Article

Implementing "Link Nurses" as Spiritual Care Support in a General Hospital

Bart Cusveller [1,*], Aliza Damsma-Bakker [1], Theotimus Streefkerk [2] and René van Leeuwen [1]

[1] Spiritual Care in Nursing Research Institute, Viaa Christian University of Applied Sciences, 8021 Zwolle, The Netherlands; a.damsma@viaa.nl (A.D.-B.); r.vanleeuwen@viaa.nl (R.v.L.)

[2] Chaplaincy Services, Van Weel-Bethesda General Hospital, 3247 Dirksland, The Netherlands; t.streefkerk@vanweelbethesda.nl

[*] Correspondence: b.cusveller@viaa.nl

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Abstract: Background: spiritual care by nurses may be omitted from clinical practice when not structurally embedded in daily professional care routines. Method: a mixed method study was designed to measure qualitative and quantitative outcomes of a "link nurse" as a spiritual care resource (LNSC). Data were gathered from nurses (n = 123–86), link nurses (n = 15–18) and patients (n = 131–122) before and after an implementation and education project among (link) nurses. Results: findings show a self-reported increase of competency in providing spiritual care, especially assessment, counseling and referral in nurses, and referral in link nurses. In interviews afterwards, link nurses (n = 10) and nurses (n = 8) indicated more confidence in providing spiritual care. Patients reported high satisfaction with spiritual care by nurses, although differences in satisfaction between measurements before and after the project could not be demonstrated. Referral frequency to chaplaincy increased during the project. Conclusion(s): nurses may be willing to include spiritual care and collaboration as part of their professional role when support is provided by the hospital leadership. Education and practice development in spiritual care are supported by the implementation of link nurses, while the hospital's leadership needs to take its responsibility to provide preconditions. Intervention evaluation suggested that the wider context of professional practice, collaboration, and organization needs to be addressed as well.

Keywords: spiritual care support; link nurses; implementation strategy; general hospital; chaplaincy

1. Introduction

1.1. Background and Problem

Most models and theories of nursing practice identify spirituality as an aspect of the patient's well-being and, for that reason, spiritual care as part of the nurse's role (Raile Alligood 2017). A growing body of research and literature in nursing points to methods and competencies as well as educational strategies to prepare nurses for this role (Cockell and McSherry 2012; McSherry and Ross 2012; EPICC 2019).

This paper uses an international consensus working definition of spirituality as "*the dynamic dimension of human life that relates to the way persons (individual and community) experience, express and/or seek meaning, purpose and transcendence, and the way they connect to the moment, to self, to others, to nature, to the significant and/or the sacred*". The definition states that "the spiritual" is multidimensional, consisting of existential challenges and issues of values, attitudes, and religion (Puchalski et al. 2009; European Association of Palliative Care 2020). This working definition is useful within the context of this project because of its experiential and dimensional scope and holistic perspective, which is relevant to nursing (McSherry and Ross 2012).

Within the context of this project, spiritual care is described as "care which recognizes and responds to the human spirit when faced with life-changing events (such as birth, illness, trauma and loss) or sadness, and can include needs for meaning, for self-worth, to express oneself, for faith support, perhaps for rites, prayers or sacrament, or simply for a sensitive listener. Spiritual care begins with encouraging human contact in compassionate relationship and moves in whatever direction need required" (NHS Scotland 2010). Thus, spiritual care supports meaning and connection as described in the consensus definition.

In the daily realities of the clinical setting, however, nurses seem reluctant and hesitant regarding spiritual care. While this varies in degree and type, one challenge invariably remains: spiritual care is insufficiently embedded in the so-called "meso-level" of an organization, i.e., the level of a ward or unit team (Clarke and Baume 2019). At this level, nurses' responsibilities are not always assigned or monitored structurally, partly depending on the personal views of superiors. As a result, nurses may ignore signs of spiritual distress in patients, omit reporting on this aspect of holistic care, and refrain from referring patients to chaplains or other experts. One way to summarize this is: "when everybody is responsible, nobody feels responsible".

Such neglect is by no means unique. Many aspects of patient care are important, depending, for one thing, on the medical field. Yet, to prevent nurses from giving less priority to one aspect or another, all key aspects need to be embedded in professional practice at the meso-level. This enables those in leadership to assign and monitor the specific roles team members have regarding such distinct responsibilities.

One common method for assuring nursing attention to any given priority is to appoint an individual unit or ward nurse as an advocate for that issue. That nurse can interface with patients, relatives, nursing colleagues, and other health professionals to assure care regarding a given area. Depending on the context, these nurses, with a specific role and expertise, are sometimes called the "resource person", "team champion" or, as we will call them, "link nurse" (Ferrell et al. 1993; White 2011; Legg et al. 2017). This unit's nurse advocate supports and coaches patients as well as other nurses in individual cases, raises awareness, puts issues on the team agenda, provides resources for practice development, liaises with management and medical staff on matters of policy, and so on.

Considering this, it is plausible to explore the value of such a form of support for spiritual care by implementing the team role of "link nurse for spiritual care" (LNSC). The authors found no literature on the use of a "spiritual care link nurse," who could serve as an advocate, coach, and resource for unit spiritual caregiving.

Nonetheless, such a link nurse was under consideration in this project's facility, a 200-bed general hospital with a Christian identity in The Netherlands, which was reorienting its chaplaincy policy. The reason for reexamining the chaplain role was the need to adapt spiritual care practices and attitudes to the increasing religious and cultural diversity of the hospital's constituency. This meant, for one thing, that the chaplain's services were expanding from individual pastoral counseling with patients into adding new forms of spiritual care support of patients and professionals.

The cooperative relationships between chaplaincy and nursing staff, however, as well as the nursing staff's role and supporting competencies in spiritual care, needed further development. The hospital needed a structure for spiritual care support of patients, especially at the micro and meso levels. In collaboration between the hospital board members, the hospital chaplain, and the present authors, a decision was made to implement and monitor a program of spiritual care education for the entire nursing staff on all units, to implement the role of a LNSC on each unit, and to provide additional education supporting competencies for that resource nurse role.

1.2. Research Questions

Given the lack of literature on this approach and the need to determine its value, the authors designed a mixed methods study to answer the following questions:

(1) What are patient and nurse perspectives on spiritual care before and after implementation of a multidimensional strategy to support spiritual care practice by nurses in a general hospital?

(2) What is the spiritual care competence development of nurses and spiritual care link nurses after the same strategy?

(3) What is the development in patient referral to chaplaincy after the same strategy?

1.3. Intervention

The multidimensional intervention included two elements: (a) basic spiritual care education for all nursing staff on spiritual care competencies necessary to their spiritual care role; and (b) additional education for LNSC nurses on additional competencies needed by all LNSCs (Table 1). Basic competencies were already published, and the addition LNSC competencies were developed by consensus of expert chaplains and nurses in September 2016. These "meso level" nursing competencies have been in use as terms of reference for an elective course in spiritual care support for undergraduate nursing students. After a trial run of two years with this course, the competency profile for link nurses was also adopted for the implementation project in the hospital.

Table 1. Spiritual care competencies for nurses and link nurses.

	General Nursing Competencies for Spiritual Care
A	Attitude towards patients' spirituality
B	Communication
C	Personal support and patient counseling
D	Assessment and planning of spiritual care
E	Referral to other professionals
F	Professionalization and improving the quality of spiritual care
	Additional Competencies for Link Nurses Spiritual Care
G	Embedding spiritual care in the primary process on the unit
H	Supporting and coaching team members in spiritual care
I	Working and collaborating inside and outside the organization
J	Contributing to the profession

A LNSC would possess both basic competencies of spiritual care as described in the literature (Van Leeuwen et al. 2009) and a more advanced understanding of spiritual care. The education part of the pilot, then, was based on the competencies in the spiritual care competency scale (A–F, Table 1). In addition to these general nursing competencies for spiritual care, consensus on competencies for link nurses was examined (G–J, Table 1).

In May 2017, the two principal investigators conducted eight explorative interviews with one group of nine head nurses and seven groups of twenty staff nurses on seven units of the hospital to determine the needs, contents, and outline of spiritual care education. Meanwhile, a steering group representing chaplaincy, education services, and head nurses from the hospital recruited two nurses on each of the units to serve as LNSC. In a meeting in November 2017, the investigators introduced the link nurses to the educational strategy and implementation of the role of link nurse.

Given the existing knowledge of spirituality and spiritual care among the nurses, as found in the explorative interviews, an e-learning course was developed by one author to be offered during Spring 2018. E-learning was chosen to facilitate individualized learning (Lo 2018). The course was included in the digital education facilities of the hospital. Two spiritual care seminars were conducted for nurses, and then the e-learning course was made available in March–August 2018.

The content of this course was built on competency principles (Rychen and Salganik 2002), and it contained items with professional information in text and video to enhance knowledge, as well as exercises concerning the use of self, the use of practice, and the use of professional resources to develop skills. Also included were suggestions for reflection to influence attitudes. Each e-learning section was based on one of the six spiritual care competence scale (SCCS) competencies (Table 1, A–F), with items

on specific knowledge, skills, and attitudes in short video clips, assignments on the unit, plus reflection exercises on these assignments, both individually and in pairs. Course participants demonstrated success by scoring 80% on a final test included in the last e-learning section. Whereas the e-learning course for all nurses consisted of five sections, for a total of four hours of education time, the course for link nurses included an additional section on the role and competencies of the LNSC based on the supplemented competency profile (Table 1, G–J).

Furthermore, given the existing competencies among nurses regarding spiritual care, as found in the explorative interviews, two seminars were offered to all nurses (February and May 2018) and an additional two workshops were offered for link nurses (January and April 2018). The approximately 180 nurses from the hospital were divided into six groups of around twenty nurses, while the link nurses were placed in a separate group of their own. The seminars as well as the workshops took three hours each. Learning outcomes were based on the competency profiles mentioned above.

The first seminar for nurses (February 2018) was led by two researchers and educators in spiritual care and nursing. Topics included an introduction to the e-learning course, plus teaching, reflection and exercises on awareness of spirituality in care, one's personal attitude towards spiritual care and the use of self in care relationships. The second seminar (May 2018) was led by two of the present authors, also researchers and educators in spiritual care and nursing. Topics included teaching, reflection and exercises on how to become aware of, assess and support the spirituality of patients, using Leget's "diamond model" (Leget 2017), and on how to discuss and report needs and support in one's team.

The first workshop for link nurses (January 2018) was led by two researchers and educators in spiritual care and nursing. Topics included an introduction to the e-learning course, plus teaching, reflection and exercises on being a team champion, responding to group resistance, and doing a SWOT analysis (strengths, weaknesses, opportunities, threats) of one's own team as regards spiritual care. The second workshop for link nurses (April 2018) was led by one of the present authors, an educator and researcher in spiritual care and nursing. Topics included teaching, reflection, and exercises on the outcomes of the SWOT analysis, a plan to improve practice in one's team, and improving conditions for practice on the meso level.

The project as a whole included a concluding symposium for a wider audience from both inside and outside the hospital, such as representatives from faith communities in the hospitals' constituency as well as chaplains and nurses from other hospitals. This provided link nurses with the exercise to present pitches of improvements necessary, improvements made, and "lessons learned", thus adding to the project a further learning experience as "team champion" in spiritual care. For an overview, see Table 2.

Table 2. Study timeline.

Time	Intervention	Participants *	Content	Modus Operandi	Monitoring
May 2017					Explorative interviews
Oct 2017					Start of data collection referral
Nov 2017	Introduction to educational intervention	LNSC	Overview role, competencies, e-learning course and meetings		
Jan 2018	First workshop	LNSC	Being a champion: "dreaming, thinking and doing"	Teaching and assignment	Baseline measurement
Feb 2018	First seminar	Nurses	Interpersonal and intrapersonal spirituality: "me, you and us"	Teaching and discussion	
Mar 2018	Start of e-learning course	Nurses	Spiritual care competencies		
Apr 2018	Second workshop	LNSC	Acting as a champion: "practice development"	Teaching and assignment	
May 2018	Second seminar	Nurses	Spiritual care: assessing, planning and supporting	Teaching and exercise	
Aug 2018	End of e-learning course	Nurses			Follow-up measurement
Sept 2018		Nurses			Concluding interviews
Nov 2018	Final Symposium	Nurses	Learning outcomes	Pitches	
Dec 2018					Finalize data collection referral

* Nurses include link nurses.

2. Method

2.1. Design and Samples

A before and after study was designed to collect quantitative and qualitative data in order to monitor the results of the intervention and the experiences among participants. Samples were drawn from three populations in the 200-bed setting described above: (a) all of the patients in all of the units admitted to the hospital on one randomly chosen day; (b) all twenty link nurses; and (c) unit nurses receiving basic spiritual care education. In addition, data on referral to chaplaincy were available. Within each of these samples, a baseline measurement (before education and LNSC intervention) and a follow-up measurement (after the intervention) were planned. Table 2 shows the chronological order of the measurements. A supervising researcher (one of the authors) and a nurse educator, who were not involved in the development and execution of the intervention, collected data. Bachelor students of nursing assisted in patient interviews.

2.2. Data Collection

Data were collected using a count of chaplain referrals, multiple written and electronic tools, and one post-intervention focus group (three months after the second seminar).

For the measurement of patients' views regarding spiritual care, a short questionnaire was used in face-to-face interviews that were translated from the validated patient reported outcome measure of spiritual care (PROMS) (Snowden and Telfer 2017). Only the first four questions from the PROMS were selected as applicable to spiritual care by nurses.

For the measurement of spiritual care competence development among link nurses and nurses, the Dutch version of the validated spiritual care competence scale (SCCS) was used (Van Leeuwen et al. 2009). Nurses were approached by email to fill out the questionnaire. The link nurses were also asked to fill out an investigator-designed questionnaire about the specific LNSC competences. The hospital's steering group asked all LNSCs through email to fill out the questionnaire online.

After the concluding symposium, one focus group interview took place with available link nurses (n = 10) and two with randomly selected nurses (n = 6 + 2). For these interviews, a topic list was used regarding the participants' experiences during the intervention and their role in spiritual care (e.g., the overall process of the project, such as project communication, relevance, and points for improvement). The interviews were recorded on audio files and transcribed for qualitative analysis.

Lastly, the frequency of referrals to the hospital chaplain was obtained by quantifying anonymous data from electronic patient files.

2.3. Analysis

The quantitative data were analyzed statistically (descriptive) by use of SPSS. Before–after measurements of PROMS and SCCS were tested with the Mann–Whitney U test (MW-test), as the outcomes were not normally distributed. The significance level was set at $p < 0.05$. Data from the focus groups were analyzed qualitatively by one researcher using content analysis (open coding) and peer review. Qualitative results from this analysis were discussed within a group of qualified fellow researchers.

2.4. Ethical Approval

Written ethical approval for this study was given by the ethics committee of the hospital where the study took place.

3. Results

3.1. Patients

In order to examine patients' views regarding spiritual care and to determine if these changed after the intervention, we analyzed PROMS data; Table 3 shows that patients reported a high appreciation for the work nurses do with respect to spiritual care, both before and after the intervention, but showed no significant change after. Implementation of educating nurses and selecting link nurses did not show significant differences ($p < 0.05$).

Table 3. Patient reported outcome measure of spiritual care (PROMS) questionnaire.

During My Stay *	Before (n = 131)	After (n = 122)	*p*-Value MW-Test
I was listened to	95% ** (128)	98% (121)	0.89
I was able to talk about what was on my mind	95% (126)	96% (121)	0.32
My situation was understood	91% (127)	95% (122)	0.42
My faith/beliefs were valued	98% (114)	92% (110)	0.40

* Scores range between "not at all", "rarely", "some of the time", "often", and "all of the time"; ** Scores for "some of the time", "often", and "all of the time" are taken together. MW-test: Mann–Whitney U test.

Answers to open questions in the questionnaire (almost half of the patients made use of the opportunity) offered both positive and negative general feedback on the work nurses do, including the following:

Appreciative:

- "They are friendly, professional and hardworking people";
- "I am grateful for the love that shows from the care they provide";
- "Nurses truly put their heart and soul into their work";
- "They do what they're trained for and do it with kindness and an encouraging word. The same goes for the chaplain".

Room for improvement:

- "They're very busy and rushed and seem understaffed";
- "Organization and communication in the unit leaves something to be desired";
- "Some should show more tact and manners. Some of them seem to be working too much on automatic pilot";
- "It wasn't always made clear to me what was waiting for me, which made me anxious and irritable".

Measurements before and after show a consistent pattern in patient's evaluation of nurses' contribution to their spiritual well-being. This is mostly expressed in terms of attitude—nurses' *way* of working. Especially nurses' concern and involvement are praised. A notable point in the open answers afterwards is the mention of the chaplains' role and the commitment nurse demonstrate.

3.2. Nurse Competence

The e-learning course was successfully completed by 178 nurses (of a total of 246 nurses) by the end of August 2018 for a 72% response rate. Another 65 nurses started the course but did not finish it. Only three nurses who started and completed the course did not pass the test with an 80% score.

During the live workshops for the nurses, attendance was mandatory and registered, meaning that with the exception of those who were on sick leave or maternity leave, all hospital nurses attended both workshops. All link nurses attended both training sessions, during which they were supported in setting up projects regarding spirituality in nursing care on their units. The projects they chose included a visual application of the diamond model, the introduction of moral case deliberation to the unit, developing a pocket card on spiritual issues for patient with cancer, inclusion of a spiritual

assessment during intake, adding spirituality to the electronic patient file (EPD), adopting the "theory of presence" in the emergency unit, and the development of a video on moral case deliberation in intensive care. Eight projects were completed during the research period. Six of these projects were presented by the link nurses at the closing conference.

Table 4 shows that among nurses' scores for the competencies for planning spiritual care, personal patient support and referral increased significantly. Interestingly, the increase of mean scores in nurses between before and after showed an identical increase compared to link nurses (0.2–0.3), with two exceptions. The attitude of link nurses toward the patients' spirituality increased, whereas the attitude of nurses stayed the same. With regard to communication with patients, the situation was the other way around: mean scores for nurses increased somewhat, whereas scores for link nurses remained the same.

Table 4. Spiritual care competency scale (SCCS) results.

SCCS, Mean Score *	LNSC			Nurses		
	Before (n = 15)	After (n = 18)	*p*-Value MW-Test	Before (n = 123)	After (n = 86)	*p*-Value MW-Test
Assessment and planning	3.7	3.9	0.12	3.6 **	3.8 **	0.01 **
Professionalization and quality assurance	3.1	3.4	0.06	3.0	3.3	0.08
Personal support and patient counseling	3.7	4.0	0.11	3.6 **	3.9 **	0.00 **
Referral to other professionals	3.9 **	4.1 **	0.04 **	3.8 **	4.0 **	0.02 **
Attitude towards patients' spirituality	4.1	4.3	0.16	4.3	4.3	0.70
Communication	4.3	4.3	0.63	4.3	4.3	0.90

* Score 1: disagree completely; 2: disagree; 3: neither agree nor disagree; 4: agree; 5: agree completely; ** Mann–Whitney test, $p < 0.05$.

3.3. Nurses: Follow-Up Focus Group

The results from the focus group interview with nurses range from positive to negative feedback. The e-learning course, the seminars and the workshops contributed to an awareness of the importance of spiritual care, to insight into one's personal and professional role, and to a toolkit for clinical practice. There was less feedback on the vagueness of the topic and the project than beforehand. A holistic approach and practical know-how seem to have come to the fore. Respondents seem to have made a step from abstract to concrete insights.

In addition to those positive points, the following points for improvement were mentioned:

- "What about continuity? If we do not keep bringing spiritual care to each other's attention, if only in team meetings and evaluations every six months or so, then what? And why were the medical staff not involved?";
- "Case deliberation in our own team would be helpful. The link nurse could prepare this";
- "We need to make contact with the link nurse, familiarize ourselves with what she is doing";
- "Management/administration should make more time available for e-learning and make spiritual care part of the regular educational programs of the hospital. Also, this e-learning course it too long";
- "The objectives and content of education should be introduced much clearer beforehand";
- "Include more information of world religions and cultural differences".

3.4. Link Nurses: Competency Scale

As Table 4 shows, scores on nursing competencies for spiritual care have all increased in link nurses and, in the case of referral, significantly so. This suggests link nurses clearly said to have developed this precondition for their role during the project. It is also noteworthy that the link nurses started with slightly higher mean scores on five of the six competencies compared to the nurses, which suggests that they see themselves as a little more prepared for their roles as link nurses compared to their colleagues. In four of the six scores, they also ended up with slightly higher mean scores compared to other nurses, which also suggests a relevance of their role as champion among their peers.

Table 5 shows mean scores for link nurse competencies on all items, although the response was too small to do a helpful statistical analysis of significance. Even so, competency scores for some items have increased by no less than 0.8–0.9 on a five point scale. Additionally, on items where link nurses had relatively low scores or were undecided when rating themselves before the project, they scored substantially higher after the project. This suggests an increase of confidence in themselves in their role as link nurses.

Table 5. Link nurse competencies for spiritual care.

Nursing Competencies for Spiritual Care in Link Nurses, Mean Score Per Item *	Before (n = 15)	After (n = 18)	*p*-Value MW-Test
Professionalization and quality assurance in the role as a link nurse			
I can contribute to the improvement of my colleagues' expertise regarding spiritual care to patients	3.0 **	3.8 **	0.01 **
I can advise my team/unit on quality improvement regarding spiritual care to patients	3.1	3.7	0.08
I can develop an education program for my team/unit regarding spiritual care	2.5 **	3.4 **	0.01 **
Referral to other professionals in the role of link nurse			
I can liaise with professionals in my organization with a special role in spiritual care (chaplains, link nurses, social workers, psychologists)	3.4	4.1	0.07
I can report and hand over spiritual care to professionals in my organization with a special role in spiritual care	3.3	3.7	0.20
I can refer patients and colleagues to professionals in my organization with a special role in spiritual care	3.5	4.1	0.08
I can act as an advocate for spiritual care within my team/on my unit (as a champion or resource person).	3.3	3.6	0.40
Collaboration in the role of link nurse			
I can liaise on behalf of patients or colleagues with professionals, organizations, and communities outside my own organization with a special role in spiritual care	2.4	3.0	0.22
I know world religions and value systems important in my country	2.5	2.8	0.68
Advocating spiritual care in the role of link nurse			
I am able to function as a role model in spiritual care for my team/unit	3.1	3.6	0.13
I can explain the role of link nurse to members of my profession	2.7	3.4	0.06
Professionalizing and organizing in the role of link nurse			
I can organize an ethics meeting or moral case deliberation for my team/unit	3.1	3.4	0.28

* Score 1: disagree completely; 2: disagree; 3: neither agree nor disagree; 4: agree; 5: agree completely; ** Mann–Whitney test, $p < 0.05$.

3.5. Link Nurses: Follow-Up Focus Group

The focus group interview with link nurses after the project suggests a nuanced picture of positive and negative experiences with opportunities for improvement.

Examples of positive experiences include:

- "The whole project set something in motion; if the goal was to raise awareness, it succeeded. The topic is being addressed more openly now";
- "We became more aware of the need to really be there for the patient, it forced us to sit down and think how to put it into practice";
- "The chaplain was a positive factor in the spiritual care to both patients and nurses";
- "We now see more and better reports of patient–nurse interaction on spirituality. The use of model questions was a big help for intake as well as probing spirituality later on".

Examples of negative experiences are:

- "There was more than a little grumbling and opposition during the project, a hostile reception even";
- "It was required of us on top of everything else, and it cost a lot of time, it was burdensome";
- "We did not see the point, as we were in fact already doing it";
- "It was unclear if spirituality was seen as religious or as something broader";
- "The objectives of the project were communicated insufficiently, the hospital gave it too little support, was this what the board wanted with its Christian heritage?".

Opportunities for improvement:

- "As LNSC, we should meet as a group at least twice a year, together with the steering group and the chaplain, to compare notes and develop expertise";
- "Continuity of the link nurse's role should be secured in the unit's policy, meaning when one resigns another is appointed. The head nurse and senior nurses obviously have to be behind it";
- "Continuing education for link nurses should be provided after the project";
- "Make educational strategies more interactive (attuned to the experiences and development to my own team), more customized (attuned to the medical specialty and patient category of my own unit), and even more practical (attuned to the needs of the individual patient)";
- "I want to motivate my colleagues in a natural way: how to do that?";
- "How am I supposed to move forward with the SWOT analysis and plan for improvement in the longer run? What are the objectives in the long run?";
- "It was important to ask the chaplain to join patient consultations. We need to formalize this way of working. It lowers the threshold to consult him".

These points of feedback suggest that—after the first steps of raising awareness of spiritual care and developing expertise—further steps need to be taken after the project in collaborative relationships and in securing aspects of practice at the meso level of procedures, preconditions, and policy.

3.6. Chaplaincy

During the project and especially after concluding the educational program, nurses referred patients more often to the hospital chaplain based on numbers of referrals. This increase in referrals is shown in Figure 1. Especially after the start of the e-learning course (April 2018), the frequency of referral was higher than before. According to personal communication from hospital services, the chaplain was also consulted more often by nurses for their personal benefit.
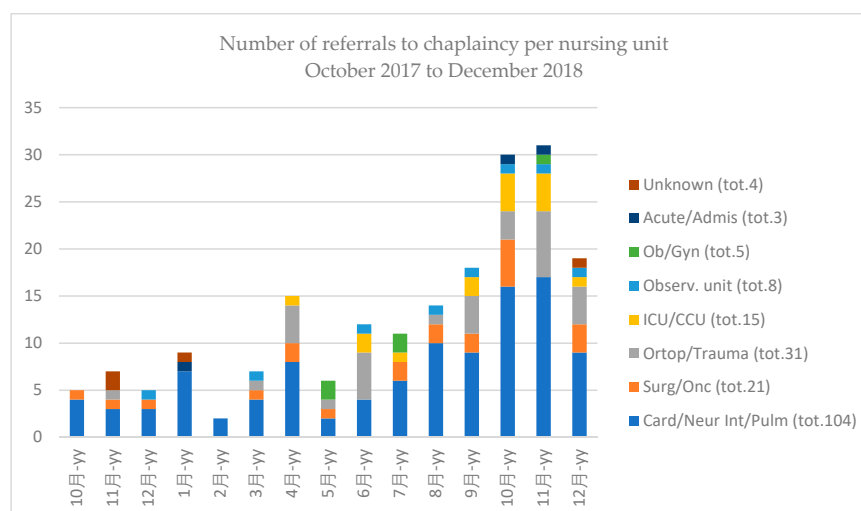

Figure 1. Referral to chaplaincy during the project.

4. Discussion

4.1. Practice

Our assumption was that changes in practice could be demonstrated in terms of competencies, referrals to chaplaincy, and patient satisfaction. The first assumption seems to have been correct, as was shown by data before and after the education and implementation project, using both quantitative and qualitative data. The second assumption seems to have been correct as well. The third assumption was neither confirmed nor refuted, as patient satisfaction with nurses' spiritual care remained high but unchanged.

Concerning nurses, firstly, the average scores on the SCCS show some significant improvements. An earlier study on spiritual care competencies in nursing practice shows that scores on "I can" are a predictor for "I do" (Vogel and Schep-Akkerman 2018). In addition, chaplaincy data confirmed a notable increase in the number of entries on spiritual care during the project, as did the number of referrals. Therefore, not only nurses' competencies improved during the project, but also their actual practice. This effect of practice development in comparable fields has been shown in the literature before, although long-term effects have not been shown in our study. In the literature there is some indication that the numbers of referral to chaplaincy decrease again after a while (Vlasblom 2015).

The open-ended questions (in questionnaires and interviews) suggest that nurses did (grow to) see the relevance of spiritual care and the learning curve they went through in practice. Some expressed hesitations or negative feedback, however, concerned the process and the organization of the project as such. Nurses also indicated the need for more practical guidance, especially regarding the application of assessment and support of spirituality. Lastly, their feedback suggests an interest in professional development in less general and in more patient category-specific terms.

Concerning link nurses, secondly, the average scores on the SCCS before the project indicate that link nurses already had a slightly higher confidence in their spiritual care competencies and were in that sense rightly appointed to lead their colleagues in this respect. Their average scores after the project indicate that they were still ahead of their colleagues in terms of competencies. They grew in confidence in their role at the meso level, for instance concerning referral, liaising with leadership, and supporting colleagues. In their responses to open questions they showed sensitivity to a supportive institutional context and collaboration as preconditions for improvement of spiritual care practice.

4.2. Intervention

Scores on the scales, answers to open-ended questions and interviews, and the number of referrals to the chaplain all increased during the project. The frequency of referrals seems to indicate a correlation with educational activities (Table 2). Although this does not demonstrate a causal relationship between intervention and effects, this points toward a need for more study to see whether we would see significant results if the intervention were prolonged, Respondents indicated that both the educational strategy and the implementation of the LNSC role improved their competencies and practice of spiritual care.

Additionally, an effect on patient satisfaction has not been demonstrated by use of the PROMS. Answers to open questions, however, suggest high levels of appreciation for the way the nurses show respect, compassion, and presence. Any support for staff education and link nurses is then viewed positively as a part of nurses' holistic care.

To be sure, the intervention seems to prompt changes in nurses and link nurses during six months, but it cannot be said how long these changes will last. The team role of link nurses, the e-learning course, and support from the chaplain are now permanent features of clinical practice in the units, supporting the way in which spiritual care is embedded in patient care. Additionally, a coordinating, hospital-wide "LNSC plus" has been appointed to facilitate mutual exchange and support among link nurses. Still, without the encouragement of the project as such—i.e., the backing from the steering group

and the board of directors—the durability of the improvements remains to be monitored. Follow-up research is being prepared.

Feedback from the participants showed an awareness that a project like this does not only involve a change in the organizational structure and work processes; it also requires a change in attitudes and organization culture. But this cannot be considered to be completed within twelve months. Some summarized this by saying: "let's close this project with a comma, not a period". This feedback also suggests that a project like this leaves room for improvement. Effects of an innovation like a new team role have been demonstrated, but particularly the long term effects are potentially jeopardized by the realities of everyday nursing practice (Vlasblom 2015). Examples of limitations have been mentioned and require attention in the near future:

- Anticipating resistance to change is key: management of expectations and sharing information on objectives and activities at all levels of the organization were not recognized by all nurses and link nurses.
- Involving support staff (education, communication) and leadership is key: the role of head nurses and the PR department as well as communication was not recognized by all nurses and link nurses.
- Repeating, fine-tuning and/or supplementing activities involved in the project is key: not all link nurses followed through on their own improvement plans by themselves, nor on liaising with the chaplaincy.
- Participants indicated the need to feel part of a bigger whole: some nurses and link nurses felt that without involvement of all or most other health professionals in the hospital, such as midwives, social workers, and medical staff, they were not so much frontrunners but rather an odd exception in the development of professional practice.
- A project like this is only possible when those formally responsible are explicitly behind it and "put their money where their mouth is": not all nurses and link nurses recognized this as actually being the case.

Vital preconditions—besides practice development through training, coaching and education—turned out to be a shared vision of spiritual care and the roles and competencies involved and, last but not least, leadership and commitment at the level of the hospital's executive management.

4.3. Method

The validated SCCS and the supplemental scale for link nurses (though not validated) proved useful to making changes in self-scores on spiritual care competencies visible. Coupled with observations, interviews, and referral data, this also made changes in practice visible. To be sure, sample sizes of the follow-up interviews afterwards were so small that hardly any conclusions can be drawn from them.

It is hard to say whether use of the PROMS has been helpful. Apparently, levels of satisfaction were already high and consistent with responses to open-ended questions, and maybe this prevented further improvement. On the other hand, it may or not have been the right tool. At the very least the data did not show a decrease of patient satisfaction, which we might interpret as a good thing in itself.

5. Conclusions

Before the start of the project, the problem was that spiritual care in a general hospital was insufficiently embedded in nursing practice. Nursing leaders and nursing educators did not have a model to facilitate spiritual care. Spiritual care education of nurses in the units supported by introduction of link nurses for spiritual care in nursing may be a promising strategy to improve professional practice. The core of the LNSC strategy was to find and secure procedures and standards for daily practice—intake, planning, reporting, evaluating, collaborating, and so on. Reluctance and barriers were replaced by increased confidence and competence during this innovation, while nurses and patients still saw room for improvement.

One noteworthy side-effect of the project, though it does not add to the profession's knowledge base as such, is the "symbolic value" of the innovation itself. In principle, *all* nurses of this one hospital have been exposed to the appeal not to ignore the patient's spirituality and to see spiritual care as a professional role. In the closing symposium, some 90 participant from outside the hospital witnessed how link nurses from half a dozen units presented diverse plans for improvement of spiritual care. As far as we know, this has not been achieved in a general hospital before (at least not in the Netherlands).

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