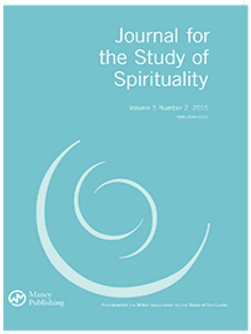

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Preparing undergraduate nurses and midwives for spiritual care: Some developments in European education over the last decade

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ABSTRACT

In recent years, preparing nurses and midwives to feel competent and confident in providing spiritual care has become the subject of international research. There is an emerging body of evidence affirming the importance of spirituality in promoting the health

KEYWORDS

European; Spirituality; spiritual care; students; nursing/midwifery; competence

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and wellbeing of individuals. Despite this growing recognition, there are still inconsistencies in the way that undergraduate students in nursing and midwifery are taught and prepared to assess and address this dimension of the person, and fundamentally how these concepts are integrated within programmes of education. This article charts the evolution of a European programme of research, spanning a decade, exploring undergraduate nurses' and midwives' perception of spirituality and perceived competence in providing spiritual care. The research culminated in an educational research study that led to the co-production and development of best practice standards for spiritual care education and the launch of a network to sustain and advance this neglected area of nursing and midwifery practice.

Background

Most Governments recognise the importance of the spiritual part of life for the health and wellbeing of their citizens (European Commission 2010), particularly when facing life-challenging events such as birth, illness and/or death (Welsh Government 2015; NHS England 2015; The Scottish Government 2009; Norwegian Helsedirektoratet [Directorate of Health] 2015; Norwegian Health Library 2019). Furthermore, a significant evidence-base highlights the health benefits of spiritual wellbeing on quality of life, anxiety/depression and coping (Koenig, King, and Carson 2012; Balboni et al. 2017; Steinhauser et al. 2017).

Spiritual care, which responds to people's personal, religious and spiritual beliefs and needs is important to health service users (Ross 2006; Giske and Cone 2015; Ross and Austin 2015; Selman et al. 2018) and providers (NHS Education Scotland [NES] 2009; Marie Curie Cancer Care 2003; Department of Health [DH] 2008) but is often overlooked (Royal College of Physicians [RCP] 2016; Giske and Cone 2015; Ross and Austin 2015).

Over the past decade, within the UK, there have been several reports highlighting significant failings in the quality and standards of care (The Patients Association 2009, 2010, 2011; DH 2012; The Mid Staffordshire NHS Foundation Trust Public Inquiry 2013; Dementia Services Development Centre 2015). The findings and recommendations from these reports have implications for nursing and healthcare practice. These failings have, in part, been attributed to a lack of compassion, dignity and respect; attributes which are closely linked with spirituality (Fenton and Mitchell 2002; Lewinson 2016; Ali et al. 2018). Lord Francis, who led the 2013 Public Inquiry into The Mid Staffordshire NHS Foundation Trust, recommended that health services should re-focus on what is fundamental: high-quality care which 'puts the patient first' ensuring that they are the focal point for the provision of all care, services and treatments. When healthcare settings, systems and processes lose sight of the 'person' then they become susceptible to a range of values, attitudes and behaviours that violate peoples' humanity and dignity.

The European Commission (2010) recommends that the caring professions are educated to address the spiritual, religious and cultural needs of people. Nursing and midwifery regulatory and educational bodies similarly require nurses/midwives to be able to provide spiritual care as part of person-centred holistic care at point of registration (International Council of Nurses [ICN] 2012; International Confederation of Midwives [ICM]

2008; Nursing Midwifery Council [NMC] 2018; Ministry of Education and Research [Norway] 2017). However, there has been a lack of clarity around what spirituality means and what spiritual care looks like for these professions (Royal College of Nursing [RCN] 2011).

The concept of spirituality has always been, and for some, will always remain a contentious issue both within healthcare and indeed wider society. In an attempt to resolve some of these issues (such as lack of clarity and inconsistency in meaning) an international panel proposed a definition that they had developed using a consensus method (Puchalski et al. 2014). This definition may go some way towards offering a more coherent understanding of the concept, especially within healthcare. A number of health-related organisations, such as the European Association of Palliative Care, have adopted this definition in which spirituality is considered to be:

> 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 spiritual field is multidimensional:

1. Existential challenges (e.g. questions concerning identity, meaning, suffering and death, guilt and shame, reconciliation and forgiveness, freedom and responsibility, hope and despair, love and joy).
2. Value-based considerations and attitudes (e.g. what is most important for each person, such as relations to oneself, family, friends, work, aspects of nature, art and culture, ethics and morals, and life itself).
3. Religious considerations and foundations (e.g. faith, beliefs and practices, the relationship with God or the ultimate; EAPC 2011).

This definition reflects the common attributes of spirituality that have been captured through international research across disciplines, namely meaning and purpose, connection and transcendence (Weathers, McCarthy, and Coffey 2016; McSherry 2016; Selman et al. 2018; WHO 2002).

NES describes spiritual care as:

> Care which recognises and responds to the human spirit when faced with trauma, ill health or sadness, and can include the need for meaning, for self-worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener. Spiritual care begins with encouraging human contact in compassionate relationship and moves in whatever direction need requires. (NES 2009, 6)

We are acutely aware that, despite the attempts of one panel or group to provide a more coherent and consensus-based approach to understanding concepts such as spirituality and spiritual care, the outcome of such deliberations and activities may not be transferrable or universally acceptable. For example, limitations might arise due to culture, context and language.

Although international definitions of spirituality and spiritual care have been reached, the thorny issues of exactly what nurses and midwives need to demonstrate in order to be classed as competent in spiritual care, and how they can be helped to achieve this, still require a more coherent unified and standardised approach. Attempts have been made

to achieve this by individuals (Baldacchino 2006) or small groups of researchers (van Leeuwen and Cusveller 2004) and more recently interest in this area has extended outside Europe (see Adib-Hajbaghery, Zehtabchi, and Fini 2017). This initial pioneering work has been conducted over several years but there has never been a trans-European approach to construct a Standard for Spiritual Care Education. Several competency documents have been developed in this area. For example, the MCCC (2003) developed *Spiritual and religious care competencies for specialist palliative care* while Manitoba's Spiritual Health Care Partners (2017) created *Core competencies for spiritual health care practitioners.* In Australia, *National Guidelines for Spiritual Care in Aged Care* have been developed (Meaningful Ageing Australia 2016) but the explicit focus of all these documents has been in other contexts than developing competence in undergraduate nursing and midwifery education.

Therefore, the specific focus and context of this article is on developments within Europe involving nursing and midwifery. Researchers in the area of spiritual care education from the UK, Netherlands, Malta and Norway (several leading the field in competency development in nursing and midwifery) formed an informal network: the 'European Spirituality Research Network for Nursing and Midwifery', to respond to this need. A number of gaps were identified (Table 1) and three landmark studies were conducted to address these gaps.

Three landmark European studies

Three studies were conducted over a period of six years (2010–2016). Two of these studies focused on identifying student nurses'/midwives' perceptions of spirituality and factors contributing to the development of spiritual care competency (SCC). The third study developed a spiritual care competency framework. They are described below.

Study 1

In 2010, a cross-sectional study of 531 pre-registration nursing/midwifery students from six universities in four European countries identified the following:

- Students held a broad view of spirituality (measured by the Spirituality & Spiritual Care Rating Scale [SSCRS]; McSherry, Draper, and Kendrick 2002) and considered themselves to be more competent than not in spiritual care (measured by Spiritual Care Competency Scale [SCCS]; van Leeuwen et al. 2009) at the start of their studies.

Table 1. Gaps in nursing/midwifery spiritual care education.

1. It was not clear what spiritual care competency looked like or how it might be assessed; there were no spiritual care competencies. It was also unclear how spiritual care may differ from good nursing care (Biro 2012).
2. It was unclear how learners might acquire spiritual caring skills and how they may open up to this aspect of nursing practice (Giske and Cone 2012).
3. Spiritual care teaching within undergraduate nursing/midwifery education programmes was inconsistent, and in some places non-existent (Lewinson 2016; Ali et al. 2018).
4. Practising nurses/midwives reported over a number of decades that they felt inadequately prepared for spiritual care and in need of further education (Ross 1994; RCN 2011; Austin et al. 2017; Egan et al. 2017).
5. Whilst some educational materials were available for practising nurses/midwives (RCN 2012), the evidence on which to base them was scant, and no educational materials were publicly available for pre-registration nurses/midwives.

- Personal spirituality of the student (measured by Spiritual Attitude and Involvement Scale [SAIL], $p < .001$; Meezenbroek, Garssen, and van den Berg 2008 and JAREL Spiritual Wellbeing Scale, $p < .001$; Hungelmann et al. 1996) and perception of spirituality (SSCRS, $p = .002$) correlated with perceived SCC (Ross et al. 2014, 2016).

Study 2

Between 2011 and 2016, a longitudinal prospective follow-on study of 2193 (dropping to 595) students from 21 universities in eight European countries:

- Confirmed the findings from the first study; personal spirituality of the student (high spirituality scores preferable [SAIL $p < .01$; JAREL $p < .01$) and perception of spirituality (holding a broad view preferable, SSCRS $p < .01$) correlated with perceived SCC.
- SCC developed significantly over the duration of the course of study ($p < .01$), which students attributed to caring for patients in clinical practice, personal life events and teaching/discussion in university and with other students (Ross et al. 2018).

These findings provided the first evidence-based guidance for educators on what should be taught, and how to help students to become competent in spiritual care. These two studies highlighted those factors that students felt contributed to the development of their self-perception of competency in the provision of spiritual care, such as having a high sense of personal spirituality while holding a broad view of what constitutes spirituality and spiritual care (i.e. not just something religious). Students also identified that one of the greatest influences on developing awareness of spirituality and spiritual care was caring directly for patients in clinical practice. While at university, the use of scenarios and reflective exercises that focused upon patients were considered valuable.

Study 3

Between 2011 and 2015, a PhD study developed the first SCC framework for pre-registration nurses/midwives from an in-depth review of the international literature, stakeholder focus groups and modified Delphi method. The Framework consisted of 54 items arranged in 7 domains: knowledge in spiritual care; self-awareness and the use of self; communication and interpersonal skills; ethical and legal issues; quality assurance in spiritual care; assessment and implementation of spiritual care; and informatics in spiritual care (Attard, Ross, and Weeks 2019).

The next step was to consider how the significant new evidence obtained from these three studies might be used to establish best practice in undergraduate nurse/midwifery spiritual care education. European funding (Erasmus+ KA2 Grant Agreement Number: 2016-1-UK01-KA203-024467) brought together nursing/midwifery educators, students and other stakeholders from across Europe to undertake that task. That project was called 'EPICC': **E**nhancing nurses' and midwives' competence in **P**roviding spiritual care through **I**nnovative education and **C**ompassionate **C**are (www.epicc-project.eu).

The EPICC project (2016–2019)

Aims

Using evidence from the research to date, the EPICC project aimed to:

1. Develop a set of core spiritual care competencies for undergraduate nurses and midwives, called the 'Spiritual Care Education Standard'.
2. Develop a 'Gold Standard Matrix for Spiritual Care Education' to provide context and evidence to underpin the 'Standard'.
3. Develop an Adoption Toolkit with teaching and learning activities to help students attain the competencies outlined in the 'Standard'.
4. Establish a Network to enable educators, researchers, and other stakeholders to communicate and share ideas about best practice in spiritual care education.
5. Establish a website, as the hub for all of the above outputs.

Method

The methodology employed in the project was co-production, involving a series of facilitated Action Learning cycles and consensus surveys to create the four competences and all the key outputs. The high level of engagement meant all the outputs were rigorously reviewed and subject to intense testing, ensuring they are fit for purpose. The Spiritual Care Education Standard will guide improvements in the way spiritual aspects of nursing/midwifery care are integrated and taught within curricula across Europe and internationally. Ethical approval was gained from the Lead Partner's University.

Participants

Six Partners, known as 'EPICC Strategic Partners' (funding applicants), and 31 'EPICC Participants' (pre-registration nurse/midwifery educators from 21 European countries identified through EPICC Partners' networks and an advertisement on Research Gate) participated. Table 2 shows the participating countries and examples of stakeholders involved in co-production of the outputs. International stakeholders were referred to as 'EPICC Participants+' and these included students; members of the public; educators; clinicians; policy makers; professional organisations; healthcare managers; and service users.

Collectively, the three EPICC groups all made a significant contribution to co-production of the EPICC Project outputs. The groups can be viewed diagrammatically as an equilateral triangle, which became known as 'The EPICC Triangle'. This represented a unity in the way these three distinct groups were working in terms of vision and having the same goals of achieving the aims and objectives of the project. This approach is novel and innovative in that it emphasises the importance of true collaboration and co-production. This was not in some tokenistic way, but in a way that was meaningful and directed towards achieving shared goals and creating a shared vision. 'The EPICC Triangle' enabled the development of a culture where everyone was valued, their contribution welcomed, and where they were supported by EPICC Strategic Partners to

Table 2. Participating countries and stakeholder examples.

Participating countries (alphabetical order)		
Europe		Outside Europe
Belgium	Poland	Brazil
Croatia	Portugal	China
Czech Republic	Portugal	Iran
Denmark	Spain	Malaysia
Germany	Sweden	New Zealand
Greece	Turkey	Thailand
Ireland	Ukraine	
Lithuania	United Kingdom: England, Scotland,	
Malta	Wales, (Northern Ireland)	
Netherlands		
Norway		
Stakeholder examples		
Country	Organisation	
England	NHS England, Public Health England.	
Norway	Norwegian Nursing Association.	
Netherlands	Danish Ethical Board, Dutch Higher Education Board.	
Republic of Malta	Nursing & Midwifery Board.	
UK	RCN, NHS Chaplaincy.	
Wales	Welsh Government (Chief Nursing Officer), Health Education Improvement Wales (HEIW), Social Care Wales, Executive Nurse Directors (ENDs), Council of Deans Wales (CoD), students.	

ensure the success of the project. Should one side of the triangle fail to deliver or make a significant contribution then the entire outcomes of the project would be potentially compromised. This means all involved were empowered and given a true stake and voice in achieving the aims and outcomes of the project. This has consistently been evidenced from the feedback provided by EPICC Participants and Participants+ throughout the project, emphasising how this unique and person-centred approach created a sense of identity and community.

Process

The project aims were achieved through a series of activities:

- Two, week-long *learning/teaching/training activities (LTTA)*: the first in the Netherlands (October/November 2017), with 52 attending across the 5 days; and the second in the Republic of Malta (September 2018), with 110 attending across the five days. These events enabled EPICC Participants to spend dedicated time working face-to-face on the outputs. Between these meetings, the EPICC Strategic Partners and the EPICC Participants maintained contact *via* email and Skype through mentor groups.
- Two, two-day long *multiplier events* (ME) were held: one at the beginning (Stoke-on-Trent, UK [April 2017]) with 61 attendees, and one at the end (Cardiff. UK [July 2019]) with over 120 attendees. This level of participation enabled wider stakeholder discussion and engagement with the project outputs.
- Annual, two-day face-to-face *Transnational Project Meetings (TPM)* (6 EPICC Strategic Partners plus 6 guests from their organisations in the Netherlands). The total attendance across the four meetings was 51.
- Bi-monthly EPICC Strategic Partner Skype meetings (36 in total) ensured the project ran effectively and efficiently.

Ways of working and results

1. Development of the 'spiritual care education standard'

At ME 1 (April 2017), we discussed the results of the three studies (Ross et al. 2014, 2016, 2018). Through small group discussions, EPICC Participants considered the implications of the results for their own practice and identified actions to take back to their universities to consider in developing their undergraduate curricula. We also discussed the 54-item Competency Framework developed by Attard, Ross, and Weeks (2019) and agreed that the 54 items needed to be refined. In an online questionnaire, we rated each of the items in terms of relevance and priority using a 5-point Likert scale. This enabled respondents to rank each item and categorise those items according to the percentage agreement: green (>90% agreement), yellow (70–90% agreement), or red (<70% agreement). These results were analysed in SPSS using descriptive statistics. The findings of the questionnaire were used as a starting point to identify those competences that scored/ranked highly by the participants.

At T&L Event 1 (November 2017), EPICC Participants provided feedback on discussions/actions within their universities, specifically: what activities they had undertaken; who was involved; which competencies were used; the outcomes and how they were documented; and the barriers/facilitators. Results from the online survey were presented and the 54 competencies were reduced to 16. This was still considered to be too many to be practical, so EPICC Participants worked in small groups to refine the competencies further. Consensus was reached in a plenary session resulting in 9 competencies. The European Association Palliative Care definition of spirituality (EAPC 2011) and the NES description of spiritual care (NES 2009) were adopted for the preamble to the draft Spiritual Care Education Standard.

At T&L Event 2 (September 2018), the nine competencies were reduced to four through small-group discussion followed by consensus in a plenary. In respect of the preamble, the NES (2009) adapted description of spiritual care was amended to include a wellness perspective, ensuring its relevance to midwives. The changes are highlighted in bold below:

> Care which recognises and responds to the human spirit when faced with **life changing events (such as birth**, trauma, ill health, **loss**) or sadness, and can include the need for meaning, for self-worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener. Spiritual care begins with encouraging human contact in compassionate relationship and moves in whatever direction need requires.

The final four-item Spiritual Care Education Standard was agreed (Table 3).

2. Development of the 'Gold Standard Matrix for Spiritual Care Education'

A draft Matrix explaining the cultural, social and political environment in which spiritual care competencies in nursing education evolves, was developed by the EPICC Strategic Partners and was emailed to EPICC Participants ahead of T&L Event 2 (September 2018). It was presented at T&L Event 2, and EPICC Participants discussed it in groups and gave feedback during a plenary session. The draft was amended and the final version of the Matrix and the narrative explaining it were approved electronically by EPICC Participants.

3. Development of the Adoption Toolkit

At ME 1 (April 2017), participants presented examples of their spiritual care teaching and learning activities from their own practice. At T&L Event 1 (November 2017), EPICC Participants produced posters of one teaching/learning activity in enough detail to enable

Table 3. EPICC Spiritual Care Education Standard (Competency Framework).

	Competencies	Knowledge (Cognitive)	Skills (Functional)	Attitude (Behavioural)
1	Intrapersonal spirituality Is aware of the importance of spirituality on health and well-being.	• Understands the concept of spirituality. • Can explain the impact of spirituality on a person's health and well-being across the lifespan for oneself and others. • Understands the impact of one's own values and beliefs in providing spiritual care.	• Reflects meaningfully upon one's own values and beliefs and recognises that these may be different from other persons'. • Takes care of oneself.	• Willing to explore one's own and individuals' personal, religious and spiritual beliefs. • Is open and respectful to persons' diverse expressions of spirituality.
2	Interpersonal spirituality Engages with persons' spirituality, acknowledging their unique spiritual and cultural worldviews, beliefs and practices.	• Understands the ways that persons' express their spirituality. • Is aware of the different world/religious views and how these may impact upon persons' responses to key life events.	• Recognises the uniqueness of persons' spirituality. • Interacts with, and responds sensitively to the person's spirituality.	• Is trustworthy, approachable and respectful of persons' expressions of spirituality and different world/ religious views.
3	Spiritual care: assessment and planning Assesses spiritual needs and resources using appropriate formal or informal approaches, and plans spiritual care, maintaining confidentiality and obtaining informed consent.	• Understands the concept of spiritual care. • Is aware of different approaches to spiritual assessment. • Understands other professionals' roles in providing spiritual care.	• Conducts and documents a spiritual assessment to identify spiritual needs and resources. • Collaborates with other professionals. • Be able to appropriately contain and deal with emotions.	• Is open, approachable and non-judgemental. • Has a willingness to deal with emotions.
4	Spiritual care: intervention and evaluation Responds to spiritual needs and resources within a caring, compassionate relationship.	• Understands the concept of compassion and presence and its importance in spiritual care. • Knows how to respond appropriately to identified spiritual needs and resources. • Knows how to evaluate whether spiritual needs have been met.	• Recognises personal limitations in spiritual care giving and refers to others as appropriate. • Evaluates and documents personal, professional and organisational aspects of spiritual care giving, and reassess appropriately.	• Shows compassion and presence. • Shows willingness to collaborate with and refer to others (professional/non-professional). • Is welcoming and accepting and shows empathy, openness, professional humility and trustworthiness in seeking additional spiritual support.

it to be replicated by someone else. The poster provided the title, teaching strategy, learning objectives, detailed description of activity, teacher's role, resources, assessment details and references. Participants were invited to provide additional examples if they wished. All these examples formed the Toolkit. Each example is aligned with one or more of the four competencies to make it easy to navigate. Project resources can be found at www.epicc-project.eu (refer to 'resources').

4. Establishment of the EPICC Network and website

The EPICC Network was launched at ME 2. EPICC Strategic Partners and EPICC Participants automatically became members of the Network, however, anyone with an interest in spiritual care education can join by completing the application form at www.epicc-project.eu (refer to 'Network'). The Network provides the means for people to continue to communicate and share ideas about best practice in spiritual care education. The Network exists to achieve the following:

- Engage nursing/midwifery educators, practitioners, researchers and students in sharing best practice, evidence and resources related to spiritual care.
- Provide a platform and forum where nursing/midwifery educators, practitioners, researchers and students can develop and acquire new knowledge/skills in the learning and teaching of spirituality and spiritual care.
- Integrate a compassionate and holistic approach within nursing/midwifery practice, education and research where the personal, religious and spiritual aspects of care are positively promoted.
- Capture ways in which the outputs (Standard, Matrix/narrative, and Toolkit) from the EPICC project are being used internationally to inform policy, practice, education and research.
- Collaborate with key stakeholders to ensure the EPICC Network is responsive to changing global healthcare needs.

Impact/discussion

1. Engagement

The level of engagement with the research studies and the EPICC project, from so many groups from a wide range of countries over a prolonged period, is indicative of the importance and timeliness of efforts to develop best practice in spiritual care education. It feels like this work is 'of the moment', aligning with the needs of wider society, health providers, policymakers, and service users, putting the person and what is most important to them at the heart of care delivery. Over the three years of the EPICC project, over 200 different people participated at the different events. Of the 31 EPICC Participants, 21 of these contributed in a significant way by attending the different events and participating in all the Action Learning Cycles/consensus surveys. Collectively, these participants had considerable experience in nursing/midwifery education and practice, with the majority directly involved in the teaching of spirituality. This group comprised of deans; professors; associate professors; lecturers; practitioners; newly qualified nurses; and students.

Feedback from those involved in the EPICC project was overwhelmingly positive. For example, attendees ($n = 45$) at ME 2 rated the event as 'fantastic' scoring it 4.7 out of 5. When asked to provide two words to sum up the event, 'inspirational' and 'encouraging' were the most frequently chosen (Figure 1).

2. Impact on practice

In 2018, EPICC Participants reported the benefits of the project and its outputs for their practice in a survey. A total of 37 responses were received from EPICC Strategic Partners and Participants from 16 countries indicated that the Standard and Matrix were informing their curricula ($n = 24$) and teaching ($n = 26$); along with shaping policy ($n = 11$), research ($n = 20$) and clinical practice ($n = 8$) in their country. Some countries provided specific examples.

- Example 1: Wales (shaping teaching and learning at one university)

At the University of South Wales (USW), the evidence from studies 1 and 2 is informing what is taught, where and how. The spirituality teaching has been moved from year 1 to years 2–3 (by which time students have gained more clinical experience). Furthermore, teaching/learning activities focus on the exploration of and reflection on personal values/beliefs/meaning of spirituality and patient encounters and are delivered through small-group discussion. Ongoing evaluations indicate that students at this university value the sessions, which they say enhance their knowledge, understanding and practice of spiritual care. So far, it has been possible to continue to deliver the teaching in this way, even with large student cohorts of 300 or more.

In the UK, all pre-registration nursing/midwifery programmes are being rewritten to align with the new NMC (2018) future nurse standards of proficiency. At USW, the

Figure 1. Attendees at the second Multiplier event rated description of the event.

EPICC Standard is being mapped to the new curriculum where staff are testing new innovative teaching and learning exercises from the EPICC Toolkit.

In Wales, the EPICC Standard is informing the rewrite of pre-registration nursing/midwifery curricula (https://heiw.nhs.wales/news/spiritual-care-to-become-part-of-welsh-nursing-curriculum/) and assessment of students in practice. This means that from September 2020, all nursing students in Wales will need to demonstrate that they have attained the 4 competencies by being assessed both in university and in clinical practice.

- Example 2: Norway research

At VID Specialized University, Faculty of Health Studies, a research team from the EPICC project was awarded funding for a project focusing on Spiritual Care Education and Practice Development (SEP) for 2020–2023. The project will develop:

- New and innovative approaches to clinical teaching and learning of spirituality within the undergraduate nursing programme in nursing homes and in mental health settings.
- Practice to foster environments that promote spiritual and holistic patient care.
- Students' confidence and competence in the assessment and delivery of spiritual care by facilitating learning within clinical placements.
- A model for practice to strengthen clinical nurses as spiritual care providers, role models and supervisors for nursing students, as well as enhancing patient lifeworld-led care.
- And test a questionnaire using the four core competencies from the EPICC Standard that students can use to self-assess their competency.

The SEP project will extend the work outside Europe through collaboration with the School of Nursing in the Faculty of Health Sciences at Christian University of North Haiti (UCNH).

Future impact

As the examples above outline, the anticipated impact of the EPICC project is far-reaching. It has the potential to influence and inform nursing, midwifery and healthcare at several levels, locally, regionally, nationally and internationally. The impact of the EPICC project is currently being captured by recording the extent to which it informs curriculum design/delivery, healthcare policy and further research and innovation at the following different levels:

1. Beyond Europe and beyond nursing/midwifery

Interest has been expressed in adopting the EPICC Standard and Matrix in pre-registration nursing/midwifery programmes in Western Australia, China, Brazil, and Asia, as well as in pre-registration programmes of other health-related disciplines such as medicine and allied health. Discussions are underway to further explore these opportunities. This interest suggests the potential applicability of the Standard and Matrix across countries, cultures and disciplines.

2. Educating the existing nursing/midwifery workforce

The research findings and EPICC outputs are informing redesign of the RCN spiritual care educational resources, ensuring they are based upon best evidence.

3. Professional bodies

A long-standing campaign to see spiritual care reinstated within the NMC (2015) Code for Nurses/Midwives in the UK, has resulted in discussions about this possibility. In Norway, the Spiritual Care Education and Practice Development (SEP) project has established formal links with the Norwegian Nursing Association, a subgroup of the Norwegian Nursing Organization, that works with educators and researchers. They have agreed to support the SEP project. Furthermore, in Denmark EPICC Strategic Partners have a long-standing collaboration with the Danish Nursing Association.

Conclusion

Our research highlights that the teaching undergraduate nursing/midwifery students receive is important in their learning about spiritual/person-centred care. However, there is significant inconsistency in how this topic is addressed within programmes of nurse and midwifery education across Europe (Ross et al. 2014, 2016, 2018).

Our research, culminating in the EPICC Project, is concerned with developing best practice in undergraduate nursing/midwifery spiritual care education at all levels, locally, nationally and internationally.

EPICC provides a set of competencies (Spiritual Care Education Standard) to assess newly qualified nurses'/midwives' ability to provide spiritual care, as well as tools to help them to achieve that. By focusing on what is important to people, EPICC aligns with the current person-centred care agenda. The outputs are informing pre-registration nursing/midwifery education internationally and their wider utility is being considered for education, practice, policy and research.

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