Practice set out the standards of practice and behaviour expected of everyone who works in social services in Scotland.</p> <p>For Employers:</p> <p>4.6 Put into action written policies and procedures that promote the wellbeing and equality of workers and respect diversity.</p> <p>4.8 Make sure that where care has or may have caused physical, emotional, financial, or material harm or loss, this is reported to the appropriate authorities.</p> <p>For Employees:</p> <p>1.1 Treat each person as an individual.</p> <p>1.4 Respect and maintain the dignity and privacy of people who use services.</p> <p>1.5 Work in a way that promotes diversity and respects different cultures and values.</p> <p>The above are those qualities that are nearest to SC without articulating the language.</p>
32	<p>Feeley Report 2021: Independent Review of Adult Social Care in Scotland  Published by Scottish Government</p>	<p>This review took place during the pandemic over a period of three months, from a variety of care backgrounds, with over 1,000 people views, all of whom required care and support at different levels. The</p>



	<p><a href="https://www.alliance-scotland.org.uk/blog/resources/independent-review-of-adult-social-care-in-scotland-engagement-report/">https://www.alliance-scotland.org.uk/blog/resources/independent-review-of-adult-social-care-in-scotland-engagement-report/</a></p> <p>Scotland</p>	<p>message from staff was that they suffered from burnout which came as a result of having too often to respond to a crisis for which they were ill prepared. Being undervalued, despite their necessary role gave rise to lack of support and training; inadequate assessments because assessors do not have sufficient training to understand individual circumstances (p14). This often caused retention difficulties. A large section is given (p80) to valuing the work force and recommendations for training and development without medicalising the training.</p> <p>The review stated that culture, values, and behaviours need to be respected at all levels in social care. The desire of the present SNP government is to create the National Care Service as a way of enabling all the recommendations in this document to be put into effect. It appears that this will, along with the NHS, report to Scottish Ministers and manage care in all settings including prisons. One of the key guiding principles is taken from the World Economic forum: The dignity of the human person, whatever their race, gender, background, or beliefs. It is to be hoped that these values will be seen at the coal face of social care with both staff and clients. Although SC is a basic human right it does not appear in this document.</p>
33	<p>THE MALCOLM GOLDSMITH LECTURE 2021 The fullness of humanity: human rights and spirituality Dr Donald Macaskill – Chief Executive of Scottish Care</p> <p>Scotland</p>	<p>Main points of this lecture covered: The human rights and spirituality 'clash'; The religious roots of human rights; The modern human rights movement; The individual and the communitarian; Human rights in social care practice; Towards a spirituality of human rights. Key moral principles and ethical framework of the modern human rights movement is rooted in a shared heritage with religious and spiritual belief systems. The Scottish Church leader and founder of the Iona Community, George MacLeod, used to describe the island of Iona as a "thin place" – where barely a sheet of tissue paper "as thin as gossamer" separated the material from the spiritual. It was an image borrowed from the broader Celtic idea that there are places where the spiritual and the divine is experienced more nearly than</p>

		others. Elsewhere George MacLeod describes these locations as “the eternal seeping through the physical.”
34	Williams H Carroll J 2021 Church of England to work more closely with Further Education colleges <i>Church Times</i> 5 May  England	This report was published on the back of a vision to engage church and education. Chaplaincy, pastoral support, and community networks are ideally placed to bring to life skills development, social mobility, and national prosperity by serving the common good in tackling poverty and social injustice. The statistics are interesting: 244 FE colleges in the UK, catering for 2.2 million students; 11,000 staff and a collective budget of 6.9 million. A collaborative engagement between church and colleges could form long lasting relationships on both sides which would enable and empower communities.
35	Baker C Dinham A 2021 <i>Religion and Belief in Health and Social Care Assessments with Service Users</i> Published by Goldsmiths University of London Arts and Humanities Research Council  <a href="https://www.gold.ac.uk/media/documents-by-section/departments/research-centres-and-units/research-units/faiths-and-civil-society/Religion-and-Belief-in-Health-and-Social-Care-Assessments-with-Service-Users.pdf">https://www.gold.ac.uk/media/documents-by-section/departments/research-centres-and-units/research-units/faiths-and-civil-society/Religion-and-Belief-in-Health-and-Social-Care-Assessments-with-Service-Users.pdf</a>  England	Standards benchmarks and ethical codes all agree that religion and belief are upheld in person centred care. However, in practice, there is a dissonance between theoretical knowledge and delivery of such care. Although the paper does not define ‘Social Workers’ there is a recognition that all health and social care workers have a responsibility to provide spiritual care which includes religious needs. This paper is primarily written for the inclusion of religious beliefs in care, defining equality as equal care for all regardless of personal circumstances. However, spirituality delivery encompasses all possible inequalities, transcending every area of life digging down deep into the soul of needs. Crucially this paper which conducted a metanalysis of literature concerning beliefs and religion in healthcare education, did not find a definition of terms that enabled theory to turn into practice. It underlines the importance of giving clients permission and space to ask deeper questions. It also addresses the use of tools for practitioner reflection using The Furness and Gilligan Framework (2010).
36	Baker C Dinham A 2021 <i>A Religion and Belief Literacy Framework</i> Published by Goldsmiths University of London Arts and Humanities Research Council	This paper outlines four key groups of questions for Social Workers and carers to ask of themselves when considering their organisation’s care of all peoples. Religious literacy has a history in American sociology of the 1950s but is essentially an understanding

	<p><a href="https://www.gold.ac.uk/media/documents-by-section/departments/research-centres-and-units/research-units/faiths-and-civil-society/Religion-and-Belief-Literacy-Framework.pdf">https://www.gold.ac.uk/media/documents-by-section/departments/research-centres-and-units/research-units/faiths-and-civil-society/Religion-and-Belief-Literacy-Framework.pdf</a></p> <p>England</p>	<p>of the religious institutions that exist globally and to use that understanding when communicating with others, particularly in this context of care. It is critical for each organisation to define and categorise religion, faith, or non-faith, understanding the precepts by which they can work. Religion and belief literacy is contemporarily described as a stretchy and fluid concept.</p>
37	<p>Caribbean and African Health Network</p> <p><a href="https://www.cahn.org.uk/">https://www.cahn.org.uk/</a></p>	<p>Improving health and well-being amongst Caribbean and African people in Manchester and beyond.</p>

*Appendix 2*

Interviews for Scoping Review February - June 2021

Spiritual Care Education for Health and Social Care students in FECs, Scotland

**Each interview will maintain anonymity for both interviewee and the name of the FEC in question when writing up the scoping paper and disseminating information. The interviews are recorded on zoom, transcribed, and then deleted.**

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.’

Interview guidelines for areas of inquiry:

*A. The meaning and value of life:*

1. How are health and social care workers equipped during training to deal with the meaning and value of life to themselves and their clients?
2. How would your students understand the meaning of spiritual care to their clients?

*B. Spiritual Care Education in the curriculum*

1. Can you tell us about the spiritual care education component in your curriculum?
2. What methods of learning do you employ to deliver spiritual care education?
3. How are your students taught to make a distinction between their professional duties and their personal views in order to offer spiritual care to the client?

*C. Assessment and competency*

1. How does your curriculum assess spiritual care education during training?
2. Do you use any of the spiritual care client 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

3. Where does spiritual care fit into the present competency framework for SVQ training?

*D. Spiritual Care Educational Resources*

1. Are there any educational resources that you use which have a spiritual care approach?
2. If so, what is the driver for choice of spiritual care educational resources?
3. We have a register of these resources if you would like us to send them to you.

*E. Further thoughts on Spiritual Care Education in Colleges*

1. Having thought about Spiritual Care Education during this discussion can you tell us of any other thoughts you might have on the subject?
2. In what way you think that the Coronavirus pandemic has increased the need for an existential component to the curriculum?

References

Mowat H Swinton J The Purple Bicycle Project 2018 Available at:

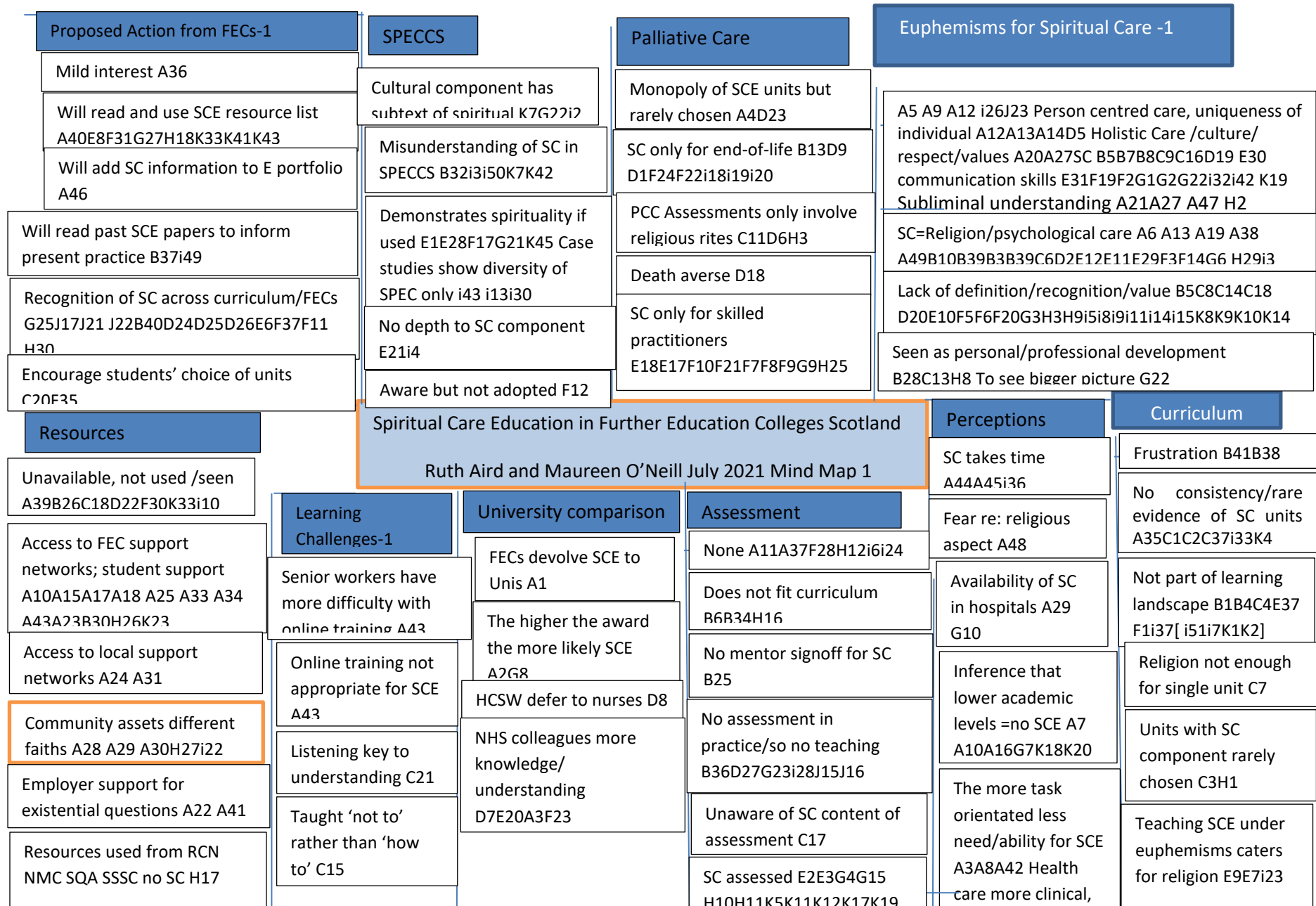
[https://www.abdn.ac.uk/sdhp/documents/TPBP\\_Booklet\\_1.pdf](https://www.abdn.ac.uk/sdhp/documents/TPBP_Booklet_1.pdf)

Aird R O'Neill M 2020 A scoping review into Spiritual Care Education in Scottish Universities

<https://mk0faithinoldervar11.kinstacdn.com/wp-content/uploads/2021/01/Scoping-Review.pdf>

Appendix 3

Mind mapping all data from interviews with Scottish FECs



Lecturer Confidence	Covid-1	SQA	Assumptions-1	Mental Health
No expertise/knowledge creates ethical dilemma of confidence E14 E34K6 F15	Grief has been normalised D17H20	Top-down approach required B35H14H32i40J5K36K39K40	Younger students sidestep life issues B11G12H7	MH students better equipped personally D12D13i17i27i38
Specialist lecturers against MDT Approach E16J13YetJ14K5	Without placements teaching remains theoretical/reduces discussion D3E33F32G17G16	Dual responsibility with regulatory bodies G26i35	Possibility of being upset during placement B27	Allowed to discuss death D15
Afraid of personal bias E30	Less access to chaplains/ limited referrals F22	Resources directed by SQA but not articulated in SPECCS G19i34i12	Social Care doesn't need SC because of extreme health challenges C19F25	SC embedded in MH F4J4
	Staff needed 2 step up E23i47	Require no element of SC H13J3J7K35	Historical approach affects teaching D11E26	<b>Awareness of existential issues</b>
	More time to listen/easier to talk with mask on E24E25	Open to interpretation but accreditation needed H15K38	Social care deal more with individual needs -SC D10F36	Emotional upheaval/not addressing it B27
	More awareness of death/exist qs F34 i48H21H23		Fear of inappropriateness D14E15	Recognition of need to address coping strategies B29B31K22
	Lack of relationship building G18			
<b>Learning Challenges-2</b>	<b>Dissonance of HCSWs and SCE</b>	<b>Spiritual Care Education FECs Mind Map 2</b>	<b>Subjective Approach</b>	
SCE requires good mentors in practice G13	^numbers of care workers -no training F26	Ruth Aird and Maureen O'Neill July 2021	Dependant on lecturer interpretation/tolerance/ awareness B6B2J12	No one asks about issues/no discussion/no understanding C5C10C12E27E13
^care home beds yet SC non-existent J18	Students unlikely to deal with SC F26	<b>Care in your pocket App</b>	Students' education depends on units chosen F5	Social influences taught but not exist. Qs D16
Lack of UK research J1	Need for training - more confident more able i45K21	Guidelines for HCSWs religious care i1	Healthcare practical Social care different level F38F39	Students not oblivious to SC F13K24K15K16
UK partnerships far behind EU J2		Care organisations requested religion in App i44		
Practical placements in faith-based org K26				

**Euphemisms for SC - 2**

Self-evaluation, ethical conversations, morality of care, prof boundaries seen as SC K27K28K29K30K31

**Spiritual Care Education FECs Mind Map 3**

Ruth Aird and Maureen O'Neill July 2021

**Assumptions-2**

Scotland not religious F14

Students engage in physical tasks F18

Students rarely talk about SC F29  
Students rarely think deeper than surface D21

That students build relationships to inform care G11

Students dismiss religion H28i24

Students empowered by challenge, but lecturers still worry H31

	<b>Action from FECs-2</b>
<b>Covid - 2</b>	Share resources with universities K44
Impact on students H19H24	Improve SCE terminology G5 i39K3
Covid increased desire to learn more about MH F33	Improve gap in visiting specialists G14J14J18J19J20
More in-depth counselling H22H26	Raise awareness at planning meetings G24 G27J6J9K34
Lecturers anxious about students coping i46	Placement debriefing highlighting SC i21
	Challenge SQA i41J8
	arer's/nurses discussion



During the writing of this paper the authors identified a gap before the commencement of training enabling the carers/nurses to understand why they have chosen this career and what they are going to do with the emotions which will inevitably become apparent when caring for those who are dependent on others for their survival; for those who are dying; for those who find themselves struggling for better mental health. The questions which may arise in their minds are probably of an existential nature and the answers they seek are both subjective and individual.

It seemed useful to put together a set of questions which could be of value during the introductory stage of a health and social care course which would form the basis of a discussion group.

1. What made you chose this particular course?
2. Is there anybody that you know who is a carer that you would like to emulate?
3. What is it about this person that you admire?
4. Have you ever been in a situation before where you were caring for another person?
5. What is it that motivates you to care?
6. Scenario of caring.....
7. Imagine yourself as the carer in this situation.....
8. How would you feel if you were put in this situation?
9. Now imagine yourself as the client.....
10. How would you want to be cared for?
11. What kind of things could you do for this person that would make them feel better even if the situation was not able to be changed?
12. What would prompt you to act, or not to act?

These questions may enable potential carers/ nurses to address issues in their own lives before trying to care for similar situations in other people's lives.

#### Appendix 5

Table 2 is the completed version within the body of the text which charted and coded the data as patterns emerged. The Lit code corresponds with the literature table in App 1 and the FEC code corresponds with data gathered through interviews.

*Table 2: Themes from literature search*

Lit Code	Description	FEC Code
1	Theme 1: <u>Use of SC assessment tools</u> Educational Assessment tool	
11	Educational tool	
12	Tool for research into spirituality	
29	Spiritual Care Assessment tool used as an educational tool.	B36: Student/assessor understanding D27: Lack of assessor direction
4	Challenges of mechanistic approach to assessment if no training	G23:SC integrated into assessment J15: Learning to pass exams
15		J16: Teaching to pass exams

29 35 6a	<p>Necessity for SC assessment of patients – no guidance on who assesses. Compulsory assessment in Norway resulted in student awareness of own spirituality and deep need of patient conversations. Recognition of students during assessment showed them the gaps in their learning and understanding of SC.</p> <p>Assessment for practitioner reflection. Limitations of assessments for clients with Alzheimer's.</p>	<p>i28: Enabling self-development K15: Worldview bias</p> <p>K24: Confidence to deliver their learning</p> <p>F13: SCE within curriculum not taught</p>
2 33 35	<p>Theme 2: <u>Policies underpin necessity of SCE</u> Spiritual care policy to assist training and delivery. Spiritual care and therefore training, integral to healthcare</p> <p>The necessity of recognising that SC is a human rights issue and therefore should be an integral part of all learning.</p> <p>Policies serve to highlight the dissonance between theory and practice</p>	<p>H13: Generic Verification by SQA; SSSC</p> <p>J3: Need to assess SC learning J7: Need for specialist lecturers K35: Need for writing modules for SC H15: Interpretation of policies/SQA K38: Specialist writing policies for SC</p>
3 29 11	<p>Theme 3: <u>The 'normalness' of SC</u> Everyday conversation between carer and client can lead to SC.</p> <p>Theory of conversations taught then applied. Listening is the 'ultimate patient-centred therapeutic activity'</p>	<p>J17: Accidental SC made intentional</p> <p>C21: 'I understood because I listened' E24: More time to listen during covid E25: Easier to speak with mask on</p>
5 5a 6 11 15 6a 16 17 20	<p>Theme 4: <u>Inadequate SC training for HCSWs</u> HCSW approach to existential issues: minimized; abdication of answers; showing affection. Conclusion: care should be improved.</p> <p>Lack of training most clinicians experience during learning.</p> <p>Inadequate training</p> <p>Support staff tend not to have SC as part of core training, but it is advised as well as CPD for all NHS staff.</p> <p>Evidence of widespread need of training for all health and social care providers Various documents call for all staff to have basic training in SC.</p> <p>Interdisciplinary models of training for SC. Avoidance of client's unmet spiritual needs due to feelings of inadequacy of HCSWs.</p> <p>Research shows little evidence of SC training for HCSWs.</p> <p>HCSWs have shortest education yet closest contact with older people. HCSWs actively discouraged existential conversations in order to protect themselves.</p>	<p>F26: Undervaluing role of HCSW</p> <p>i45: Informal education does not include SC</p> <p>K21: Different levels of maturity require different teaching</p> <p>J18: Using assets-based model of learning B27H31: Need help with emotional fallout i46: Lack of placements mean inadequate emotional preparation C15: Taught not to rather than how to D18: Death averse society</p>

<p>21</p> <p>27</p> <p>30</p> <p>32</p> <p>22</p> <p>15</p> <p>13</p> <p>29</p> <p>5a</p>	<p>HCSW are closest to clients but have limited prerequisites for their role. HCSW lack confidence in talking to clients particularly during the last days of life. Leadership encouraged selfcare and existential needs of clients but not enough to change organisational philosophy of care. HCSW should have their attitudes considered and their subsequent care would benefit from training. Training necessary for staff to understand distinction between professional duties and their own personalities in order to offer SC. Lack of funding for HCSWs and even if funding is found, work conditions are not always conducive to learning environments: zero hours contract and low confidence in personal ability. Insufficient training gives rise to retention difficulties; being undervalued so not receiving appropriate support; having to respond to crises for which they are ill prepared, so suffering from burnout; inadequate patient assessments.</p> <p>Theme 5: <u>Positive outcomes for teaching HCSWs SC</u> SC Focus groups do enhance HCSW care: When experts guide novices, they become more courageous in addressing existential issues with positive outcomes for practitioners and carers. Addressed fear and uncertainty; bedside teaching; courage and competency. SC training has a positive effect on patients and carers. Training of HCSW results in empowerment and confidence in delivery of SC. There is a need for greater resilience and when taught the theory students respond positively. Evidence that training found to be immediately helpful and applicable in the workplace.</p>	<p>K26: Student bias against some placements E23: Is time made available for care? A43: Senior workers more difficulty with online training E20D7: Disparity between nurses and HCSWs. i47: Anxiety from lecturers that students not well prepared</p> <p>A2A3: Different awards recognise SC more tangibly</p> <p>G8: Expectation of lecturer for level of emotional understanding D8F23: Deferring to nursing colleagues, stress if not available</p> <p>A48: Perception of fear of proselyting if SC is addressed through charitable placements that are faith based K16: SC relevant in service user's life</p>
<p>7</p> <p>10</p> <p>2</p> <p>11</p> <p>15</p> <p>24</p> <p>34</p>	<p>Theme 6: <u>Multi-Disciplinary Team (MDT) includes HCSWs</u> SC belongs to MDT – everyone's responsibility. Chaplaincy encouraged to work with MDT SC given by all members of team. Spiritual caregivers for all religions and none All staff have a vital role to play in SC Responsibility of SC rests with every care worker Recognises the need for spiritual care to be available to all staff Church of England recognise the need to involve all community in the FEC education and care of others and wish to engage in this.</p>	<p>A28A23: Perception of in-house SC A29: Perception of visiting ministers A30: Perception of community involvement H27H26i22: Positives of community involvement A29: Perception and reality differ G10: No knowledge of community assets or MDT working A15F38F39: Higher the award more likely SC A10A16A17: Assessment involves MDT G7K18K20: No expectation of lower grade MDT working</p>

		K23: Expectation of MDT support
8	Theme 7: <u>Primary definition of SC unavailable in FEC literature and guidelines</u> Lack of SC language in FEC Module, uses respect; worth; dignity; social justice and social welfare as necessary values of care. 5 specific pillars of learning: Social, Physical, Emotional, Cognitive and Cultural (SPECC). Cultural now includes spiritual	A5F14i11F20C14C18H3: Perception that SC is religious rites or emotional needs i26H9: SC not defined by students i2i3i5i8i9K7K45E1E2F17i12: Confusion over understanding SPECC G22G21G3: Recognition of importance of SC without words C8: SC not a focus
26	Lack of SC language in framework but does allude to PCC	i14i15J23K8K9K10K14E3E10F5F6D5B5B6: Lack of definition for lecturers
28	Lack of SC language in health and social care standards	A9A12A13A14: Using individuality to understand rather than spirituality
31	Lack of SC language in the primary document for all Social Service Workers and Employers which uphold HCSWs registration.	
35	No consistent definition of religion and belief terms to enable theory to turn into practice.	
9	Theme 8: <u>Lack of SCE from the SQA</u> No evidence of SCE within the main intermediate Level 2 SQA for older people	H13: Wording from SQA generic, so no definition of spiritual
31	No evidence of SC within the document that SQA is preparing workers for registration – the Triple SC Code of Practice.	J3: No assessment for SC from SQA J7: No specialist writers for SQA in SCE K35G19: Need for SCE within SQA modules but lack of subject definition i34: Governed by SQA so little scope for manoeuvre
10	Theme 9: <u>SC definitions</u> Spiritual care umbrella term for which religious care is a part. Spiritual care defined as the need to give and receive love; the need to be understood; the need to be valued as a human being; the need for forgiveness, hope; trust; the need to explore beliefs and values; the need to express feelings honestly; the need to find meaning and purpose in life.	A21A27A47A19B39H2H29D2: Recognition that SC is not just religion A6A13A38A49B10E11E29F14G6i3: Confusion between spiritual and religious when defining SC – both students and lecturers
11	Further definitions of SC: repeats the above adding needs of the human spirit when faced with trauma, ill health; to express oneself; faith support.	C6F3: Defining SC as religion means placing little value in educating students in this subject
14	Delivery of SC – encouraging human contact in compassionate relationships.	E12: Religion given value and respect
16	Key definitions from literature. SC as defined by clients: meaning; purpose and hope; relationship with God; spiritual practice; religious obligations; interpersonal connection and professional staff interactions (the human face of the health care system).	
33	Descriptions from George Macleod which articulate the very thin space between the spiritual and the physical.	
	Theme 10: <u>Challenges to training</u>	

13 4 29 6 18 36 5a	<p>Multiple definitions of spirituality</p> <p>Varying spiritual maturity of students (in undergraduates)</p> <p>Little spirituality definition</p> <p>Need for compulsory assignment in order to teach students that they did not have the necessary skills to navigate existential conversations.</p> <p>Lack of time to learn about SC – nurses delegate to HCSW, despite learning available to them in HEI – HCSW put in firing line of patient SC needs, without learning.</p> <p>HCSW needed to recognise SC before being able to know what they were offering. Focus groups enabled intuitive care but not theoretical knowledge.</p> <p>Critical necessity for organisations to define faith, belief, and spirituality in order to deliver appropriate care.</p> <p>The existence of critical papers decrying the need for SC.</p>	<p>G3H3H9i14i15C14C18E10K8K9: Lack of definition</p> <p>K10 K14: SC a ‘hidden layer’</p> <p>B11G12H7: Lack of maturity equates to lack of SC understanding and being overly emotional</p> <p>B36G23: Need assessment to gain understanding of student learning</p> <p>A45: Covid impact</p> <p>D8: HCSWs defer to nurse colleagues</p> <p>i11: Growing recognition that SC needed</p> <p>A44: Overwhelming workload</p> <p>B5i28i36i8i9J15J16: No focus, no assessment so becomes ‘woolly’</p> <p>D24D27: Gap in understanding</p> <p>C8: Practical units more important than SC- not used on a daily basis</p> <p>F5F6: Not taught, not valued</p> <p>F20: Emotional care valued</p>
19 15	<p>Theme 11: <u>Paucity of literature</u></p> <p>Worldwide only 15 papers over a 10-year period were able to describe SCE offered to palliative care students and these were UGs.</p> <p>Bulk of literature focuses on palliative care</p>	<p>J1: Lack of Literature sends message to FECs</p> <p>B13: SC only needed in palliative situations</p> <p>D9F24F22: HCSWs rarely placed in palliative care settings; defer to nursing colleagues</p> <p>D1: HCSWs given optional units for palliative care</p> <p>i18i19i20: Higher level units might discuss SC in conjunction with death and dying</p>
23 28 30 32	<p>Theme 12: <u>Gap in National Guidelines</u></p> <p>Scottish Career Framework for HCSW: support for PDP which could include SC but does not articulate it.</p> <p>Health and Social Care Standards support human rights for all clients which could include SC but does not articulate it.</p> <p>Fair Work in Scotland calls for funding and CPD amongst HCSWs which presently does not exist at a mandatory level.</p> <p>Recommendation from Feeley report for training and development without medicalising the training. The guiding principle of this document is the dignity of the human person as regards race, gender, background, or beliefs.</p>	<p>None of the interviewees mentioned SC in conjunction with national guidelines</p>
24 25	<p>Theme 13: <u>What matters to you</u></p> <p>Calls for creating greater resilience in the workplace through VBRP and other tools.</p>	<p>A18A25A33A34A43B30H26K23: Student selfcare and support</p> <p>A23: Employer support</p>

29 36	Guidelines for all staff to communicate with clients what matters to them. Introduces the importance of the spiritual dynamic to patients. Shows the necessity of the spiritual dynamic to both students and patients. Understanding belief literacy PCC.	A10A15A17: Students taught reflective practice to encourage recognition of client support
28 31	Theme 14: <u>Standards of Care</u> Standards of care uphold human rights to experience no discrimination and to experience confidence in those who are the carers. Code of Practice ensures appropriate treatment of individuals respecting all differences in values and culture, without articulating spirituality.	K1aK39H13H14: Quality assurance of awarding body ensures module leaders response, SC cited as a gap in a required skill C17G19: Confusion as to whether SSSC and standards of care mentions SC