Towards nursing competencies in spiritual care
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Document Version
Publisher's PDF, also known as Version of record

Publication date:
2008

Link to publication in University of Groningen/UMCG research database

Citation for published version (APA):

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An Instrument to measure Nursing Competencies in Spiritual Care: validity and reliability of the Spiritual Care Competence Scale (SCCS)


Submitted
Abstract

Aim. The purpose of this study is to develop and determine the validity and reliability of the Spiritual Care Competence Scale (SCCS) as a tool to measure nurses' competencies in providing spiritual care to patients.

Background. According to nursing literature, care for patients’ spiritual needs and/or problems is an aspect of nurses’ patient care. Acquiring the relevant competencies to provide spiritual care is indicated as an essential professional skill. Measuring these competencies and their development is therefore important and the construction of a tool was thus recommended.

Method. Students from two bachelor level nursing schools in the Netherlands (N=197) participating in a cross-sectional study were assessed. Construct validity was evaluated by factor analysis and internal consistency was estimated with Cronbach’s alpha and the average inter-item correlation. In addition, the test-retest reliability of the measure was determined at a 2-week interval between baseline and follow-up (n=109).

Results. In this study an instrument (Spiritual Care Competence Scale) was developed, consisting of six core domains of spiritual care-related nursing competencies. These domains were labelled as: assessment and implementation of spiritual care (Cronbach’s alpha 0.82), professionalization and improving quality of spiritual care (Cronbach’s alpha 0.82), personal support and patient counselling (Cronbach’s alpha 0.81), referral to professionals (Cronbach’s alpha 0.79), attitude towards patient’s spirituality (Cronbach’s alpha 0.56) and communication (Cronbach’s alpha 0.71). These subscales showed a good internal consistency, sufficient average inter-item correlations and a good test-retest reliability.

Conclusion. Testing the psychometric properties of a tool for measuring nursing competencies in spiritual care among a nursing student population demonstrated valid and reliable scales for measuring nurses’ spiritual care competencies. The psychometric quality of the instrument was satisfactory.
Introduction

In nursing literature, the need to educate nurses in spiritual care and the measurement of the effects of such education is widely recognized (Highfield & Amenta, 2000; Stranahan, 2001; Strang et al. 2002; Ross, 2006). With regard to competencies related to spiritual care in the field of nursing, there is a call for the testing of already existing competency profiles and relevant frameworks to determine to what extent they contribute to caregivers’ ability to provide spiritual care (McSherry, 2006).

One question to be answered is surely exactly which competencies nurses are expected to acquire so as to provide spiritual care, and how these can be assessed. This article describes a research study investigating the development of a tool for measuring nursing competencies for spiritual care. Spiritual care in nursing concerns the care nurses deliver relative to the religious and existential needs of patients, including their questions and experiences of meaning and purpose (Jochemsen et al. 2002). Competencies in spiritual care refer to a complex set of skills employed in a professional context, that is, the clinical nursing process. A competence is defined as the ability to perform a task with desirable outcomes. It integrates the cognitive, affective and psychomotor domains of nursing practice (Meretoja et al. 2004). More than one author describes the nature and content of nursing competencies for spiritual care (Van Leeuwen & Cusveller, 2004; Baldacchino, 2006). Several studies describe the use of an assessment tool for spiritual care. All studies describe the effects of the education and training of nurses in the area of spiritual care. Table 1 provides an overview of these studies and the assessment tools they considered.

We can distinguish between different measures developed to assess the effects of training in the area of spiritual care. On the one hand, some measures include aspects which do not seem relevant in relation to the measurement of a set of competencies, such as the frequency of the spiritual care given, the content of the training programme and items evaluating the programme’s adequacy (Highfield et al. 2000; Meyer, 2003). On the other hand, there are items concerning the opinions or attitudes of health professionals toward spirituality and spiritual care (Meyer, 2003) and these elements can be seen as relevant aspects of spiritual care.
competencies. Furthermore, there are studies of factors that may influence the provision of spiritual care itself, such as the burden of the disease on the patient or the level of fear of death, the extent to which patients have adapted their lives to the disease and the nurse’s compassion for the patient (Wasner et al. 2005).

### Table 1  
Tools to measure the effects of education and training in spiritual care

<table>
<thead>
<tr>
<th>Title, Authors</th>
<th>Items considered</th>
<th>Scale</th>
</tr>
</thead>
</table>
| Spiritual Care Perspectives Scale (SCPS)  
Highfield et al. 2000 | • Frequency of providing spiritual care  
• Ability to provide spiritual care  
• Comfort level while providing spiritual care  
• Training/education in spiritual care (checklist)  
• Adequacy of training  
• Influence of people living with cancer/terminal illness on spirituality | Rating 1–5  
1=rarely or never  
5=every day (except item 4) |
| Student Survey of Spiritual Care (SSSC)  
Meyer, 2003 | • Spiritual care is an essential component of holistic nursing care  
• Spiritual wellbeing is an important part of health promotion  
• I have sufficient knowledge to conduct a spiritual assessment  
• I am able to identify spiritual distress  
• I am not interested in the topic of spirituality  
• I feel adequately prepared to provide spiritual care  
• I respond to spiritual distress by listening and being concerned  
• I feel spirituality is a personal matter that should not be discussed with the patient  
• I respond to spiritual distress by asking the patient and/or his or her family whether they have any special practices they use to express their spirituality | Rating 1–6  
1=strongly disagree  
6=strongly agree |
| Numeric Rating Scale (NRS)  
Wasner et al. 2005 | • Quality of life  
• Compassion for the dying  
• Compassion for oneself  
• Attitude towards one’s family  
• Fear of dying  
• Fear of death  
• Satisfaction with work  
• Work meaningful  
• Attitude toward colleagues  
• Work-related stress | Rating 0–10  
0=not at all  
10=very much |
To us, the origin of these instruments remains unclear and their psychometric properties have not been evaluated. As these tools measure at the item level, the reliability or internal consistency of single items cannot be evaluated. Items were not analysed by exploratory factor analysis used to detect the underlying dimensions of spiritual care competencies. Meyer (2003) gives a reliability coefficient of .84 for her 9-item scale. However, the absence of indices of psychometric quality for these assessment tools raises questions about their validity and reliability. In all the above-mentioned studies the students’ spirituality was assessed with the assumption that this may also serve as a predictor of the capacity to provide spiritual care. For these purposes, existing tools were used (Paloutzian and Ellison, 1982; Idler, 1987; Howden, 1992; Cella, 1997; Reed, 1991).

This study focuses on an instrument’s psychometric aspects in measuring nursing spiritual care competencies. The tool developed for this purpose was based on the nursing competency profile described by Van Leeuwen & Cusveller (2004). This profile is based on an extensive literature review. Baldacchino (2006) confirms these competencies in a study performed among nurses. In their competence profile, Van Leeuwen & Cusveller (2004) distinguish spiritual care competencies that focus on the role of the self in delivering spiritual care, spirituality as part of the nursing process and the nurses’ contribution to quality assurance and promotion of expertise within the healthcare institution.

The question we are addressing is whether a reliable and validated assessment tool for measuring the spiritual care competencies of nurses can be developed on the basis of this competency profile. This issue was elaborated into the following research questions for our study:

1. What is the construct validity of the chosen assessment tool (SCCS) to measure the nurses’ spiritual care competencies?
2. What is the internal consistency of such an instrument?
3. What is the test-retest reliability of the instrument?
Method

Design: cross-sectional study.

Subjects: a sample was used comprising third and fourth-year nursing students from two bachelor level nursing schools (n=197).

Measures: The questionnaire contained 35 questions concerning spiritual care competencies derived from the nursing competency profile as developed by Van Leeuwen & Cusveller (2004). Students were asked to indicate on a 5-point Likert scale how they estimated their own level of competency in spiritual care. For example: ‘Helping the patient continue his daily spiritual customs and rituals’, with the response options 1=strongly disagree – 5=strongly agree.

Procedure: the data were collected in January 2006. Respondents completed the questionnaire independently, in their classrooms under the guidance of field workers. Permission to conduct the study in the schools was obtained from the schools’ management. Students received written information about the study prior to participation and gave informed written consent.

Analyses: items belonging to the six hypothesized dimensions of competencies with respect to spirituality were explored with factor analysis. To reduce the set of items to a smaller set of variables with common characteristics based on underlying dimensions, principal component analysis (PCA) with Varimax rotation was performed. Communalities (the proportion of a variable’s variance shared by two or more variables), Eigen values (the proportion of variance by one factor), scree plots (graph-plotting of each factor showing the relative importance of each factor), explained variance and component loadings were examined to determine the factor structure. A scree plot indicated six dimensions. Items were selected according to the following criteria:

1. A factor loading >.50 on the hypothesized factor and <.30 on the other factor were set as evidence.
   A component is a group of linear combinations of items all indicating the same underlying construct. This criterion was considered appropriate in this study in order to create homogeneous and robust scales.
2. Items with dual factor loadings >.40 were eliminated from the factor analysis. Thus, where an item loaded inconsistently on one factor this was considered to be a violation of the assumption that the item should contribute exclusively to the hypothetical factor or construct.
Reliability was examined with the Cronbach’s alpha internal consistency coefficient for each dimension of the scale. A Cronbach’s alpha ≥.70 was considered sufficient (Streiner & Norman, 2003). However, since the alpha coefficient is dependent on the number of items in the scale, a high internal consistency reliability estimate can be obtained by either having many items, highly intercorrelated items, or a combination of the two (Clark & Watson, 1995). Thus, Cronbach’s alpha is essentially a function of two parameters: the number of scale items and the mean inter-item correlation (MIIC) among the items (Cortina, 1993). Whereas the degree of item intercorrelation is a straightforward indicator of internal consistency, the number of items is not meaningfully related to the internal consistency of a construct. According to the guideline produced by Briggs & Cheek (1986), the MIIC should fall within an optimal range of between .20 and .50 but should not be less than .15 (Clark & Watson, 1995; Taylor et al., 2003). Therefore, taking the upper value of the range MIIC ≥ 0.25 seems reasonable. In estimating the internal validity of the scales, the following criteria were used:

1. Cronbach’s alpha coefficient between ≥.70 (Nunnally & Bernstein, 1994) and ≤.90 (Streiner & Norman, 2003) were considered as indicators of a reliable scale.
2. MIIC ≥ 25 was considered as a sufficient level of internal consistency or reliability. Scales with a lower mean inter-item correlation were removed.

To determine the instrument’s stability, the test-retest reliability was determined by means of a t-test in a different sample (n=109).

Approval from an ethics committee was not necessary. The research was not burdensome or risky. The directors of the nursing schools consented to the performance of this research in writing. The students were informed about this research on paper and they were asked to participate voluntarily. They were told that they could withdraw from the research at any time in the process.

Translation procedure
The translation of the 27 Dutch items in the ultimate questionnaire into English was carried out by forward-backward translation (Jones et al., 2001) performed by a native speaker from the Groningen University Language Center. It was concluded that most of the items were translated in such a way as to leave no meaningful semantic differences between the Dutch and the English versions, though a few
items needed to be discussed with the researchers involved in this study and the translators in order to clarify minor differences. Some item descriptions were modified to attain a greater degree of familiarity among those items belonging to the same domain. The current English version of the questionnaire is a valid instrument that accords with the original Dutch version (see Appendix A).

Results

All of the questionnaires returned (n=197) were suitable for this study. The mean age of the respondents was 20 (SD 1.3, min. 18, max. 30).

From the explorative factor analysis, six spiritual care competency dimensions can be derived. These six dimensions explain 53% of the total variance. They were identified under the following labels: assessment and implementation of spiritual care, professionalization and improving the quality of spiritual care, the personal support and counselling of patients, referral to professionals, the attitude towards the patient’s spirituality, and communication. Out of the original 35 items, 27 were included in the final version of the measure. Table 2 shows the six dimensions (subscales) with their respective related items, the factor loading per item, Cronbach’s alpha, and the mean inter-item correlation (MIIC) of each dimension.

The ‘assessment and implementation of spiritual care’ dimension refers to the ability to determine a patient’s spiritual needs and/or problem, and to the planning of multidisciplinary spiritual care. This includes written intra and inter-professional communication of spiritual needs and spiritual care. The ‘professionalization and improving the quality of spiritual care’ dimension contains the activities of the nurse aimed at quality assurance and policy development in the area of spiritual care. It refers to contributions to the institutional level that transcend the primary process of care, and with which the nurse also contributes to the promotion of professional practice. The ‘personal support and patient counselling’ dimension was seen as the heart of spiritual care, with items operationalized in terms of interventions. They indicate the actual provision and evaluation of spiritual care with patients and their relatives. ‘Referral to professionals’ is the dimension relating to cooperation with other disciplines in healthcare that take responsibility for spiritual care, for which
Table 2  Principal component analysis of nursing competencies for spiritual care

<table>
<thead>
<tr>
<th>Nr.</th>
<th>Dimensions and items</th>
<th>Loading</th>
<th>CA</th>
<th>MIIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Oral nursing reports on the spiritual functioning of the patient</td>
<td>.82</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Written nursing reports on the spiritual functioning of the patient</td>
<td>.78</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Documenting the nurse’s contribution to spiritual care in the patient’s care plan.</td>
<td>.68</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Coordinating spiritual care in multidisciplinary consultation</td>
<td>.57</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Coordinating spiritual care in dialogue with the patient</td>
<td>.55</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Oral and written reporting of the spiritual needs of the patient</td>
<td>.52</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Professionalization and improving the quality of spiritual care</strong></td>
<td><strong>.82</strong></td>
<td><strong>.43</strong></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Policy recommendations to management regarding spiritual care</td>
<td>.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Contributing to professionalism and expertise in spiritual care</td>
<td>.70</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Coaching healthcare workers in providing spiritual care</td>
<td>.70</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Implementing quality improvement projects in spiritual care</td>
<td>.63</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Contributing to quality of care regarding spiritual care</td>
<td>.62</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Addressing work related problems in relation to spiritual care</td>
<td>.55</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Personal support and patient counselling</strong></td>
<td><strong>.81</strong></td>
<td><strong>.41</strong></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Helping the patient to continue his daily spiritual customs and rituals</td>
<td>.72</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>Providing spiritual care to the patient</td>
<td>.71</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>Providing information to the patient regarding facilities for spirituality and spiritual care in the healthcare institution</td>
<td>.69</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>Addressing questions regarding spirituality to the patient’s relatives</td>
<td>.68</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>Attending to the patient’s spirituality during daily care</td>
<td>.68</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>Evaluating spiritual care with the patient and the team</td>
<td>.58</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Referral to professionals</strong></td>
<td><strong>.79</strong></td>
<td><strong>.56</strong></td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>Referring the patient with spiritual needs adequately to another healthcare worker</td>
<td>.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>Assigning spiritual care adequately</td>
<td>.64</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>Knowing when to consult chaplaincy</td>
<td>.61</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Attitude towards patient spirituality</strong></td>
<td><strong>.56</strong></td>
<td><strong>.25</strong></td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>Being open to (other) spiritual beliefs in patients</td>
<td>.70</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>Not forcing personal spirituality upon patients</td>
<td>.64</td>
<td></td>
<td></td>
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</tbody>
</table>
the chaplaincy is mentioned explicitly as a core discipline. Personal factors relevant to providing spiritual care, furthermore, were placed under the ‘attitude towards patient spirituality’ dimension. This dimension revealed a poor Cronbach’s alpha, but the inter-item correlation indicates a homogeneous scale. Lastly, contact and communication between nurse and patient are essential aspects of spiritual care. This surfaces as a separate dimension in the factor analysis and was designated as the ‘communication’ dimension. Eight items did not correlate with the underlying hypothesized construct and were removed from the original list of 35 items.

The principal component analysis with Varimax rotation provided evidence of the multidimensionality of SCCS. The Pearson correlation coefficients ($r$) between the components were calculated using summated respondent scores on the individual scale components and the proportion of linearly explained variance ($r^2$) between components, were estimated by squaring (Table 3). Although only the associations between communication, referral and caring were trivial due to random error, the other ten statistically significant correlations were appraised as weak. However, the associations between professionalization, assessment and referral were appraised as substantial (with proportions of explained variance $>0.20$) indicating that those regarding spiritual care as being a significant part of care delivery and health policy are more likely to evaluate, implement and refer spiritual care to those with more expertise in this field. A similar result was found in appraising the association between the attitude towards assessment, evaluation and referral to more skilled professionals, indicating that those who tend to assess and report a patient’s spiritual needs and implement spiritual care in the organization are more likely to refer patients with spiritual needs to professionals with professional religious or spiritual expertise.
The test-retest procedure (Table 4) revealed a statistically significant difference between baseline and follow-up for the ‘professionalization and improving the quality of spiritual care’ subscale. However, the importance of these changes over time was found to be trivial according to the Cohen (1988) thresholds (ES ≤ 0.20).

Table 3  Scale components correlations (r) and linearly explained variance (R²) between components

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>I Assessment</td>
<td>.51 (.26)</td>
<td>.39 (.15)</td>
<td>.48 (.23)</td>
<td>.16 (.02)</td>
<td>.21 (.04)</td>
<td></td>
</tr>
<tr>
<td>II Professionalization</td>
<td>.43 (.18)</td>
<td>.47 (.22)</td>
<td>.20 (.04)</td>
<td>.14 (.02)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>III Spiritual support</td>
<td>.40 (.16)</td>
<td>.12 (.01)</td>
<td>.17 (.03)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV Referral</td>
<td>.11 (.01)</td>
<td></td>
<td>.21 (.04)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>V Communication</td>
<td></td>
<td>.30 (.09)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VI Attitude</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

Table 4  Test-retest reliability analysis at 2-week time interval

<table>
<thead>
<tr>
<th></th>
<th>Baseline Mean(SD)</th>
<th>Follow-up Mean(SD)</th>
<th>P-value</th>
<th>Effect Size</th>
<th>95% CI (ES)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment and implementation of</td>
<td>19.95 (3.19)</td>
<td>19.77 (2.94)</td>
<td>0.53</td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>spiritual care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professionalization and improving</td>
<td>16.24 (3.54)</td>
<td>16.89 (3.64)</td>
<td>0.03</td>
<td>0.18</td>
<td>-0.09 0.45</td>
</tr>
<tr>
<td>quality of care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal support and counselling of</td>
<td>19.40 (2.84)</td>
<td>19.63 (2.78)</td>
<td>0.37</td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral to professionals</td>
<td>9.38 (1.87)</td>
<td>9.39 (1.72)</td>
<td>0.95</td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>Attitude towards patients spirituality</td>
<td>15.25 (1.65)</td>
<td>15.20 (1.78)</td>
<td>0.83</td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>8.02 (0.95)</td>
<td>7.88 (0.92)</td>
<td>0.16</td>
<td>ns</td>
<td></td>
</tr>
</tbody>
</table>
After completing the psychometric analysis, additional interviews were performed with individual students (n=8) to clarify the content of the ‘attitude towards patient’s spirituality’ subscale. Although the psychometric outcomes of this subscale were satisfactory, obtaining more insight in the students’ considerations through self-assessment on this dimension might be helpful in promoting the validity and reliability of this subscale. The students were selected at random. Written transcripts of the interviews were analysed. The results of the interviews showed that students had different interpretations of the items according to their ‘attitude towards patient’s spirituality’. Some interpreted them mainly from their own, usually religious, frames of reference and asked themselves to what extent they would be able and prepared to interact in the support of patients of other faiths or convictions, such as Muslims. Other students approached the items from a wider perspective than merely their own convictions and asked themselves what could be expected from a nurse in a professional sense. Some students made an immediate connection with one or more specific themes within the realm of spiritual care, such as praying with a patient, euthanasia or interacting with other faiths. Others wrestled with the fact that they wanted to see how their own faith might influence the relationship with the patient. From this perspective, for instance, they had difficulties with ‘not forcing one’s own religion or faith upon another’ item. They thought this item had been formulated with a negative connotation and found it difficult to score themselves. These students admitted that they had given a socially acceptable answer. Lastly, students indicated how certain items, such as showing respect, being open or not imposing their own faiths, seemed to overlap, so that they tended to give the same scores.

Other factors that were mentioned and may have influenced scores on these items related to the availability of clinical experience. Recent experience in nursing practice, especially in mental health, was clearly relevant to the scores on the scale. After having had such experience, students tended score themselves lower in the interview than they did previously when filling out the questionnaire. Students without clinical experience scored themselves on the basis of their own opinions of the spirituality theme acquired through classes and literature. From the interviews it also became clear that students tended to give themselves scores regarding spiritual care on the basis of their own ways of dealing with spiritual experiences and issues in their personal lives. Some described themselves as being open-minded and proactive towards others, while other students did not feel very comfortable...
with the topic, spirituality being a personal matter and something they found difficult to communicate about with others.

Conclusion and discussion

On the basis of this study a valid and reliable tool (SCCS) could be developed for the measurement of nursing competencies in spiritual care. It consisted of the following dimensions: assessment and implementation of spiritual care, professionalization and improving quality of spiritual care, personal support and patient counselling, referral to professionals, attitude towards patient spirituality, and communication. According to this study’s research questions we conclude that the subscales of the SCCS show a strong construct validity and internal consistency. The test-retest procedure demonstrated a significant difference between baseline and follow-up for the ‘professionalization and improving the quality of spiritual care’ subscale. However, the importance of these changes over time was trivial according to the psychometric thresholds. The SCCS is suitable for measuring nursing competencies on a group level in the education or training of students and nurses in institutional teams, for instance. It can also serve as a tool for the further research into nursing care competencies. In general, the items relating to attitude were too abstract and vague, causing respondents to read their own operationalizations into them.

Nurses’ attitudes towards a patient’s spirituality as a component of spiritual care is regarded as an important aspect of nursing competency (Van Leeuwen & Cusveller, 2004; Baldacchino, 2006; McSherry, 2006). Studies have shown that the way a nurse relates to his or her own spirituality is an important predictor of the quality of the spiritual care he or she will provide (Highfield et al. 2000; Meyer, 2003; Wasner, 2005). The interviews performed as part of the present study support this conclusion. The students’ individual interpretations of the ‘attitude towards patient’s spirituality’ subscale items seemed to have played an important role in creating more diversity in responses on these items. The other derived subscales of the tool pertain to more instrumental aspects of the competency (assessment, quality control and communication skills). During their training students possibly acquired a more uniform understanding of such items, whereas aspects of attitude touch upon the personality of the particular nurse. The confrontation with spirituality
involves the nurses’ personal beliefs and convictions. We are inclined to conclude that the students’ own convictions about spirituality played an important role when filling out the questions, especially where aspects of attitude are concerned. The same applies to the degree to which students already had some clinical experience with patient spirituality. This study shows how recent, often intense experiences during internships influence how students score themselves. This is in line with Meyer (2003), who found that clinical experience leads to a reassessment of values, especially those involved in spiritual care. This would explain why Highfield et al. (2000) and Wasner et al. (2005) included items in their assessment tools that refer to aspects of nurses’ attitude, for example, what it means for the nurses’ attitude to care for patients with cancer or a terminal condition, or on their deathbed. Some of the students interviewed indicated that clinical experiences during internships particularly influenced their scores, as after the experience they saw themselves as being less competent. This will then be a systematic factor leading to differences in scores, as students from the same year may be in different stages of their development when it comes to such aspects of attitude. In any event, the items corresponding to aspects of ‘attitude’ allow too much room for respondents to read their own personal opinions and experiences into the questionnaire.

Relevance for practice

The SCCS can be used for practical, educational and research purposes to assess students’ and fully qualified nurses’ competencies in the provision of spiritual care at a group level. Assessment can provide information about the areas in which nurses should receive training to become competent. The tool can be used in follow-up research on nursing competencies in providing spiritual care. Despite the fact that the instrument has primarily been developed on the basis of sources in nursing (literature and students), it is interesting to consider to what extent the instrument is sufficiently generic to be of use in other healthcare disciplines (physicians, paramedics or social workers for example). Recent literature suggests that spiritual care may also be a task required of other healthcare workers (McSherry, 2006). Therefore, we recommend the SCCS also be tested in disciplines other than nursing.
Limitations

The instrument was tested on a homogeneous group of Christian nursing students. They did not represent the total population of nursing students. It would be interesting to study the scores of non-Christian respondents. Clinical and life experiences may also be important predictors of nurses scoring on competence in delivering spiritual care. Such experience, in general, remains limited among nursing students. Therefore, another topic for further research would be to determine how more experienced nurses would score the items and what this might mean for the quality of the instrument. The above-mentioned limitations require further research into the SCCS in order to eliminate the effects of selection and information bias and limiting factors to strengthen the validity and reliability obtained thus far.

Contributions

Study design: RvL, LJT, BM, HJ, DP; Data collection: RvL; Statistical analysis: BM, RvL, LJT; Manuscript preparation: RvL, LJT, BM, HJ, DP

This study is part of the Ethics of Care research group research programme of the Ede Christian University headed by Henk Jochemsen.
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### Appendix: Spiritual Care Competence Scale

1 = completely disagree/2 = disagree/3 = neither agree or disagree/4 = agree/5 = fully agree

#### Attitude towards patient spirituality

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1) I show unprejudiced respect for a patient’s spiritual/religious beliefs regardless of his or her spiritual/religious background

2) I am open to a patient’s spiritual/religious beliefs, even if they differ from my own

3) I do not try to impose my own spiritual/religious beliefs on a patient

4) I am aware of my personal limitations when dealing with a patient’s spiritual/religious beliefs

#### Communication

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5) I can listen actively to a patient’s ‘life story’ in relation to his or her illness/handicap

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

#### Assessment and implementation of spiritual care

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7) I can report orally and/or in writing on a patient’s spiritual needs

8) I can tailor care to a patient’s spiritual needs/problems in consultation with the patient

9) I can tailor care to a patient’s spiritual needs/problems through multidisciplinary consultation

10) I can record the nursing component of a patient’s spiritual care in the nursing plan

11) I can report in writing on a patient’s spiritual functioning

12) I can report orally on a patient’s spiritual functioning
### Referral

13) I can effectively assign care for a patient’s spiritual needs to another care provider/care worker/care discipline

- 1 - 2 - 3 - 4 - 5

14) At the request of a patient with spiritual needs, I can in a timely and effective manner refer him or her to another care worker (e.g. a chaplain/the patient’s own priest/imam)

- 1 - 2 - 3 - 4 - 5

15) I know when I should consult a spiritual advisor concerning a patient’s spiritual care

- 1 - 2 - 3 - 4 - 5

### Personal support and patient counselling

16) I can provide a patient with spiritual care

- 1 - 2 - 3 - 4 - 5

17) I can evaluate the spiritual care that I have provided in consultation with the patient and in the disciplinary/multi-disciplinary team

- 1 - 2 - 3 - 4 - 5

18) I can give a patient information about spiritual facilities within the care institution (including spiritual care, meditation centre, religious services)

- 1 - 2 - 3 - 4 - 5

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

- 1 - 2 - 3 - 4 - 5

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

- 1 - 2 - 3 - 4 - 5

21) I can refer members of a patient’s family to a spiritual advisor/pastor, etc. if they ask me and/or if they express spiritual needs

- 1 - 2 - 3 - 4 - 5

### Professionalization and improving the quality of spiritual care

22) Within the department, I can contribute to quality assurance in the area of spiritual care

- 1 - 2 - 3 - 4 - 5

23) Within the department, I can contribute to professional development in the area of spiritual care

- 1 - 2 - 3 - 4 - 5

24) Within the department, I can identify problems relating to spiritual care in peer discussions session

- 1 - 2 - 3 - 4 - 5
Chapter 6

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<td>25) I can coach other care workers in the area of spiritual care delivery to patients</td>
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<td>26) I can make policy recommendations on aspects of spiritual care to the management of the nursing ward</td>
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<td>27) I can implement a spiritual-care improvement project in the nursing ward</td>
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