Symposium ID: 25663

Spirituality & Health Research Collaboration to Enhance Local & Global Health Outcomes

This symposium presents 4 ways Spirituality & Health Research Center in 1 California School of Nursing has demonstrated interprofessional &/or global research collaboration to connect with students, nurses, & the community to catalyze local & global health.

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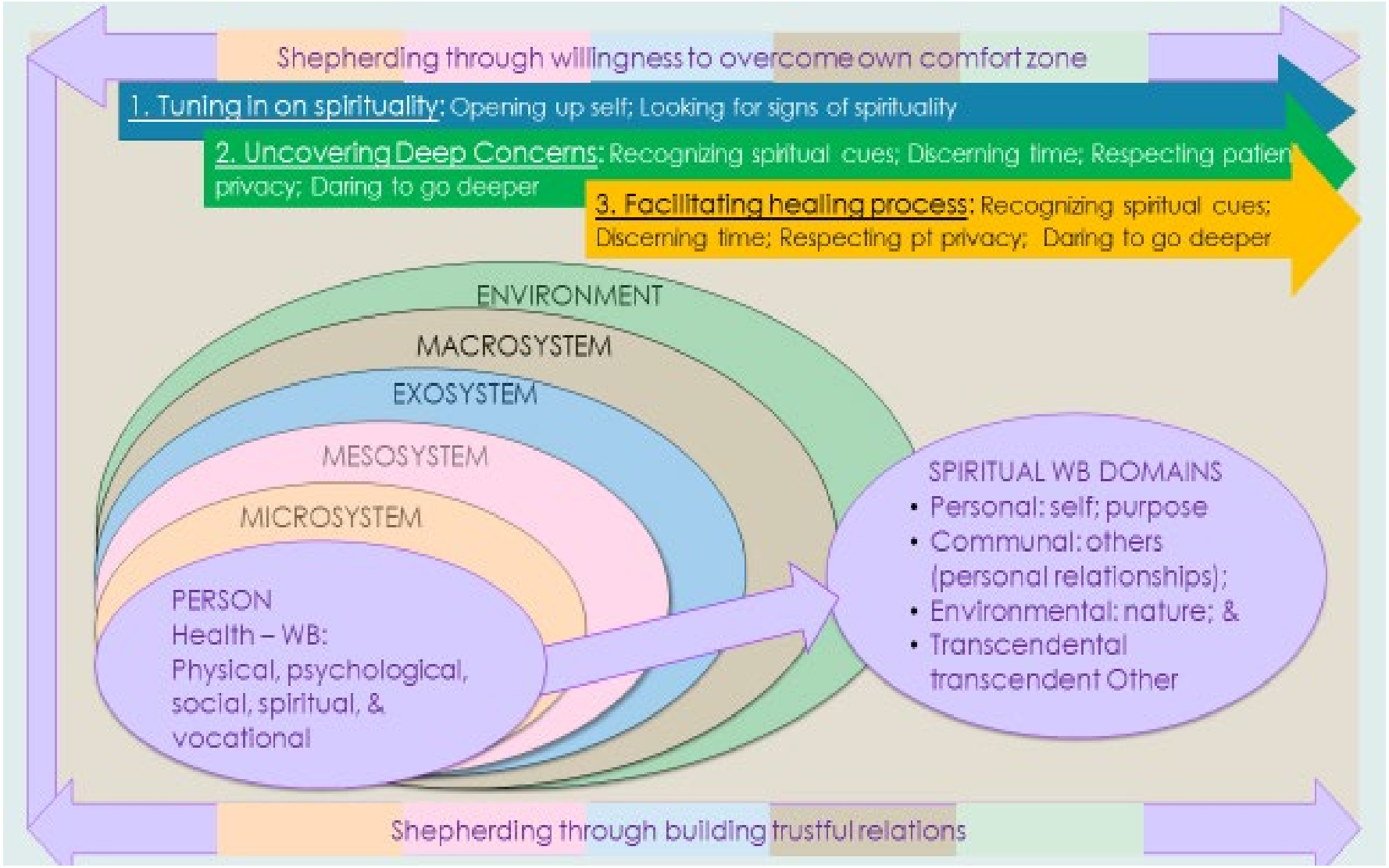
Sigma Theta Tau International Honor Society of Nursing

Connect. Collaborate. Catalyze.

45th Biennial Convention

16-20 November 2019 in Washington, DC, USA

SHRC Theoretical Framework



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Workshop Objectives:

1. Compare nurse and patient spiritual care perspectives in international collaboration
2. Demonstrate the efficacy of a collaborative spiritual care educational intervention to enhance nurses' spiritual care attitudes
3. Describe the European standard for spiritual care competencies in nursing education
4. Discuss findings from an assessment of community health through a neighborhood and church collaboration

Nurse and Patient Spiritual Care Perspectives Compared: A Cross-National Collaboration

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AZUSA PACIFIC UNIVERSITY

VID

Understanding Spiritual Care

- [illegible] part of holistic nursing, and it is the nurse's [illegible]ional responsibility to address this domain
- Spiri[illegible]ality is embedded in nursing theories and must be integrated into the nursing practice
- Spiritual care is care which recognizes and responds to the needs of the human spirit
- Spiritual care begins with encouraging the human contact in compassionate relationship, and moves in whatever direction need requires (NES, 2009, p. 6)
- Religious literacy is the nurse's ability to understand and be knowledgeable in different religions and faith traditions
- Spiritual literacy is about the nurse's ability to see and recognize patient cures & signs that demonstrate a spirit need

International Research Collaboration

- Drs. Giske & Cone met at APU in 2001 Grounded Theory & Spiritual Care workshop & in Azusa, CA
- Did GT workshops for doctoral students, Norway 2004/2006
- Cone: Fulbright Scholar in Norway 2008–2009 & BHS Grant in 2014 with planned research in Norway 2020
- Giske: Visiting Research Scholar to APU Fall 2014, 2017, 2018

Note to audience:

- The nurse phase research has been published in the *Journal of Clinical Nursing (see references)*
- *The patient phase is in submission, so please, no screen shots of data.*
- *This presentation is not currently for distribution or attribution.*


The study was done in
western Norway

Mixed-method, 2-Phased Spiritual Care Study

Aim of the Nurse Phase:

to determine the nurses' comfort level with assessing & addressing spiritual concerns

Aim of the Patient Phase:

to determine the patient perspective on her/his own comfort level with being assessed on spiritual issues

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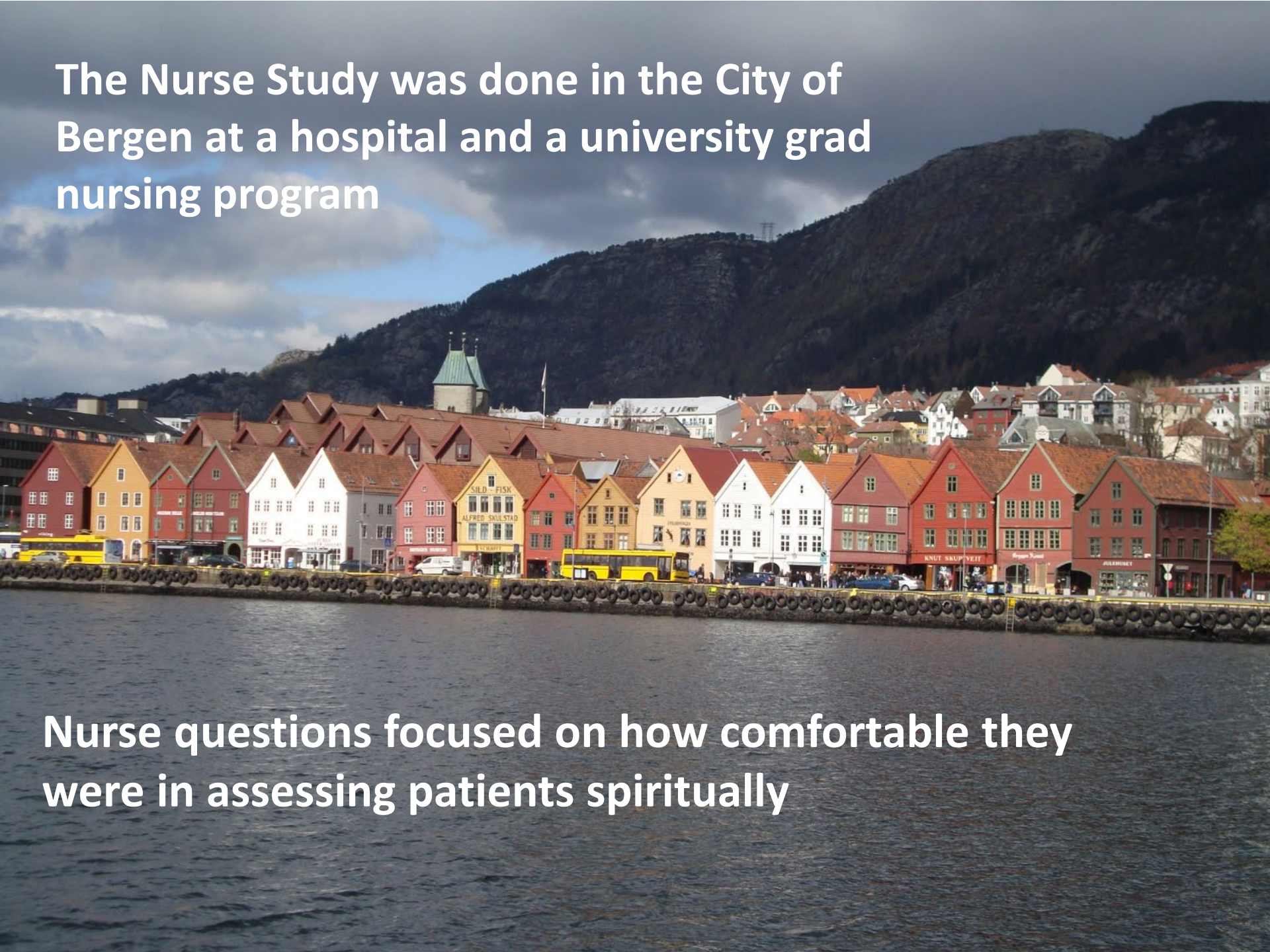
Quantitative aspect: Questionnaire

- Instrument from EJ Taylor's 2012 New Zealand study among hospice/palliative care nurses and patients
- 21 questions related to spiritual assessment using a Likert Scale
  1. Extremely uncomfortable
  2. Somewhat uncomfortable
  3. Somewhat comfortable
  4. Quite comfortable
  5. I do not understand the question
  6. Comments

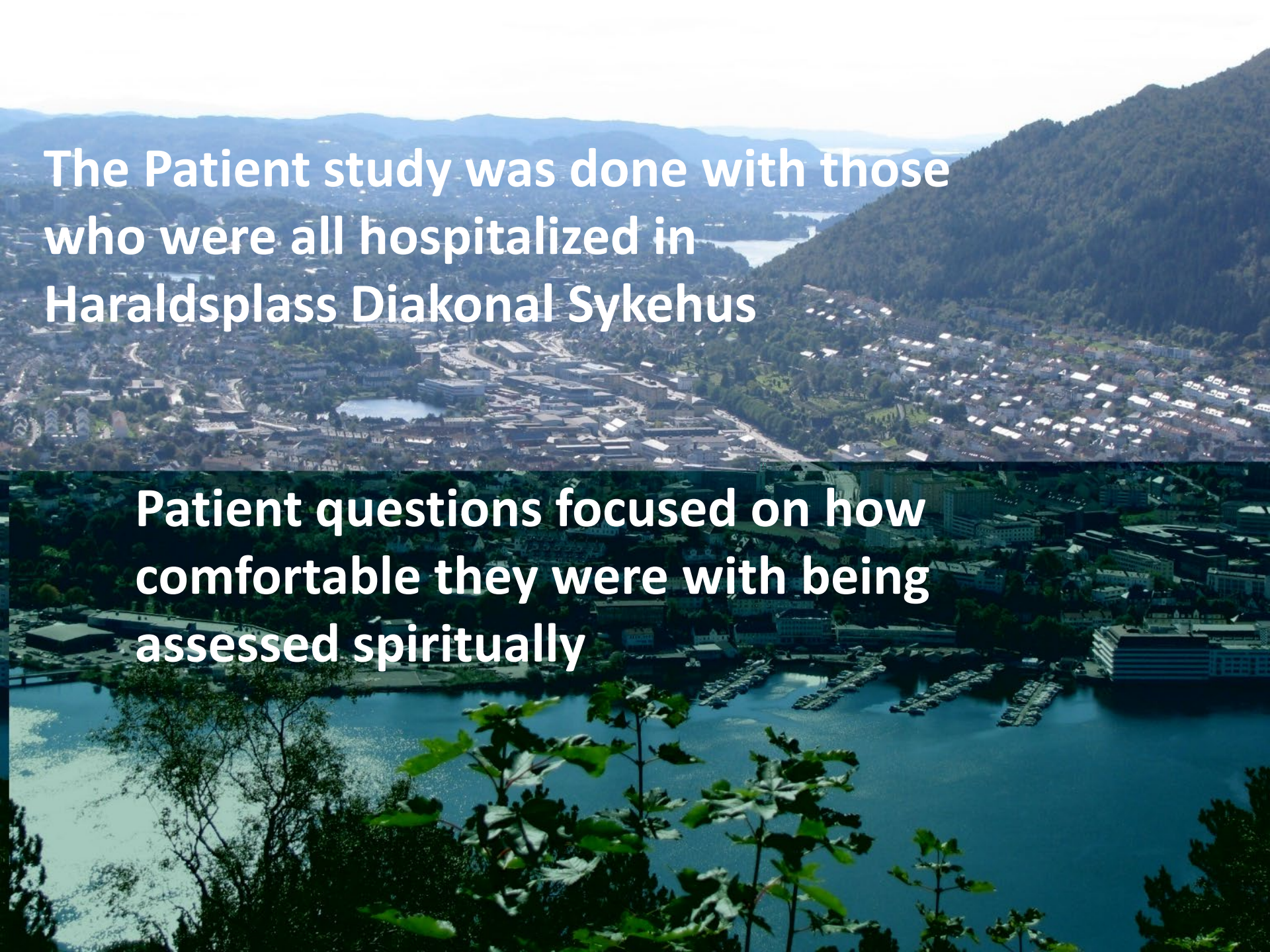
Questions were identified from literature & randomly listed


The Nurse Study was done in the City of Bergen at a hospital and a university grad nursing program
Nurse questions focused on how comfortable they were in assessing patients spiritually

Nurse Participants

- Survey questionnaires: 172 respondants
  - 77 post-grad working nurses:
    11 home health, 26 palliative care, & 40 other diverse care
  - 95 hospital nurses:
    45 on medical units, 34 surgical units, 14 - ICU, & 2 - admitting
- 8 focus groups with 22 nurses
  - 5 masters students in 2 groups
  - 8 post graduates in 3 groups from various settings
  - 9 nurses in 3 groups from 3 hospital units

A grounded theory emerged (see references)


The Patient study was done with those who were all hospitalized in Haraldsplass Diakonal Sykehus
Patient questions focused on how comfortable they were with being assessed spiritually

Patient Participants

- **Survey questionnaires – 157 respondents:**
  - Patients were recruited if nurses felt they would not be burdened by a survey
    - 90 respondants initially
    - 51 on the second wave of data collection
    - Plus 16 added later, all into SPSS 21
  - 95 in medical units; 62 in surgical units in an acute care hospital
- **Individual patient interviews for qualitative focus (n=6) are currently under analysis**

Nurse Demographics & questions

1. How many years have you worked as a nurse? _____
2. How many years old are you? _____
3. Gender _____Male _____Female (91 %female)
4. Where do you work and how many years have you worked in a hospital:
   Surgical nurse _____ Medical nurse _____ Other post _____
5. Please circle the number for each item here that best reflects your perspective:
1---not spiritual-------2----------3----------4------very spiritual-----5
6. Please circle the number for each item here that best reflects your perspective:
1---not religious-------2----------3----------4-------very religious----5
7. What culture influences you the most? _____Norwegian _____Other: _____
8. Have you received any instruction about spiritual/existential assessment? _____
No _____ Yes. Please describe: _____(lecture/article etc)
9. How important do you think it is for nurses to be able to do a spiritual assessment? 1---not at all-----2----------3----------4------very important----5
10. How well prepared do you think you are to conduct a spiritual screening or assessment? 1---not at all-----2----------3----------4----very well prepared--5
11. What spiritual assessment questions or prompts do you use now in your work?
12. In what other ways do you go about getting information for a spiritual assessment?

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Patient Demographics & questions

1. How many days have you been in hospital? __(2 days most common)
2. How many years old are you? _____
3. Gender _____Male _____Female (59% male)
4. Where are you located in the acute care hospital:
   Surgical _____ Medical _____ Other _____
5. What culture influences you the most? __Norwegian __Other: _____
6. Please circle the number for each item here that best reflects your perspective: 1---not spiritual----2-------3--------4----very spiritual-----5
7. Please circle the number for each item here that best reflects your perspective: 1---not religious---2--------3--------4----very religious----5
8. What is your understanding of spiritual care while in the hospital?
9. How important is spiritual care to you while in the hospital?
10. How comfortable are you receiving spiritual care?
11. What spiritual resources and/or strengths do you use when ill?
12. Who would you prefer to conduct a spiritual screening/assessment?

1--Nurse------2--Doctor-------3--Priest-------4--Social Worker

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Nurse Frequencies (n=172)

1. Years experience: ***M*=11 years**
2. Age: ***M*=37 years**
3. Gender: **Males=15, Females=157**
4. Work site: **Surgical=40, Medical=71, Diverse=61**
5. Spirituality: (1-5) ***M*=3.0**
6. Religiosity: (1-5) ***M*=2.8**
7. Cultural Influence: **162=Norse, 8=other, 2=missing**
8. Spiritual Assessment Education: **105=No, 65=Yes, 2=miss.**
9. Importance of Spiritual Assessment: (1-5) ***M*=3.6**
10. Preparation for Spiritual Assessment: (1-5) ***M*=2.8**

Patient Frequencies (n=157)

1. Days in hospital: ***Mean* =5, Median =3, Mode =2**
2. Age: ***Mean* = 56, Median = 62, Mode = 67 yrs**
3. Gender: **Males = 95, Females = 61 (1 missing)**
4. Hospital unit: **Surgical = 70, Medical = 87**
5. Spirituality: (1-5) ***Mean = 2.35 SD = 1.23***
6. Religiosity: (1-5) ***Mean = 2.31, SD = 1.21***
7. Cultural Influence: **Norwegian = 150, other = 5**
8. **Who do you want to do spiritual assessment?**

Priest 1st = 75, Nurse 1st = 47, Doctor 1st = 22, Social Worker 1st = 13

Nurse Demographic Results

Variables (N=164)	Spirituality Level	Religiosity Level	Importance of Spiritual Assessment	How Well Prepared for Spiritual Care
Age in Years	**r = .249 p = .001**	**r = .233 p = .003**	**r = .093 p = .238**	**r = .221 p = .004**
Years of Experience	**r = .307 p = .000**	**r = .286 p = .000**	**r = .073 p = .356**	**r = .202 p = .010**
Education in Spiritual Care	**r = -.083 p = .288**	**r = -.079 p = .312**	**r = -.083 p = .288**	**r = .277 p = .000**
How Well Prepared	**r = .381 p = .000**	**r = .258 p = .001**	**r = .321 p = .000**	**1**

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Patient Demographic Results

Variables (N=155) Spearman's rho		Degree of spirituality	Degree of religiosity	Spirituality or religion important	Faith, religion, or spirituality important during illness
Age (years)	*r*	.148	**.286****	.131	.074
	p	.069	**.000**	.107	.373
Degree of spirituality	*r*	1.000	**.752****	**.457****	**.455****
	p	.	**.000**	**.000**	**.000**
Degree of religiosity	*r*	**.752****	1.000	**.502****	**.506****
	p	**.000**	.	**.000**	**.000**
Spirituality or religion important	*r*	**.457****	**.502****	1.000	**.757****
	p	**.000**	**.000**	.	**.000**

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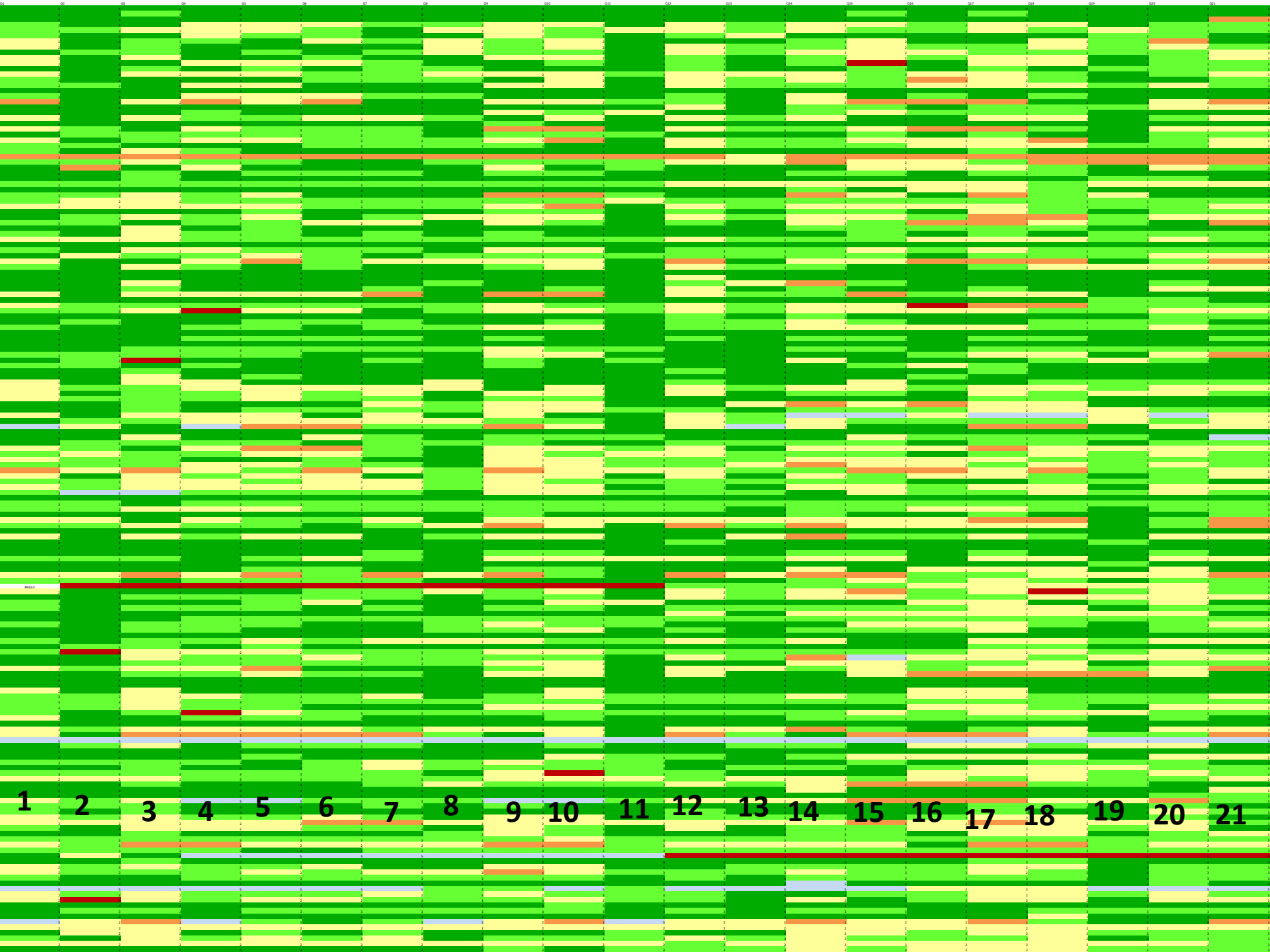
Correlations of spirituality with how important spiritual assessment is for nurses when working in hospital

Symmetric Measures (n=141)					
		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Ordinal by Ordinal	Kendall's tau-b	.366	.068	5.265	.000
	Spearman Correlation	**.418**	.078	5.430	**.000[c]**
Interval by Interval	Pearson's R	.407	.078	5.249	.000[c]

Correlations of spirituality with how important spiritual care is for patients when experiencing illness

Symmetric Measures (n=151)					
		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Ordinal by Ordinal	Kendall's tau-b	.389	.068	5.531	.000
	Spearman Correlation	**.455**	.078	5.504	**.000[c]**
Interval by Interval	Pearson's R	.457	.078	5.521	.000[c]

Assessment question: Taylor, 2014). Journal of Hospice & Palliative Care Nursing				
Response scale: If I were doing an initial spiritual assessment (i.e., interviewing a patient or family carer), asking this question would be. . .				
Extremely uncomfortable	Extremely uncomfortable	Extremely uncomfortable	Extremely uncomfortable	Extremely uncomfortable
1. How important is spirituality or religion to you?				
2. What do you rely on in times of illness?				
3. Are you at peace?				
4. Is faith, religion, and/or spirituality important to you during this illness?				
5. Is your spirituality, religion, or faith helpful to you in handling your illness?				
6. I was wondering if spirituality or religion is important to you?				
7. Are there spiritual beliefs and practices that you find helpful to deal with problems?				
8. Are there any spiritual needs or concerns I/we can help you with?				
9. Would you describe yourself—in the broadest sense of the term—as a believing/spiritual/religious person?				
10. What is the place of spirituality in your life?				
11. Who/what supports you when you are ill?				
12. What can I/we do to support your faith or religious commitments?				
13. Do you have someone to talk to about religious matters?				
14. Would you like to explore religious matters with someone?				
15. What role would you like to assign to your health care team regarding spirituality?				
16. I was wondering if you attend a church or some other type of spiritual community?				
17. How integrated are you in a spiritual community?				
18. Spirituality often influences how people deal with illness. How, if at all, has your spirituality influenced how you have dealt with your medical condition?				
19. When life is hard, how have you kept going? Is there anyone or anything that has helped you? How helpful are these supports?				
20+. Spirituality is very personal. Is spirituality, your viewpoint, or philosophy on life (this might include religion or God), something you think about? If yes, can you describe in what way? Has this changed since you've been ill?				
21. If you would like to continue to practice or explore your spirituality or religion, what would help?				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21

Comparing Perspectives

Questions nurses are most comfortable with asking

- Q 11: Who or what supports you when you are ill?
- Q 2: What do you rely on in times of illness?
- Q 8: Are there spiritual needs or concerns I/we can help you with?
- Q 13: Do you have someone to talk to about religious matters?
- Q 19: When life is hard, how have you kept going? Is there anyone or anything that has helped you? How helpful are these supports?

Questions patients are most comfortable being asked

- Q 3: **Are you at peace?** (*M = 2.895)*
- Q 11: Who or what do you rely on when you are ill? (*M = 2.883)*
- Q 19: When life is hard, how have you kept going? Is there anyone or anything that has helped you? How helpful are these supports? (*M = 2.845)*
- Q 2: What do you rely on in times of illness? (*M = 2.826)*

Reflections

- Findings on spirituality are useful in all settings
- Nurses and patients are more willing than not to explore deeply important issues of the inner spirit
- The patient experience is fairly universal but is not well explored from the perspective of the patient
- Nurses have similar holistic views but have different levels of preparation & engagement related to the deeply spiritual
- **Patients and nurses feel fairly comfortable with nurses asking about difficult/sensitive issues**

Discerning the Healing Path

Willingness to overcome own comfort zone

1) Tuning In on Spirituality

- -Opening up Self
- -Looking for Signs from the Patient
- -Becoming Aware of the Spiritual

2) Uncovering Deep Concerns

- -Recognizing Cues of Spiritual Nature
- -Discerning Time
- -Respecting Patient Privacy
- - Daring to go deeper

3) Facilitating Healing

- -Following patient pace
- -Attentive engaging
- -Balancing self in the profession
- -Collaborating w/family
- -Teamworking
- -Advocating Priest care

Building Trustful Relations

Giske, T. & Cone P. (2015) Discerning the healing path – How nurses assist patients spiritually in diverse health care settings. *Journal of Clinical Nursing.* 24(19-20), 2926-2935. doi: 10.1111/jocn.12907.

Patient Perspective Spectrum

Don't Ask

- Not the nurses domain - call a chaplain/priest
- Very private to the patient - only family
- Address only health needs that are most pressing

May Ask

- Make sure that the patient wants to be asked
- If it is important to what patient needs, then ask
- Have a non-judgmental attitude before asking

Do Ask

- Ask respectfully and in a straight forward way
- Ask about anything that will help the patient
- When trusted, ask anything the nurse wants to ask

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What does this research contribute to wider global clinical community?

- Patients may have other views on spirituality & spiritual care as compared to nurses.
- Spirituality has relevance in all areas & patient age groups, not just dying patients.
- Spiritual concerns are pivotal to patients' wellbeing.
- Critically important that nurses are willing & able to uncover spiritual concerns & facilitate healing process in whatever way patients need.
- Spirituality is deeply related to health & healing & affects both patient & nurse.

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Tusen takk – Thousand Thanks!

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Questions?
Additional thoughts?

Efficacy of a collaborative, spiritual care educational intervention to enhance nurses' spiritual care attitudes

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Background & significance

- 17-72% hospitalized patients report unmet spiritual needs by health care system healthcare providers (Balboni et al., 2011; Hermann, 2007; Pearce, Coan, Herndon JE, Koenig, Abernethy, 2012)
- Addressing spiritual needs linked with important patient outcomes:
  - ↓ depression (Ganatra, Zafar, Qidwai, Rozi, 2008; Pearce, Coan, Herndon JE, Koenig, Abernethy, 2012)
  - ↓ medical costs (Balboni et al., 2011)
  - ↑ levels of spiritual meaning, peace (Pearce, Coan, Herndon JE, Koenig, Abernethy, 2012) & quality of life (Balboni et al., 2007; Balboni et al., 2010; Kang, et al., 2012; Taylor, 2003)
  - ↑ quality of care (Astrow, Wexler, Texeira, He, Sulmasy, 2007) & overall satisfaction with service provision (Astrow, Wexler, Texeira, He, Sulmasy, 2007; Clark, Drain, Malone, 2003; Johnson et al., 2014; Pearce, Coan, Herndon JE, Koenig, Abernethy, 2012; Williams, Meltzer, Arora, Chung, Curlin, 2011)

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Background & significance

- Addressing spirituality of clinicians mitigates burnout (Holland & Neimeyer, 2005)
- Nurses' ability to provide SC & burnout are inversely related (Nussbaum, 2003; Wright, 2002)
- Spiritual care training diminishes clinicians' work-related stress (Wasner, Longaker, Fegg, & Borasio, 2005)
- Thus, attention to spiritual needs and spiritual care is beneficial for patients and nurses.

Background & significance

- Joint Commission on Accreditation for Healthcare Organizations requires all patients be assessed for spiritual beliefs & have spiritual support offered
  http://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx
- Main barriers to spiritual-care provision include nurses'
  - Lack of knowledge (Baldacchino, 2003; Rushton, 2014)
  - Attitudes about spiritual care (Baldacchino, 2003; Rushton, 2014)
  - Uncertainty about their personal spiritual beliefs (Stranahan, 2001; Vance, 2001)
- Curricular communication strategies on spiritual care lacking (Lemmer, 2002; Meyer, 2003)
- Perception inadequately prepared to discuss spiritual concerns with patients (Clark Drain, & Malone, 2003; Fletcher, 2004; Holmes, Rabow, & Dibble, 2006)
- Better RNs' personal attitudes toward spirituality, better perceived spiritual care (Vance, 2001)

Background & significance

- Spiritual-care needs can be addressed by nurses
- Tested interventional formats have included
  - 60 minutes to 2-week F2F classes (O-Shea, Wallace, Griffin, & Fitzpatrick, 2011)
  - 4-hour study unit on spiritual coping (Sandor, Sierpina, Vanderpool, & Owen, 2006)
  - 10-hours of self-study work-book & digital video disk (Taylor, Mamier, Bahjri, Anton, & Petersen, 2009)
- None have tested 2-hour class using ASSET model, values clarification & spiritual timeline exercises, + content regarding spirituality, spiritual needs, & spiritual care interventions with case study application.

Conceptual framework

ELSEVIER

Nurse Education Today
Volume 19, Issue 4, May 1999, Pages 274-285

REGULAR ARTICLE

ASSET: a model for actioning spirituality and spiritual care education and training in nursing

Aru Narayanasamy

Actioning Spirituality & Spiritual-Care Education & Training model

Structure/content	Process	Outcome
Self-awareness	Experiential learning	Value clarification
	Value clarification	Sensitivity and tolerance
Spirituality	Holism; perspectives of spirituality; broad aspects of spirituality	Knowledgeable practitioner in spiritual dimensions of nursing
Spiritual dimensions of nursing	Assessment	Competence in assessment of spiritual care needs
	Planning	Planning spiritual needs-based care
	Implementation	Competence in counselling
		Positive nurse–patient relationship
	Evaluation	Competence in judging effectiveness of spiritual dimensions of nursing; enhancing quality of care; spiritual integrity; healing and relief from spiritual pain

Study purpose

1. Describe relationships between demographics (age, gender, ethnic background, nursing education & experience, spiritual care education in nursing school & through conferences, reading & continuing education, religious education in high school, & religious service attendance frequency) & nurses' spiritual care attitudes.
2. Determine efficacy of F2F spirituality & spiritual care educational program on nurses' spiritual care attitudes.

Variables & instruments

(Taylor, Highfield, & Amenta, 1999)

Variables	Instrument
Demographics:	Information about You
Spiritual-care attitudes:	Spiritual-Care Perspectives Scale

Information about You

(Taylor, Highfield, & Amenta, 1999)

- 12-items, self-report
- Modified to include no items about nursing students
- Completed online prior to educational intervention
- Name & work site added to facilitate participant contact for provision of continuing education units & monetary incentive at study's conclusion
- Survey has no reports about validity and reliability

Please complete *before* you begin the class. Thank you!

1. Age: _____ years

2. Gender: ❍1 Male ❍2 Female

3. Dominant ethnic background:

   ❍1 European-American ❍2 Asian-American ❍3 African-American
   ❍4 Latino/Hispanic ❍5 Other *(please specify)* _____

4. What is your current religious preference? (*Please identify specific denomination, if Protestant*)
   _____

5. How often do you go to religious services?

   ❍1 More than once a week ❍2 Every week or more often
   ❍3 Once or twice a month ❍4 Every month or so
   ❍5 Once or twice a year ❍6 Never

6. Nursing Education:

   A. What is the highest degree you have completed?
   ❍1 AA/AD ❍2 Diploma
   ❍3 BS in nursing ❍4 Graduate degree in nursing

7. How much education in spiritual caregiving have you received before now?
   A. From nursing school:

      None 1 2 3 4 5 **A lot!**

   B. From conferences, reading nursing literature, and continuing education:

      None 1 2 3 4 5 **A lot!**

8. For how many years have you cared for patients as a registered nurse? _____ # of years

9. Please indicate in what setting you work mostly:

10. Please provide your name (last, first):

Last:_____ First: _____

Spiritual-Care Perspectives Scale

(Taylor, Highfield, & Amenta, 1999)

- 10-item, self-report tool
- 5-point Likert response options
- Summed item total
- Higher scores indicate (+) attitude toward spiritual care
- Completed online prior to & within 1-week of completing educational intervention
- Nurse scholar panel with expertise in spiritual care established face validity
- Internal reliability high (α=0.82) & test–retest reliability moderate (Spearman rho=0.60)
- Paired samples t-test demonstrated no significant difference across time

Please circle the number that best reflects your perspective.

1. Spiritual care is a significant part of nursing practice:

○1	○2	○3	○4	○5
strongly agree				strongly disagree

2. In general, patients have much spiritual need:

○1	○2	○3	○4	○5
strongly agree				strongly disagree

3. The domain of nursing practice should include spiritual care:

○1	○2	○3	○4	○5
strongly agree				strongly disagree

4. Spiritual care is only for religious persons:

○1	○2	○3	○4	○5
strongly agree				strongly disagree

5. A patient's spiritual concerns are none of my business:

○1	○2	○3	○4	○5
strongly agree				strongly disagree

6. Only clergy and chaplains should help patients with specifically religious activities:

○1	○2	○3	○4	○5
strongly agree				strongly disagree

7. I should assist patients in using their religious or spiritual resources to cope with illness:

○1	○2	○3	○4	○5
strongly agree				strongly disagree

8. I provide spiritual care:

○1	○2	○3	○4	○5
rarely or never				every day at work

9. My ability to provide spiritual care is:

○1	○2	○3	○4	○5
weak, limited				strong comprehensive

10. While providing spiritual care, I feel:

○1	○2	○3	○4	○5
Very uncomfortable				Very comfortable

Analysis

- **Sample characteristics & variables:** descriptive statistics [frequencies (number, percent), descriptives (mean, standard deviation)
- **Relationships between variables:** Pearson r correlation
- **Intervention's efficacy:** Paired t-test

Methods

- **Design**: Quasi-experimental, pre-post-intervention
- **Sample selection criteria**: Adult (≥18 years) RNs providing full time (≥36 hours/week) care to adult patients in 1 of 2 community-hospital settings in south Orange county, California

Methods

- **Intervention**: Collaborative intervention (1st & 2nd authors) that required
  - Reading article about spiritual care in advance of class - Narayanasamy, A. The puzzle of spirituality for nursing: a guide to practical assessment. *Br J Nurs;* 2004;13(19):1140-4.
  - Article addresses:
    - Historical & working definition of spirituality
    - Spiritual needs in context of case scenario
    - Spiritual assessment guide, interventions, & evaluation
    - Practical guidance about how spiritual care can be put into action, using ASSET model as framework

Methods

Class:

- 2-hour class about spirituality & spiritual care developed using ASSET model addressomg
- Spiritual care knowledge assessment
- RNs' personal spirituality
  - Spiritual timeline (experiential learning) and
  - Values clarification (self-awareness].
- Spiritual Care Competency Scale - self assessment
- Spiritual care patient assessment tools
- Spiritual Needs Assessment for Patients - identify & differentiate between psychosocial, spiritual, & religious needs
- Interventions
- Spiritual care evaluation discussed
- Content application using case scenario from article
- Blessing of hands offered following course evaluation submission

Sample characteristics & variables

n=183 pre- & 103 post-intervention	Low	High	Mean	SD
Age	22	66	45.75	12.8
RN experience	0	47	16.2	12.1
Religious education in…..				
High school	0	12	1.7	2.4
College	0	7	.69	1.3
SC attitude - pre	18	42	37.2	4.9
SC attitude - post	19	45	37.2	5.3

Sample characteristics & variables

n=183 pre- & 103 post-intervention	n	%
Gender - Female	93	90.3
Dominant ethnic background (n=101) - European-American	62	61.4
Religious services attendance – 1/week or so	36	35.0
Highest nursing degree - BS in nursing	64	64.0
SC-giving education from		
Nursing school - 0 years	59	57.3
Conferences, nursing literature, and CE - None	58	56.3

Correlational Results

- Spiritual care attitudes pre-intervention associated with
  - older age (r=.15, p=.041), &
  - less frequent religious services attendance (r=-.28, p<.001).
- Spiritual care attitudes pre-intervention unrelated to spiritual care attitudes post-intervention.

Intervention's Efficacy

- Spiritual care attitudes statistically significantly improved by intervention
  (t test=-2.037, p=.048)
  - Pre-intervention: low (38.4±4.7)
  - Post-intervention: moderate (40.2±4.3).

Discussion

Strengths:

- Novel intervention provided 9 times by same PhD-prepared RN

Limitations:

- Homogenous, volunteer subjects aware of research involvement potentially limiting generalizability
- Sample size limited

Discussion

Clinical implications:

- Novel intervention may be implemented at other health care institutions
- Nurses feel comfortable with spiritual care provision following additional, ASSET model focused, yet limited spiritual care education. Thus, additional spiritual care education indicated

Future research:

- Replicate with larger sample of heterogenous subjects
- Provide intervention in alternate formats

Conclusions

- Collaborative 2-hour class using values clarification & spiritual timeline exercises, & content regarding spirituality, spiritual needs, & spiritual care interventions with case study application can change nurses' spiritual care attitudes
- Nurses' changed spiritual care attitudes may augment
  - Nurses' spiritual care provision &
  - Important patient outcomes

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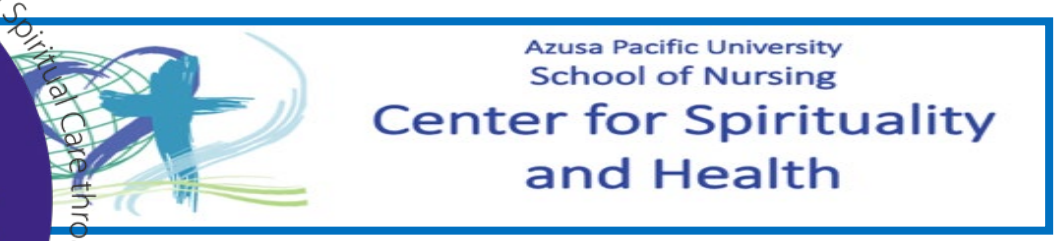
A European standard for spiritual care competences for undergraduate nursing/midwifery education



Wilf McSherry, Professor
Staffordshire University, UK

Tove Giske, Professor VID Specialized University, Norway

Pamela Cone, Professor, APU, CA

Background & significance

Why EPICC is necessary

- Nursing & midwifery regulatory & educational bodies require nurses/midwives to be able to address the personal, religious & spiritual beliefs of their clients as part of holistic care
- Nurses continue to report that they are poorly prepared through their nursing education to assess & address spiritual concerns of patients
- How learners acquire these skills, is not clear.
- Inconsistences in nursing/midwifery pre-registration education in Europe
- RCN survey – nurses asking for more educational preparedness to deal with spiritual issues

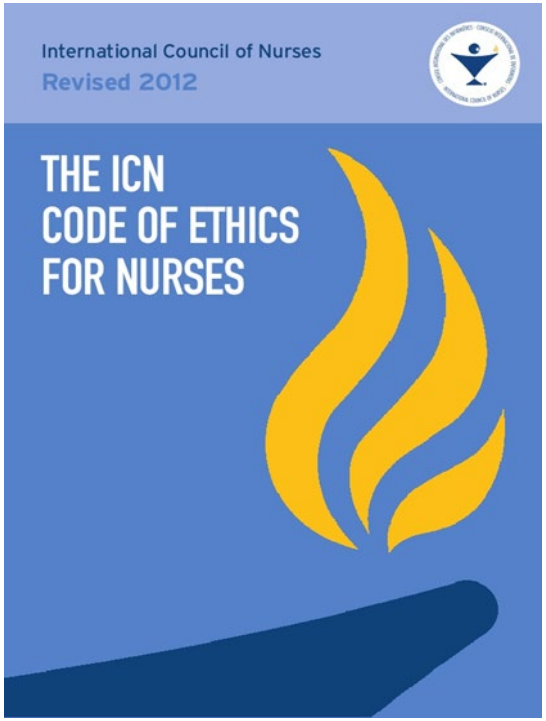
Background & significance

International Council of Nurses

Nurses have four fundamental responsibilities: to promote health, to prevent illness, to restore health & to alleviate suffering.

In providing care, the nurse promotes an environment in which the human rights, values, customs & spiritual beliefs of the individual, family & community are respected.

(ICN, 2012 p2)



Frequently used Terms

- Individualized care
- Holistic care
- Spiritual care
- Dignity in care
- Person-centered care
- Relationship/family centered care
- Compassionate care
- Integrated care
- Evidence based care

Facts & Figures from Student Projects

1. Josephine Attard PhD

- 39 competency pre-registration framework
- Reduced to 9 through 5 stage consensus process
- Reduced to 4

2. Pilot Study: 2010, 6 universities, 4 countries, Funded by USW
Cross-sectional, multinational, survey design

3. Main study: 2011-15, funded by RCN

- Longitudinal, multinational, survey
- 2193 undergraduate nurses/midwives
- 22 universities in 8 countries

(Wales UK, England UK, Scotland UK, Malta, Netherlands, Norway, Sweden, & Denmark)

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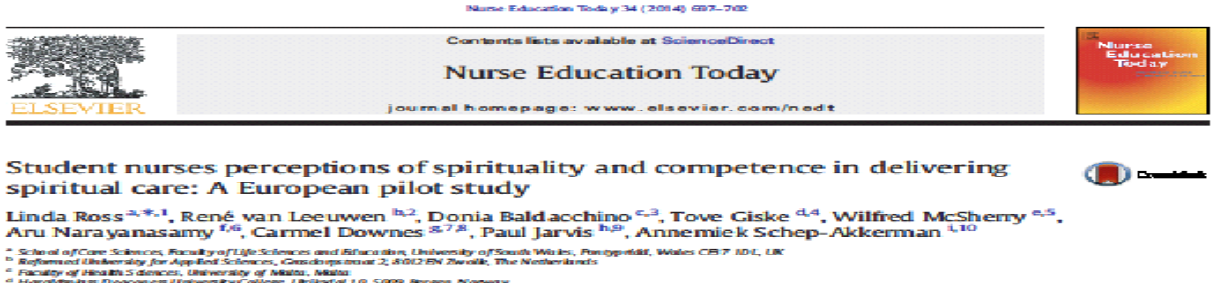
Publications to date



Nurse Education Today 34 (2014) 697–702

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Nurse Education Today

journal homepage: www.elsevier.com/nedt

Student nurses perceptions of spirituality and competence in delivering spiritual care: A European pilot study

Linda Ross [a,*,1], René van Leeuwen [b,2], Donia Baldacchino [c,3], Tove Giske [d,4], Wilfred McSherry [e,5], Aru Narayanasamy [f,6], Carmel Downes [g,7,8], Paul Jarvis [h,9], Annemiek Schep-Akkerman [i,10]

Nurse Education Today 36 (2016) 445–451

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Factors contributing to student nurses'/midwives' perceived competency in spiritual care

Linda Ross [a,*], Tove Giske [b,1], René van Leeuwen [c,2], Donia Baldacchino [d,3], Wilfred McSherry [e,4,5], Aru Narayanasamy [f,6], Paul Jarvis [a,7], Annemiek Schep-Akkerman [g,8]

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Nursing and midwifery students' perceptions of spirituality, spiritual care, and spiritual care competency: A prospective, longitudinal, correlational European study

Linda Ross [a,*], Wilfred McSherry [b,c,d], Tove Giske [d], René van Leeuwen [e], Annemiek Schep-Akkerman [e], Tiburtius Koslander [f,1], Jenny Hall [g,2], Vibeke Østergaard Steenfeldt [h], Paul Jarvis [a]

ARTICLE INFO

Keywords:
Midwifery education
Nurse education
Spirituality
Spiritual care
Spiritual care competency
Spiritual care education

ABSTRACT

Background: Nurses and midwives care for people at some of the most vulnerable moments of their lives, so it is essential that they have the skills to give care which is compassionate, dignified, holistic and person-centred. Holistic care includes spiritual care which is concerned with helping people whose beliefs, values and sense of meaning, purpose and connection is challenged by birth, illness or death. Spiritual care is expected of nurses/midwives but they feel least prepared for this part of their role. How nursing and midwifery students can be prepared for spiritual care is the focus of this study.

Objectives: 1. To describe undergraduate nursing and midwifery students' perceptions of spirituality/spiritual care, their perceived competence in giving spiritual care and how these perceptions change over time. 2. To explore factors contributing to development of spiritual care competency.

Methods: Prospective, longitudinal, multinational, correlational survey design. A convenience sample of 2198 undergraduate nursing and midwifery students (69% response rate, dropping to 33%) enrolled at 21 universities in eight countries completed questionnaires capturing demographic data (purpose designed questionnaire) and measuring perception of spirituality/spiritual care (SSCRS), spiritual care competency (SCCS), spiritual well-

The Strategic Partners

University of South Wales
Prifysgol De Cymru

STAFFORDSHIRE UNIVERSITY

viaa
Christian University of Applied Sciences

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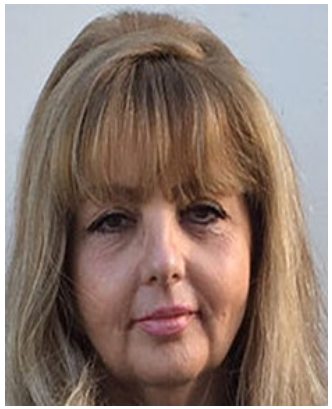
Azusa Pacific University
School of Nursing
Center for Spirituality and Health

The Strategic Partners

VID

L-Università ta' Malta



Enhancing Nurses' and Midwives' Competence in Providing Spiritual Care through Innovative Education and Compassionate Care

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The Project Manager

Enhancing Nurses' and Midwives' Competence in Providing Spiritual Care through Innovative Education and Compassionate Care

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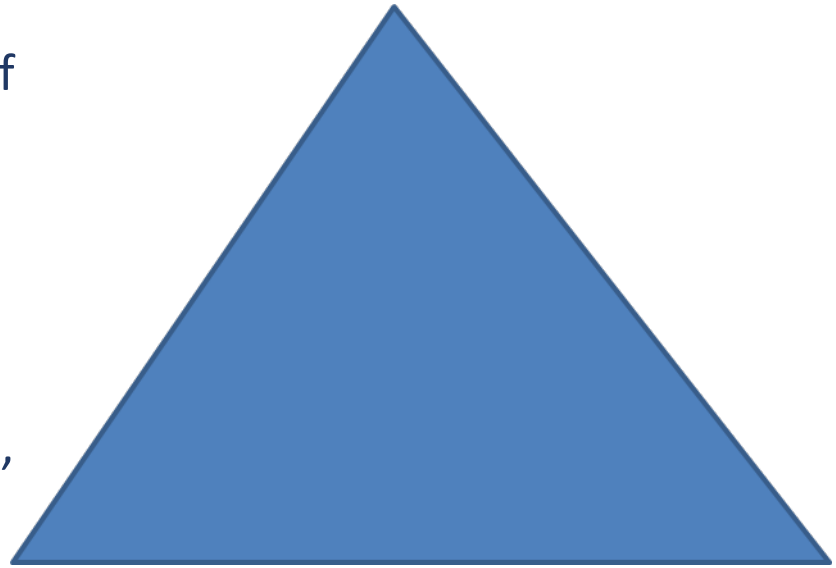
The EPICC Triangle

- **EPICC Strategic Partners** (6)
- **EPICC Participants**: nurse educators (32) from 18 countries across Europe. This group have been provided with an intense programme of peer-support, mentorship & coaching. This level of support has built trust & respect & prevented attrition from the project.
- **EPICC Participants + (18)** : this comprises of key stakeholders, representatives from allied health professionals, patient & public groups, students & professional regulatory bodies. They have attended activities & events ensuing these are informed by a wide range of cultural, ethnic & religious worldviews. This group are from 7 countries [4 outside Europe] (UK, Netherlands, Norway, Thailand, Palestine, New Zealand, Malaysia).



Countries Represented

- United Kingdom: England, Scotland, Wales, (Northern Ireland)
- Croatia
- Czech Republic
- Norway, Sweden, Denmark
- Netherlands
- Poland
- Ireland
- Malta
- Germany/Austria
- Belgium
- Lithuania
- Ukraine
- Greece
- Turkey
- Spain (mainland + Gran Canaria)
- Portugal
- China
- Malaysia
- Thailand
- Palestine
- New Zealand

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Transnational meeting 1. Jan 2017. Netherlands

Enhancing Nurses' and Midwives' Competence in Providing Spiritual Care through Innovative Education and Compassionate Care

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Multiplier event 1: Staffordshire, 19-20 April 2017

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Teaching & learning event Netherlands Oct/Nov 2017

Enhancing Nurses' and Midwives' Competence in Providing Spiritual Care through Innovative Education and Compassionate Care

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Teaching & Learning event Malta Sept 2018

Enhancing Nurses' and Midwives' Competence in Providing Spiritual Care through Innovative Education and Compassionate Care

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What we have developed:

- Established the EPICC Network (Launch 1 & 2 July 2019 Cardiff)
- Developed an EPICC Spiritual Care Education Standard for undergraduate nursing education in Europe
- Developed a Gold Standard Matrix for Spiritual Care Education
- Developed an Adoption Toolkit for education
- Developed a Website & online repository

Spiritual Care Education Standard

This EPICC Spiritual Care Education Standard describes spiritual care competencies expected from undergraduate nursing & midwifery students. For every competence, learning outcomes are described in aspects of knowledge, skills & attitudes.

- EPICC has adopted & adapted European Association for Palliative Care (EAPC) definition of spirituality
- **Spirituality**: "The dynamic dimension of human life that relates to the way persons (individual & community) experience, express &/or seek meaning, purpose & transcendence, & the way they connect to the moment, to self, to others, to nature, to the significant &/or the sacred."

Spiritual Care Education Standard

- Spiritual field is multidimensional:
  - Existential challenges (e.g., questions concerning identity, meaning, suffering & death, guilt & shame, reconciliation & forgiveness, freedom & responsibility, hope & despair, love & joy).
  - Value-based considerations & attitudes (e.g., what is most important for each person, such as relations to oneself, family, friends, work, aspects of nature, art & culture, ethics & morals, & life itself).
  - Religious considerations & foundations (e.g., faith, beliefs & practices, relationship with God or ultimate).

Spiritual care

- 'Care which recognises & responds to the human spirit when faced with life-changing events (such as birth, trauma, ill health, loss) or sadness, & 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 & moves in whatever direction need requires'

Cultural context

- Content & application of EPICC Spiritual Care Education Standard should be considered within cultural context & language of country in which used.

Terminology

- Throughout EPICC Spiritual Care Education Standard, terms 'person & individual' is used. These terms refer to the 'patient', 'client', 'service user', 'pregnant woman', 'carer', 'family member', 'relative', 'care recipient' & so on, depending on country in which standard is used, + local context.

- NHS Scotland (2010). *Spiritual Care Matters: An introductory resource for all NHS Scotland staff*. Retrieved from https://www.nes.scot.nhs.uk/media/3723/spiritualcaremattersfinal.pdf. Last accessed 18/02/19.

Spiritual Care Competency Matrix

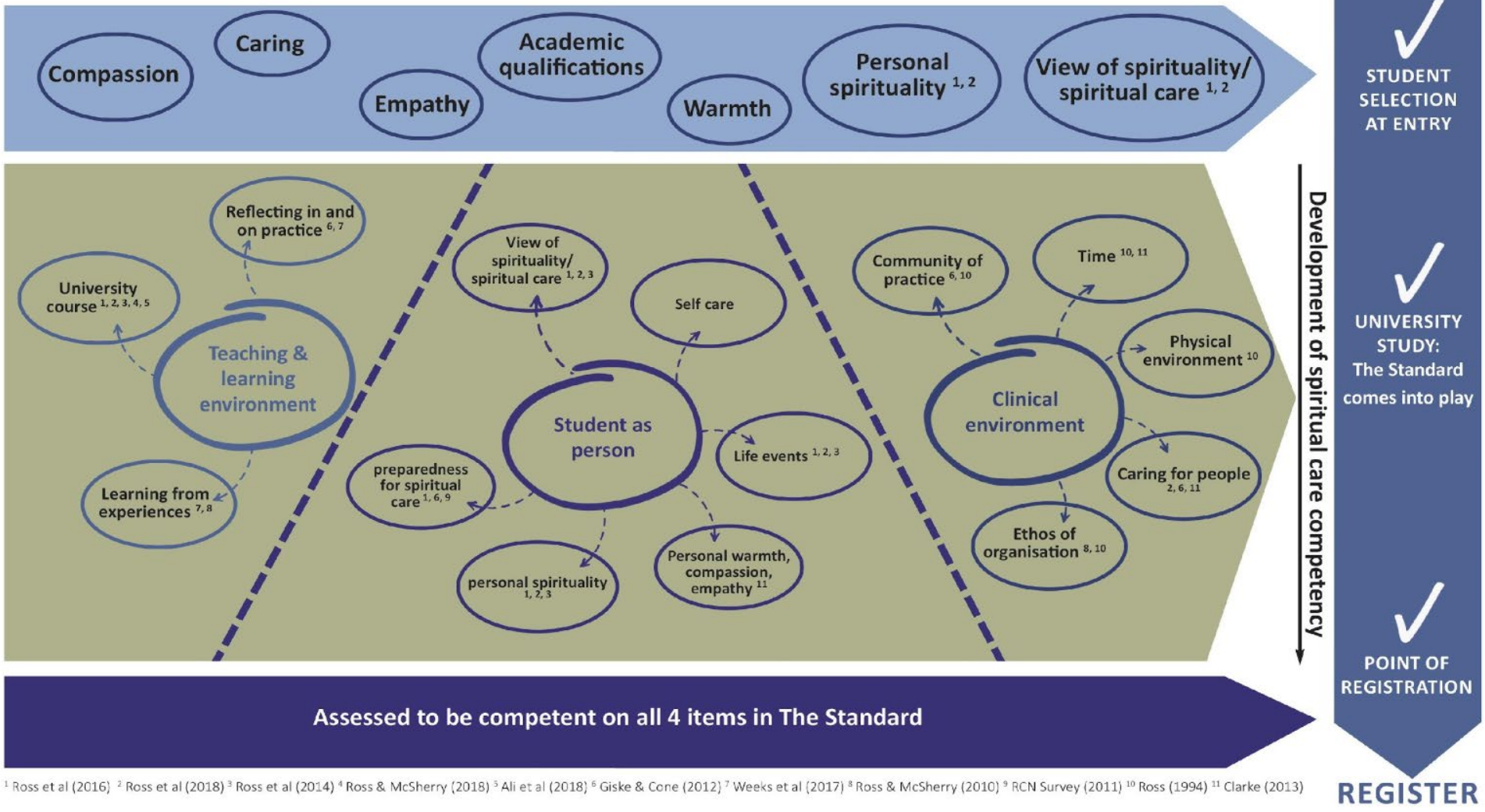
	COMPETENCIES	KNOWLEDGE (COGNITIVE)	SKILLS (FUNCTIONAL)	ATTITUDE (BEHAVIOURAL)
1	INTRAPERSONAL SPIRITUALITY Is aware of the importance of spirituality on health & wellbeing.	Understands concept of spirituality. - Can explain impact of spirituality on a person's health & well-being across lifespan for oneself & others. Understands impact of one's own values & beliefs in providing spiritual care.	Reflects meaningfully upon one's own values & beliefs & recognises that these may be different from other persons'. Takes care of oneself.	Willing to explore one's own & individuals' personal, religious & spiritual beliefs. Is open & respectful to persons' diverse expressions of spirituality.
2	INTERPERSONAL SPIRITUALITY Engages with persons' spirituality, acknowledging their unique spiritual & cultural worldviews, beliefs & practices.	Understands ways that persons' express their spirituality. Is aware of different world/religious views & how these may impact upon persons' responses to key life events.	Recognises uniqueness of persons' spirituality. Interacts with, & responds sensitively to person's spirituality.	Is trustworthy, approachable & respectful of persons' expressions of spirituality & different world/religious views.

Spiritual Care Competency Matrix

	COMPETENCIES	KNOWLEDGE (COGNITIVE)	SKILLS (FUNCTIONAL)	ATTITUDE (BEHAVIOURAL)
3	SPIRITUAL CARE: ASSESSMENT & PLANNING Assesses spiritual needs & resources using appropriate formal or informal approaches, & plans spiritual care, maintaining confidentiality & obtaining informed consent.	Understands concept of spiritual care. Is aware of different approaches to spiritual assessment. Understands other professionals' roles in providing spiritual care.	Conducts & documents spiritual assessment to identify spiritual needs & resources. Collaborates with other professionals. - Be able to appropriately contain & deal with emotions.	Is open, approachable & nonjudgemental. Has willingness to deal with emotions.
4	SPIRITUAL CARE: INTERVENTION & EVALUATION Responds to spiritual needs & resources within a caring, compassionate relationship.	Understands concept of compassion & presence & its importance in spiritual care. Knows how to respond appropriately to identified spiritual needs & resources. - Knows how to evaluate whether spiritual needs have been met.	Recognises personal limitations in spiritual care giving & refers to others as appropriate. Evaluates & documents personal, professional & organisational aspects of spiritual care giving, & reassess appropriately.	Shows compassion & presence. - Shows willingness to collaborate with & refer to others (professional/nonprofessional) Is welcoming & accepting & shows empathy, openness, professional humility & trustworthiness in seeking additional spiritual support.

The Gold Standard Matrix for Spiritual Care Education:

The cultural, social and political environment in which spiritual care competency develops (the 'amniotic sac')



[1] Ross et al (2016) [2] Ross et al (2018) [3] Ross et al (2014) [4] Ross & McSherry (2018) [5] Ali et al (2018) [6] Giske & Cone (2012) [7] Weeks et al (2017) [8] Ross & McSherry (2010) [9] RCN Survey (2011) [10] Ross (1994) [11] Clarke (2013)

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The Gold Standard Matrix for Spiritual Care Education

Narrative to the Matrix

Introduction

This narrative accompanies the figure: 'The Gold Standard Matrix for Spiritual Care Education'.
There are many definitions of a Matrix. EPICC defines it as:

'The cultural, social and political environment in which spiritual care competency develops'

How to use the Matrix?

On the right, the downward blue arrow illustrates the student journey from selection through to registration as a nurse/midwife.

STUDENT SELECTION

The way in which student nurses and midwives are selected varies across countries. For example, Ireland and Norway select on the basis of academic qualifications. Other countries, such as the UK, look for additional caring qualities such as compassion, empathy and warmth.

Personal spirituality of students, and their views on spirituality/spiritual care, impacts their development of spiritual care competency[1, 2] prompting consideration of selecting students based on these attributes.

THE ENVIRONMENT IN WHICH SPIRITUAL CARE COMPETENCY DEVELOPS

Spiritual care competency does not develop in isolation.
It develops within a complex and dynamic environment (or 'amniotic sac'), which includes:
(a) the teaching and learning environment, (b) the student as a person, and (c) the clinical environment.

Teaching & learning environment

Our research has highlighted factors that students said helped them in learning about spiritual care in university, such as: group discussions and having the chance to reflect on their beliefs/values, clinical experiences and life events[1, 2, 3, 4, 5].

Our research has also emphasised the importance of preparing personally and professionally[6] by learning from experiences; learning to know what's right and doing what's right in uncertainty[7], and seeking to get the right balance between the art and science of nursing and midwifery practice[8].

We have also found that students reflecting in, and on, practice (what went well/less well) is important in developing spiritual care competency together with clinical supervision and mentoring[6, 7].

Erasmus+

Co-funded by the Erasmus+ programme of the European Union

Student as a person

Our research has demonstrated that students who scored highest in perceived spiritual care competency viewed spirituality and spiritual care broadly, not just in religious terms (SSCRS).

Students also scored highly on personal spirituality (spiritual wellbeing [JAREL] and spiritual attitude/involvement [SAIL]) and reported experience of personal life events (although weakly correlated with perceived competency)[1, 2, 3].

Students demonstrated preparedness for spiritual care[1, 6] (something that many qualified nurses say they lack[9]). Patients tell us that other attributes, such as personal warmth, compassion and empathy are also important for spiritual care. As spiritual care requires the ability to contain and deal with emotions, self-care is important.

Clinical Environment

Many factors influence students' spiritual care competency development in the clinical environment.

Caring for people (patients/clients) in clinical practice provides students with real life experiences and helps them to gain a deeper understanding of the complexity of spiritual care[2, 6].

The leadership style of the nurse in charge (micro level), together with whether practice is task-oriented or person centred[4], will influence to what degree students feel they can provide spiritual care. The ethos can infiltrate through the organisation as a whole (macro level) and will affect whether a student feels affirmed or undermined. Spiritual care can be seen as an 'add-on' (in which case there may not be time, especially if there is short staffing[10], or as integral to good nursing care (care given in a way that is spiritual[11]). How the wider and multi-professional team operates[10], together with role models (good and bad)[6] students see on a daily basis can also help or hinder spiritual care competence development of students.

Where there is lack of peace, quiet and privacy, it may hinder the delivery of spiritual care[10]. Often the clinical environment can be a turbulent and unpredictable place with competing demands and tensions between medical and holistic models of practice[10]. If there is emphasis on the biomedical model[10] then the main focus may be on 'doing' rather than 'being'. In other words, a focus on the science rather than the art[4] of nursing, and on measurable outcomes rather than the quality of care or the patient experience. It may be difficult to provide spiritual care in an organisation where the biomedical model prevails.

ASSESSED TO BE COMPETENT IN SPIRITUAL CARE AT POINT OF REGISTRATION

The student will then be assessed as to whether they have met the 4 competencies (outlined in the EPICC Spiritual Care Education Standard) before they register. Questions to considered here include:

(1) Who assesses whether the competences have been met (the student themselves, university lecturer, clinical supervisor, or all three)?

(2) Should the competencies be mapped against the 3 or 4 years of the degree (e.g., competency 1 during year 1, competency 2 during year 2, competencies 3 and 4 during year 3 and/or 4?).

Erasmus+

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EPICC Adoption Toolkit

Learning strategies for spiritual care education in nursing and midwifery

The purpose of this EPICC Adoption Toolkit is to provide access to a range of teaching and learning strategies that can be used to support curriculum review and change in undergraduate nursing and midwifery education across Europe and beyond.

Currently 25 strategies (in order of presentation within this Adoption Toolkit):

1. Personal belief life view/faith history training in nursing education
2. Spiritually competent practice in health and social care: Face to face teaching
3. Spiritual dimensions of care: Developing an educational package for hospital nurses and nursing students
4. Student experience of learning about spirituality through the medium of art
5. Case study of how to address and assess a patient
6. How to conduct a conversation about spiritual needs
7. Spirituality in midwifery
8. Nursing the individual
9. Spiritual care in nursing
10. Value clarification
11. How to draw your life-tree
12. When does the 'spiritual' come into focus?
13. Spiritual care in nursing
14. Assessment of spiritual needs through clinical situations
15. Insider-experiences focusing on one of three dimensions (self-reflective part), I try to include in lectures: 1. Knowledge, 2. Practices, 3. Self-reflexion.
16. Education of nurses in providing spiritual care
17. Spiritual care teaching using multimedia
18. Spiritual history taking
19. Exploring patients' spirituality by use of the Diamond Model
20. Training/workshop in attention for spirituality of yourself and the other, and spiritual care
21. The patient interview
22. Minor (30 ECTS elective) 'Link Nurse Spiritual Care'
23. A practical model for spiritual assessment and person centred care: The 2Q-SAM
24. How to maintain spiritual care competences in clinical studies/practice
25. How to introduce the Spiritual Health Programme (SHP) to my patients. How I maintain my own Spiritual connection so that I am a more caring and compassionate nurse practitioner.

Conclusion

- In order to meet unmet needs of patients, spiritual care education must be enhanced & inconsistency in spiritual care education in Europe be addressed.

Study results:

- EPICC Spiritual Care Education Standard for undergraduate nursing education in Europe
- Gold Standard Matrix for Spiritual Care Education
- Adoption Toolkit for education
- EPICC website & online repository

Will inform process & ease implementation of enhanced spiritual care education throughout Europe & around world.

Conclusion

Stay connected

Erasmus project link http://ec.europa.eu/programmes/erasmus-plus/projects/eplus-project-details-page/?nodeRef=workspace://SpacesStore/763f7149-604f-4edb-a4a4-0cee162739b0

EPICC Website: http://www.epicc-project.eu/

EPICC Participants Facebook page: https://www.facebook.com/groups/1958250327790157/

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Thank you

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Questions? Other thoughts?

Assessment of Community Health by Neighborhood & Church Collaboration

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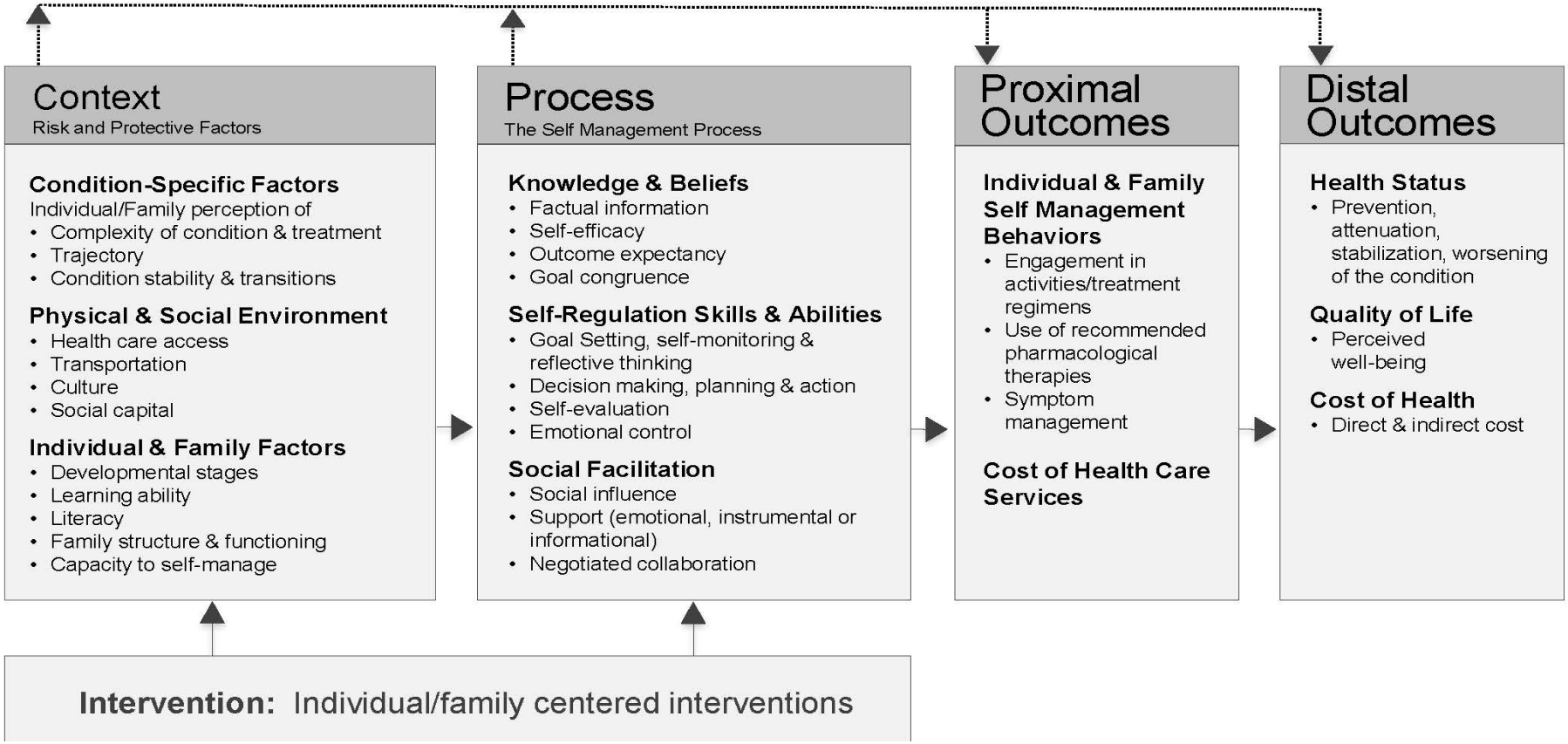
Background & significance

- San Bernardino County, California has health inequities with high rates of chronic disease, mental health problems, & risk behaviors that reflect some of worst health outcomes in State of California & United States (Supervisors, 2016).
- Faith-based partnerships have potential to
  - Empower communities
  - Reduce health disparities &
  - Shift health care outcomes (Caldwell & Takahashi, 2014; Young, Patterson, Wolff, Greer, & Wynne, 2014).

Theoretical framework

Individual and Family Self-Management Theory



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Study purpose

To assess how residents in southwestern San Bernardino within a 1-mile radius of 1-local church perceived the role of faith [religiosity (frequency attend organized church activities & private, non-organized religious activities), intrinsic religiosity, spirituality], & social support in their health & well-being.

Methods

- **IRB approval**
- **Sampling:** convenience
- **Inclusion criteria:** adult residents of three impoverished bordering towns in San Bernardino county, able to read English or Spanish
- **Design:** community-based participatory action concurrent mixed methods
- **Data collection**: self-reported inventories in Spring 2017

Independent Variables

- **Demographics:**
  - Age
  - Race
  - Education
  - Marital status
  - Ethnicity
- **Religious support**: Positive and nedeligious coping (RCOPE) - brief form (Pargament, Feuille, & Burdzy, 2011)
- **Religiosity**: Duke University Religion Index (DUREL) (Koenig, & Büssing, 2010):
  - **Organized church attendance:** Organizational religious activity subscale (Koenig, & Büssing, 2010):
  - **Private, non-organized religious activities:** Non-organizational religious activity subscale (Koenig, & Büssing, 2010):
  - **Intrinsic Religiosity:** Intrinsic Religious Motivation Scale (Hoge, 1972):

Independent Variables

- **Spirituality**
  - Sorokin Multidimensional Inventory of Love Experiences (SMILE) Love of God subscale (Levin & Kaplan, 2010):
- **Social support**: Medical Outcomes Social Support Survey (MOS-SSS) (Sherbourne & Stewart, 1991)

Dependent Variables

- **Health outcomes: Medical Outcomes Study - Short Form-12** (Ware, Kosinski, & Keller, 1996)
  - **Physical health**: Physical component
  - **Mental health**: Mental component subscale

Research Questions

In adult residents in southwestern San Bernardino within one-mile radius of one local church,

1. What is/are their demographics (age, race, education, marital status, ethnicity), religious support, religiosity (frequency attend organized church activities & private, non-organized religious activities), intrinsic religiosity, spirituality, social support, & physical & mental health?
2. What are the relationships between demographics (age, race, education, marital status, ethnicity), religious support, religiosity (frequency attend organized church activities & private, non-organized religious activities), intrinsic religiosity, spirituality, social support, & physical & mental health?

Analysis

- Descriptive analysis was used to describe the sample characteristics & variables
- Pearson and multiple regression was used for correlational analyses

Independent variables

	Instrument	Items	Responses	Data level
Demographics:				
Age	Investigator developed tool	1	<18; 18-29; 30-49; 50-64; >65	Categorical
Race		1	White, Black, Am Indian, Hawaiian or Pacific Islander, Asian, Mestizo, More than one race; other	
Education		1	None; 1-8; 9-12 no diploma; HS grad or GED; Some college; Assoc degree; Bachelors; Grad or Professional beyond	

Independent variables

	Instrument	Items	Responses	Data level
Demographics:				
Marital status	Investigator developed tool	1	Single; Married or remarried; Divorce; Separated; Widow/Widower	Categorical
Ethnicity		1	Hispanic/Non-Hispanic	
Religious support	Religious coping (RCOPE) - brief form	6	1 = not at all to 4 = a great deal	Continuous

Independent variables

	Instrument	Items	Responses	Data level
Religiosity:	Duke University Religion Index (DUREL)			
Frequency attend organized church activities	Organizational religious activity	1	1 = Never to 6 = > 1x/wk	Categorical
Frequency attend private, non-organized religious activities	Non-organizational religious activity	1	1= Rarely or never to 6 = >1x/day?	

Independent variables

	Instrument	Items	Responses	Data level
Intrinsic religiosity	IRMS (Hoge, 1972)	10	1=Definitely not true to 5=Definitely true of me	Continuous
Spirituality	SMILE: Love of God subscale (Levin & Kaplan, 2010)	4	1=Strongly disagree to 5=Strongly agree	
Social support	MOS-SSS	19	1=None of the time to 5=All of the time	

Dependent variables

Dependent variables	Instrument	Items	Responses	Data level
Health outcomes				
Physical health	SF-12 Physical component subscale	6	3- & 5-point Likert scales; 0-100; 0= lowest health level	Continuous
Mental health	SF-12 Mental component subscale	6		

Sample descriptive analysis (n=261)

	n	%
Age: 30-49 years	122	45.7
Race: White	82	30.7
Asian	47	17.6
Education: High school graduate or GED	67	25.1
Some College - No Degree	55	20.6
Marital status: Married or remarried	124	46.4
Ethnicity: Non-Hispanic	140	52.4
Religiosity - Frequency attend		
Organized religious activities – A few times/month to > 1x/wk	144	54.1
Private, non-organized religious activities –		
Rarely or never	80	30.1
Daily	56	21.1

Descriptive analysis

(n=261)

	Possible Range	Actual Range	Mean	SD
Religious coping				
Negative	1-4	1-4	2.96	.99
Positive	1-4	1-4	1.87	.92
Intrinsic religiosity	1-5	1-5	3.47	.90
Spirituality	1-5	1-5	4.2	1.2
Social support	1-5	1-5	1.78	.92
Health outcomes				
Physical health	0-100	0-100	67. 4	22.8
Mental health	0-100	6.25-100	66.5	21.5

Results - Correlations

	Physical health		Mental health	
	r	p	r	p
Age	-.25	<.001	---	---
Education	.26	<.001	.12	.049
Ethnicity - Hispanic	.18	.005	.139	.03
Race	.14	.035		
Social support	-.24	<.001	-.39	<.001
Spirituality	.21	<.001	.22	<.001
Negative religious coping	-.25	<.001	-.25	<.001

Results - Correlations

		Ethnicity – Hispanic	Race	Education
Age	r	-.308		
	p	<.001		
Marital status	r	-.223	-.156	
	p	<.001	.018	
Ethnicity - Hispanic	r		.220	-.196
	p		.001	.002
Spirituality	r			.134
	p			.030
Negative religious coping	r			-.13
	p			.025

Results - Correlations

		Social support	Intrinsic religiosity	Positive religious coping
Age	r		.140	.158
	p		.024	.010
Marital status	r			.138
	p			.027
Ethnicity – Hispanic	r	-.142	-.134*	-.143
	p	.023	.032	.022
Race	r		.146*	
	p		.027	

Results - Correlations

		Spirituality	Positive religious coping	Negative religious coping
Social support	r	-.1		
	p	.019		
Intrinsic religiosity	r	.404**	.438	
	p	<.001	<.001	
Spirituality	r		.169	-.238
	p		.006	<.001
Positive religious coping	r			.240
	p			<.001

Results – Multiple regression

- Ethnicity, race, negative religious coping, social support, & spirituality explained 22.3% of the variability in physical health ($F = 10.4$, $p < .001$)

- Education, ethnicity, negative religious coping, social support, & spirituality explained 23.1% of the variability in physical health ($F = 14.9 < .001$)

Discussion

- Majority in community are other than Caucasian, have spirituality not necessarily connected to formal church attendance, with need of support to maintain or increase both physical & mental health
- Support role for the church & nursing to collaborate in ongoing attentive assessment of community's unique perceptions of its needs
- To impact distal health outcomes for community, church will need to focus on prevention:
  - Capitalize on strategies to support mental health, increase education, & provide social support structures beyond its own walls (Ansari, Soltero, Lorenzo, & Lee, 2017) &
  - Address spiritual & religious behavior potential within the community (Persynaki, Karras & Pichard, 2017).
- Ryan's ITHBC concepts of knowledge, belief & social facilitation is supported as contributing to both proximal & distal health outcomes.

Health policy implications

- Health policy formation must include community findings & informant's voices to be relevant in forging new innovative models to address local & regional realities of physical and mental health outcomes.
- Policy formation must recognize, stimulate, and incentivize multiple entities' (cross sector) cooperation in addressing community health needs to increase population health and reduce health inequities (Artiga & Hinton, 2018).

Future research implications

- Study of individuals of non-Christian faiths from all races warranted
- Study of neighborhood participant's awareness of existing health resources for low income, low education residents
- Study comparing health outcomes of those who use existing resources (health & legal clinic) versus those who don't
- Relationship of these concepts to self-regulation skills & abilities requires further study
- Study knowledge, belief & self-regulation concepts of theory & discern if spiritual or religious strategies effect self-management behaviors necessary for whole person health (Pfeiffer, Li, Martez, & Gillespie, 2018)

Strengths & limitations

- **Strengths**
  - Sample size large & adequate
  - Inclusion of ~45% Hispanics from impoverished communities

- **Limitations**
  - Volunteer subjects who completed self-report surveys that may limit generalizability & validity
  - Data about setting not included &, thus, comparison not available
  - Categorical versus continuous data limited baseline & comparison to other national & local databases

Conclusions

- Valid community health needs assessment (CHNA) data can fuel community specific interventions & garner monies needed to address social & community determinants of health for significant change in health impact, & engage local faith communities in the process (Ayton et al. 2017; Begun, et al, 2018).
- Connecting nursing's distinctive of whole person care with perspective of shalom the church brings offers strengthened intervention to empower the community, reduce health disparities, & shift health care outcomes

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Questions?
Additional thoughts?