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# **The demand for competencies in spiritual care in nursing and midwifery education: a literature review**

*A demanda por competências em cuidado espiritual na educação em enfermagem e obstetrícia: revisão de literatura*

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## **Abstract**

Spirituality is embedded in nursing and midwifery practice and within the role of nurses and midwives. As a result, spirituality is an important element in nursing and midwifery education and practice, an area which has largely been ignored, in spite of the constant call of Professional Bodies for spiritual care competence in the provision of holistic care. This review aimed to analyze the existing literature and research to define competency and identify the key issues around the demand for competencies and education in spiritual care in nursing and midwifery. A search for articles in English was carried out using various search engines, using keywords: 'competence, competency,

definition, nursing, midwifery practice'. The findings showed that consensus on the definition of competency is still inconsistent. The majority of literature acknowledges the dimensions of knowledge, skills and attitudes which support the three components in Bloom's Taxonomy namely, the cognitive, affective and psychomotor domains. Competence in spiritual care is guided by Benner's theory: *From novice to expert*. Key issues were identified explaining the demand for competence in spiritual care such as, the complexity of spirituality and spiritual care which requires formal integration of spiritual care within the curricula by incorporating both the 'taught' and 'caught' perspectives of teaching and learning. Assessment of competence in nursing/midwifery education demands the formulation of generic and specific competencies oriented towards knowledge, skills and attitudes towards spiritual care. Thus, further research is suggested to develop a framework of competencies to be achieved by undergraduate and post-graduate students.

**Keywords:** Competences. Spiritual care. Nursing and midwifery education.

## **Resumo**

A espiritualidade está inserida na enfermagem e na prática obstétrica, bem como nas funções das enfermeiras e parteiras. Como resultado, a espiritualidade é um elemento importante na educação e prática da enfermagem e da obstetrícia, áreas que têm sido amplamente ignoradas a despeito da constante demanda das associações de profissionais por competência espiritual na provisão de acompanhamento holístico. Este estudo tem como objetivo analisar a literatura e pesquisa existentes para definir competência e identificar questões chave acerca da demanda por competências e educação no acompanhamento espiritual no âmbito da Enfermagem e da Obstetrícia. Utilizando-se diversos mecanismos de busca, foi realizada uma busca nos artigos em língua inglesa a partir das palavras-chave "competence", "competency", "definition", "nursing" e "midwifery practice". Os resultados demonstram a inconsistência na definição de competência. A maior parte da literatura disponível reconhece as dimensões de conhecimento, habilidades e atitudes que fundamentam os três componentes da taxonomia de Bloom — os domínios cognitivo, afetivo e psicomotor. A noção de competência no acompanhamento espiritual é guiada pela teoria de Benner, exposta em *From novice to expert*. Questões centrais foram identificadas para explicar a demanda

por competência no acompanhamento espiritual, como a complexidade da espiritualidade e do acompanhamento espiritual, o que requer a integração formal do cuidado espiritual ao currículo pela incorporação tanto de perspectivas de ensino e aprendizagem “ensinadas” quanto de perspectivas “apreendidas”. A avaliação de competências da educação em Enfermagem/Obstetrícia requer a formulação de competências genéricas e específicas orientadas ao conhecimento, às habilidades e às atitudes em relação ao acompanhamento espiritual. Assim, sugerem-se futuras pesquisas para desenvolver um quadro teórico de competências a ser alcançado por estudantes de graduação e pós-graduação.

**Palavras-chave:** *Competências. Acompanhamento espiritual. Educação em Enfermagem e Obstetrícia.*

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## Introduction

Competence has always been a principal aspiration within nurse education but there has been a marked transformation in recent years in the definition and its interpretation. Benner (1982) introduced the concept from novice to expert and defined nursing competency as the ability to perform a task with desirable outcomes under the varied circumstances of the real world and placed competence in the middle of the continuum ranging from: novice to advanced beginner, to competent, to proficient, to expert. Competent practitioners are consciously able to plan their actions, but lack the flexibility and speed (BENNER, 1984). The practitioner is described as ‘tolerably good but less than expert’ because when practitioners are considered competent, they would still have something more to achieve (ERAUT, 1994) for them to reach the level of proficiency and expertise (BENNER, 1984).

Spiritual care competence is defined as an active ongoing process characterized by three interrelated elements which involve a growing awareness of one’s value, developing an empathic understanding of the client’s world view and the ability to implement individualized

interventions appropriate to each client (HODGE, 2004). Similar to Benner's (1984) continuum from novice to expert, spiritual competency is placed on a continuum which ranges from spiritually negative to spiritually competent practice (MANOLEAS, 1994). This competence continuum is characterized by a set of knowledge, skills and attitudes that can be developed over time through education and practice.

## **Aims**

Define competency oriented towards the nursing and midwifery undergraduate education.

Identify key issues around the demand for competencies and education in spiritual care.

## **Method: selection of the literature**

A comprehensive search for the literature oriented towards competency in spiritual care was carried out using various search engines, such as BioMed Central, Medline, Pubmed, CINAHL, PsycINFO, SocINDEX and Cochrane database of systematic reviews. A combination of keywords were used: 'competence, competency, definition, nursing and midwifery practice, spirituality, spiritual care'. Articles published in English between (1982-2013) yielded numerous research based articles, books and grey literature. Using the Hierarchy of Evidence criteria, rigorous research and literature reviews were selected, supported by informative grey literature.

The search resulted in the identification of 71 papers/books oriented towards the definition of competency, of which six papers were selected. The literature on competence in nursing/midwifery has been synthesized by a number of comprehensive reviews (1982- 2013) (Table 1).

**Table 1** - Literature Reviews on the meaning of competence

Author and year	Focus	Findings
Griot (1993b)	Meaning of competence and assessment of competence	Literature on competency/competence is contradictory and confusing. These terms are defined as the ability to perform nursing skills and the ability to integrate cognitive, psychomotor and effective skills when providing care.
Watson, Stimson and Porock (2002)	Definition and assessment of competence in nursing	Competence described as a vague concept and defined variably as a personal quality, to what a person can do and to what a person can potentially do, performance not required. Hence, confusion between competence and performance and other concepts such as capability and expertise. Competence is difficult to measure.
McMullan et al. (2003)	Portfolios and assessment of competence	A holistic approach to competence seems to be compatible with the use of portfolios to assess competence in nursing students, but the concept and its implementation is still evolving. Reflection is an essential component of a portfolio, as are the student-teacher relationship and explicit guidelines for constructing the portfolio.
Cowan, Norman and Coopamah (2005)	Definition of competence	Little consensus on the definition of competence. Distinction between competence and competency offered. A holistic definition is recommended incorporating the application of knowledge, performance, skills, values and attitudes in order to develop precise competency standards.
Schroeter (2008)	Competence	A synthesis of literature related to the definitions and descriptions of "competence" as a concept inherent to nursing practice. Competence refers to a potential ability and/or a capability to function in a given situation. Competency focuses on one's actual performance in a situation.
Valloze (2009)	Concept analysis of competence	Focuses on competence in literature and poetry, the sciences, law, psychology, and business. Provides attributes of competence with antecedents and consequences.

Source: Research data.

## **Definition of competency in nursing and midwifery education**

Literature was found replete with controversy, confusion and lacked consensus with regards to the meaning of ‘competence’. The debate is oriented towards the distinction between competence, performance and capability (ERAUT; DUBOULAY, 1999). Discussions centred over the distinction between competence/s and competency/ies. The terms competence, competency, competencies, capability and performance are still used interchangeably and a difference appears between the meanings of competence and competency (McMULLAN et al., 2003). Competence and competences are job-related, being a description of an action that individuals should demonstrate in their performance. Eventually, competence may be seen as indicative of a degree of capability deemed sufficient to complete the task. On the other hand, competency and competencies, are person-oriented, referring to the person’s underlying characteristics and qualities that lead to an effective and/or superior performance. Competence is composed of behaviour that is, the ability to actually perform tasks, and a psychological construct that is, cognitive, affective and psychomotor skills (GIROT, 1993a). Alternatively, competency/competencies imply the actual performance according to established policies in a particular situation (McCONNELL, 2000). Also, competency/competencies is the actual performance in complying with standards of care (McCONNELL, 2000; MUSTARD, 2002).

The Nursing and Midwifery Council (NMC) in the UK, in line with the European Qualifications Framework (EQF) defines competence as “the proven ability to use knowledge, skills and personal, social and/or methodological abilities in the work or study situations and in professional and personal development” referred to as “responsibility and autonomy” (EQF, 2008, p. 11). In practice, competence/competencies is defined as having the skills and ability to practise safely and effectively without the need for direct supervision (EQF, 2008; NMC, 2002). Thus a holistic conceptualisation of competence, through knowledge, skills and attitudes is given (McMULLAN et al., 2003). This term became a popular language when discussing educational issues after the seminal work of

Bloom (1956) Taxonomy: cognitive, affective and psychomotor domains (GUILBERT, 2002).

Concept analysis of competence was attempted by (SCOTT TILLEY, 2008; VALLOZE, 2009). Competence is the application of skills for the practice role, instruction that focuses on specific outcomes or competencies, accountability of the learner, practice-based learning, self-assessment, and individualized learning experiences (SCOTT TILLEY, 2008). In contrast, the use of competence is given by Valloze (2009) in a wider context of poetry, literature, law, business, the sciences, and psychology without reference to the existing definitions of competence. Therefore, the meaning of competence is illusive with little consensus on a definition related to nursing/midwifery practice. It is argued that if incompetence is viewed as undesirable (COWAN; NORMAN; COOPAMAH, 2005), and competence viewed as its opposite, competence would connote to a minimum level of practice rather than excellence which should really be the goal (WATSON; STIMPSON; POROCK, 2002). Thus a holistic and integrative conceptualisation of competence/competencies is proposed which applies the complex combinations of knowledge, performance, skills, values and attitudes which should be agreed upon and utilised (COWAN; NORMAN; COOPAMAH, 2005). This would facilitate and underpin the research needed for the development of precise competency standards and assessment tools to measure competence. Additionally, reflection and critical incident analysis are two potential indicators of competence (McMULLAN et al., 2003) which contribute towards a holistic approach to the assessment of nursing/midwifery students' competence. The nursing/midwifery curricula has been criticised for emphasising more on clinical skills, at the expense of other personal qualities and attitudes which render their interactions with patients/clients to be professional and not simply technical tasks (WATSON, 2006).

The attainment of competence is viewed as an essential outcome of nursing/midwifery education due to the need for high quality clinical practice. The Bologna process has contributed to a greater focus on the development of professional competence across national borders also preceding the clinical education (COWAN; NORMAN; COOPAMAH, 2005). The International Council of Nurses (ICN, 2003,) and the international



Council of Midwives (ICM), through the Essential competencies for basic midwifery practice (ICM, 2013), strive for a global competence framework.

Following the transition of nursing/midwifery preparation to the higher education, this system of education envisaged the need to move away from the perceived ritualistic aspects of the apprenticeship system to research based-practice (BRADLEY; HYDE, 2002). Irrespective of the awareness of competency-based approach in nursing/midwifery education, the definition of competence and its application in nursing/midwifery clinical practice is still controversial (COWAN; NORMAN; COOPAMAH, 2005; WATSON; STIMPSON; POROCK, 2002).

Competence may be influenced by various factors such as, mentorship system, environment, ethics, and evaluation of competence (SCHROETER, 2008). Using the holistic approach, statements of the knowledge, skills, and attitudes for each competency should be developed during pre-licensure nursing education (TUNING PROJECT, 2005, 2006). Therefore, a competency based-education approach demands the formulation of competencies which incorporate knowledge, skills and attitudes specifying what nurses/midwives need to know, be able to do, and think (KIRK et al., 2003), in order to deliver spiritual care.

## **The demand for competence in spiritual care**

Nursing and midwifery have a rich spiritual heritage, tracing their origin from religious and monastic communities through 'caring' for people, and the realization that caring does not only mean treating the physical but the 'whole' person addressing all the biological, psychological, social and spiritual dimensions (BALDACCHINO, 2006). Hence, spirituality is embedded in nursing/midwifery practice and within the role of nurses and midwives, as spirituality is integral to holistic care. The healing potentials of spiritual care are well documented in medicine and nursing, in areas of palliative care, ageing and mental health (BALDACCHINO, 2003; COBB, 2001; KOENIG; KING; CARSON, 2012; NARAYANASAMY, 2001; SWINTON, 2001; WARD, 2007 ) in areas of social, and pastoral care (NASH; STEWART, 2002; WILLOWS; SWINTON, 2000) and midwifery

(HALL, 2005, 2007; JESSE, 2004, 2007). When the spiritual aspect of care is neglected, the client may become distressed spiritually and may endure further suffering compounded with pain, anger, hopelessness and isolation (McSHERRY, 2007; NARAYANASAMY, 2001).

The holistic approach to care, giving attention to the spiritual dimension of the individual is fundamental to health and wellbeing. The World Health Organization (WHO, 1998) emphasized the importance of the spiritual aspect of the person through its many statements and more recently through the development of a scale to measure the spiritual dimension of quality of life (WHO, 1995). At a European level the spiritual aspect is given importance through the Human Rights Act (UNITED KINGDOM, 2000).

Nursing and midwifery education accreditation bodies in Europe and the United States explicitly stipulate the teaching and practice of the spiritual dimension of care. In the UK, the NMC (2010) requests the nurses on registration to:

Carry out comprehensive, systematic nursing assessments that take account of the relevant physical, social, cultural, psychological, spiritual, genetic and environmental factors [...] (NMC, 2010, p 18).

The Essential Skills Clusters for pre-registration nursing programmes identifies 'skills that are essential' to be 'a proficient nurse'. Included under the 'care, compassion, and communication' cluster is the expectation that the nurse will 'demonstrate an understanding of how culture, religion, spiritual beliefs...can impact upon illness and disability' (NMC, 2010, p. 108). Similarly, the Quality Assurance Agency for Higher Education (QAAHE, 2001) expects nurses to be educated in undertaking a comprehensive assessment, planning and implementation of holistic care including the spiritual needs. Awareness about the importance of including spirituality and religiosity in care is demonstrated by the various guidelines issued by the health services sectors in the United Kingdom such as, the Department of Health (DH) (2009); palliative care (NICE, 2004) and the care of the elderly and people with heart and mental health problems (DEPARTMENT OF HEALTH, 1999, 2000, 2001a, 2001b). In

Scotland and Wales, policies and plans were also developed in order to implement spiritual care (NATIONAL HEALTH SERVICE WALES, 2010; SCOTTISH EXECUTIVE HEALTH DEPARTMENT, 2002; SCOTTISH GOVERNMENT, 2009).

Respect for the clients' religious and spiritual beliefs is also central to codes of ethics of other countries such as, United States of America, the Netherlands, Norway and Malta, including the International Council of Nurses Code of Ethics (ICN, 2006) which specifies the nurse's role of respecting the human rights, values, customs and spiritual beliefs of the individual, family and community. Nursing Theorists have also provided guidance towards the inclusion of the spiritual dimension in care, such as Leininger (2001), Neuman and Fawcett (2010), Newman (1986) and Roper, Logan and Tierney (2000). However, the complexity of spirituality in care demands a systematic attention in education and practice of spiritual care. Thus, significant educational challenges need to be met in order to ensure that students are competent in providing the spiritual dimension of care (WALLACE et al., 2008).

## **Spiritual care education**

The scarce research on spirituality in nursing education agrees on the importance of integrating spirituality and spiritual care into the nursing/midwifery education (BALDACCHINO, 2008a, 2008b, 2011; GISKE, 2012; HOOVER, 2002). However, spiritual care seems to lack the systematic attention it merits in education and practice (GISKE, 2012). The lack of attention to spirituality in the undergraduate curriculum may be similar to barriers often cited by nurses in practice (BALDACCHINO, 2009; McSHERRY, 2000). These barriers include lack of knowledge, lack of time, failure by staff to be in touch with their own spirituality, confusion about the nurse's role in providing spiritual care, fear of imposing their own philosophy on others (HUBBELL et al. 2006; MILLIGAN, 2004) and lack of competence in delivering spiritual care (HUBBELL et al., 2006; STRANAHAN, 2001). This may be due to inadequate preparation in nursing education which may generate feelings of incompetence

and avoidance of spiritual matters in practice by referring patients to chaplains/pastors (BALDACCHINO, 2008b; McSHERRY, 2007; ROYAL COLLEGE OF NURSING, 2010; TAYLOR et al., 2008). Lack of preparedness to deliver spiritual care may be due to lack of formal preparation of nurse lecturers to teach spiritual care. Hence, educators attempt to incorporate spirituality into their teaching sessions through a process of 'trial and error'. Inconsistency in teaching spiritual care in class and in the clinical practice; as a single study unit or threaded across the years of undergraduate nursing programmes, inhibit achievement of competence especially when learning is not supported by mentorship in the clinical area (McSHERRY, 2006; PAPADOPOULOS; COPP, 2005). Also, teaching spirituality and spiritual care is very often left within the devices of the individual academic lecturer and the respective institution who are interested in spirituality (PAPADOPOULOS; COPP, 2005).

Although nursing/midwifery educational and professional Bodies have acknowledged spiritual care as an area that merits competence at point of registration, few faculties define how to perceive spirituality and employ sufficient and appropriate knowledge to adequately develop spiritual competency (LEMMER, 2002). This may be due to the discrepancy between the teaching and the actual delivery of spiritual care in clinical practice. Debates have centred around ways and means of how to integrate the complex concepts of spirituality and spiritual care within the curricula such as, the appropriateness of teaching methods and the use of assessment strategies to ensure achievement of competency (BALDACCHINO, 2008a; MITCHELL; BENNETT; MANFRIN-LEDER, 2006; NARAYANASAMY, 2004) and how competencies in spiritual care could be achieved (VAN LEEUWEN et al., 2008).

While considering these limitations, education programmes on spiritual care yielded positive outcomes such as, increased knowledge and positive attitudes to spiritual/holistic care (BALDACCHINO, 2008b, 2011; TAYLOR et al., 2008; WALLACE et al., 2009). However, spirituality is 'caught' in practice as opposed to 'taught' in class. This implies that spiritual awareness is learned through clinical exposure, experience and role models without the support of formal theoretical education (BRADSHAW, 1997). However, if spirituality is only left to be 'caught' in practice, the

absence of role models in spiritual care will inhibit spiritual awareness and the development of skills necessary in the provision of spiritual care. Teaching by role modelling may not necessarily equip nurses with competences in spiritual care (McSHERRY, 2006). Also, when 'role modelling' of spiritual care practices is inappropriate or missed, addressing spiritual needs will be constantly inappropriate or neglected (McSHERRY, 2006). Therefore, the 'taught' component may support the 'caught' method by role modelling to foster the acquisition of knowledge, skills and attitudes in spiritual care (CALLISTER et al., 2004; JOHNSTON TAYLOR, 2008).

The dilemma still exists as to how, when and what should be taught to nursing/midwifery students in order to equip them with spiritual care competency. Literature on the content of formal education and methodology of teaching spiritual care is scarce (BALDACCHINO, 2008a, 2008b; GISKE, 2012; CONE; GISKE, 2013). The overall teaching programme should be guided by a theoretical framework such as, Actioning Spirituality and Spiritual care in Education (ASSET) (NARAYANASAMY, 1999). The content of teaching may consist of the definitions of spirituality, religiosity and spiritual care; spiritual distress; assessment of spiritual needs; delivery of spiritual care by the nursing process; self-reflection exercises on personal spirituality; the search for meaning and purpose in life; knowledge of world religions and the impact on illness and health (GREENSTREET, 1999). These may be taught with various methodologies in order to relate theory to practice such as, case study analysis, reflective journals, group discussions supported self-centred learning initiatives (GREENSTREET, 1999; BALDACCHINO, 2008a).

The key elements in teaching students on spirituality is to ensure that students become competent in listening to what is important to patients, respect their spiritual beliefs, provide compassionate care, and communicate effectively with patients about their spiritual beliefs and their preferences at the end of life (PUCHALSCHI; DORFF; HENDI, 2004). Learning by reflection in and on action is of utmost importance as it helps to evaluate one's actions in order to improve the necessary skills and ameliorate patient care (GIBBS, 1988; SCHON, 1991).

Research contends that achievement of competence in spiritual care may be enhanced through formal integration of spiritual care within

the educational programme (BALDACCHINO, 2006; CONE; GISKE, 2013; GISKE, 2012; PUCHALSCHI, DORFF; HENDI, 2004). This highlights the need for guidelines as to how best to equip nurses with knowledge and skills to address spiritual needs and also to develop a framework of competences in spiritual care as a guide to the education sectors as to what could be achieved by the end of undergraduate and post-graduate nursing education.

## **Conclusion: Implications to the nursing/midwifery education**

The notion of competency in spiritual care is still in its infancy, yet very much in vogue. Healthcare professional regulatory bodies such as, the Nursing and Midwifery Council and the Quality Assurance Agency for Higher Education, who are monitoring the achievements of spiritual care competency, request nurses/midwives to attend to their clients' spiritual needs. However, the complexity of spirituality and spiritual care demands theoretical and practical methods of education in order to become competent in assessing and meeting clients' spiritual needs. Additional to the generic guidelines on spiritual care to the clients receiving palliative care provided by various Health Departments in USA and the UK, specific guidelines, policies, and competences are needed which address the increasingly multicultural society, to assist nurses and health care professionals in delivering spiritual care (TUNING PROJECT, 2005, 2006).

Additionally a set of evidence-based specific competencies in spiritual care is recommended in order to guide the learners on spiritual care; assess the achievement of competency across time of the respective educational programme; and audit the educational process to maintain quality assurance.

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