

**PRACTICE THEORY FOR TEACHING-LEARNING OF SPIRITUAL CARE IN THE
UNDERGRADUATE NURSING PROGRAMME AT A HIGHER EDUCATION
INSTITUTION IN THE WESTERN CAPE**

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DEDICATION

First and foremost, this work is dedicated primarily to the **SELFLESS LIFE OF CHRIST** who was humble up to the point of death so that **ALL** might live.

Secondly, I dedicate the findings, contents, revelations of this work to **MY FAMILY** who is committed to serving Christ in this life and the life to come.

Lastly, I dedicate this work to all my **STUDY PARTICIPANTS, SOUTH AFRICANS, AFRICANS**, and any other person, sick or well, that lands his or her hands on this work. I pray that you may receive love, power, strength, and a sound mind.



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DECLARATION

I, Ntombizodwa S.B. LINDA, hereby solemnly declare that the contents of this thesis, titled: Practice Theory for Teaching-learning of Spiritual Care in the Undergraduate Nursing Programme at a Higher Education Institution in the Western Cape, presents work conducted by myself. To the best of my knowledge this work does not contain any material copied from or written by another person, except where applicable a reference is made to acknowledge the respective author(s). I declare that all sources used in this thesis are acknowledged in the bibliography. The institution's ethical standards were observed as set out by the Research Ethics Committee of the university where the study was registered and approved.

Signed: 

Date: August 2017

Ntombizodwa S.B. LINDA



ABSTRACT

TITLE: Practice theory for teaching-learning of spiritual care in the undergraduate nursing programme at a higher education institution in the Western Cape.

AUTHOR: Ntombizodwa Sarah Beauty Linda

TERMS: Theory generation, Spirituality and spiritual care, undergraduate nursing curriculum,

Literature attest that holistic approach to care is the best way to ensure that all human needs, including spiritual needs are taken care of. As such holistic approach to care accepts the notion of “wholeness” nature of the patient. However, in practice patient’s holistic needs, which are essential for optimum health, are not routinely addressed when practicing nursing. This implies that regardless of the nurses doing their best to attend to patient’s health needs, patients still do not achieve their required optimum health. Furthermore, in the face of good nursing education programmes, attempts to meet the patient’s care needs as advocated, a gap still exists in rendering nursing services that truly promote health in a holistic manner. Confusion regarding the scope and holistic nature of nursing, relates not only to nursing organisations having failed to define nursing with clarity concerning the spiritual dimension of care; but they have also not succeeded in implementing nursing that is truly holistic. In this study, it is argued that where spiritual care aspects in nursing remain at the periphery, holistic nursing cannot be truly attained. According to Burkhardt and Hogan promoting one’s spirituality within a nursing paradigm can be one way to promote and optimise health, particularly in response to illness. In view of the existing gap between teaching-learning of spiritual care and espoused theory of holistic nursing, a need to develop a theory that would guide and assist nurse educators and nursing students in the teaching and learning of spiritual care was imperative. The aim of this research was to generate a practice theory for teaching-learning of spiritual care in the undergraduate nursing programme at a higher education institution by answering the research question “how can a practice theory for teaching-learning of spiritual care in the undergraduate nursing programme at a higher education institution in the Western Cape be generated? Ethical procedures were applied in accordance to stipulations of the University Research Ethics Committee. The credibility of the study was ensured by application of Guba’s model of trustworthiness for qualitative data. The research design for this study was a theory-generative, qualitative, exploratory, descriptive and contextual design. The qualitative research was conducted to generate data in phase one (1) under the following processes: data collection, data analysis and conceptual framework. In phase two (2) theory was generated from data that was derived in phase one (1) of the research process . This data was used to develop and describe the developed model whilst portraying its concepts and their relationship. Thus creating the

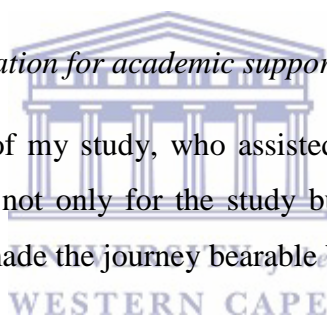
relationship and meaning between main and related concepts in step two (2). In step three (3) theory was described from various elements that constituted the model as a whole. In step four (4) the model was evaluated and refined. Data analysis was conducted by first managing qualitative data as stipulated by Tesch. AtlasTi7 was used in phase 1 to manage raw data into emergent themes. Data was further analysed and synthesized using reasoning strategy. Trustworthiness was ensured through application of truth value, applicability, consistency and neutrality strategies. Findings from the nurse educators and clinical supervisors suggest that despite certain aspects of spirituality being taught and learnt, these were mainly religious in nature which did not address the essence of spiritual care and or spirituality. This gap points to lack of formal integration of spiritual care in the undergraduate nursing curriculum. Findings from the nursing students showed that students are not only willing to provide spiritual care but they deal with it all the time in work-integrated learning. In addition, students reported that the clinical environment is toxic due to the nursing staff that does not provide spiritual care; who also hinder students from providing it. Findings from the documents review showed that despite elements of spiritual care being present in the curriculum, most elements were intended for instilling professionalism rather than spirituality. This notion was interpreted as non-spiritual-engaging nursing actions which at times merely addressed religious needs. The limitations experienced in providing spiritual care were mostly related to unfamiliarity of participants to the spirituality and spiritual care phenomenon. Another limitation relates to use of one institution for data collection which could compromise generalisation of the study findings. Recommendations were provided on the following aspects: (i) need for curriculum reform in nursing education to formally integrate spiritual care in the education of nursing students; (ii) need to sensitise nursing students about the importance of spiritual care from recruitment and throughout the programme; (iii) to conduct workshops and in service education on formal integration of spiritual care to prepare nurse educators, clinical supervisors, students and relevant stakeholders in nursing education (iv) there is a need for more research to be conducted on spiritual care in nursing from the South African nursing education context as it is currently not well understood hence not formally integrated in the curriculum

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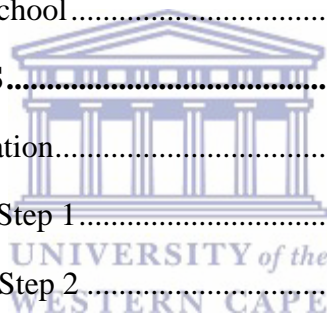


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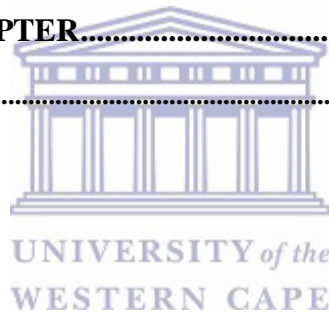
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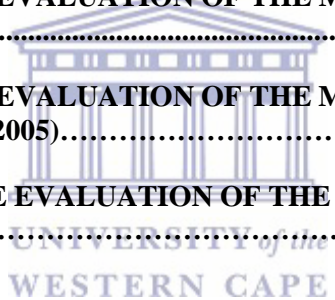
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ABBREVIATIONS AND ACRONYMS

ANA- American Nurses Association

ASS-Assessment

BCur-Bachelor's Curriculum

BN-Bachelor of Nursing

CBE-Case-Based Education

CHE-Council of Higher Education

CF-Conceptual Framework

CNA- Canadian Nurses Association

CPC- Clinical Placement Co-ordinator

CSs- Clinical Supervisors

EBP- Evidence Base Practice

ELO- Exit Level Outcome

EN- Enrolled Nurse

FG- Focus Group

GA- Graduate Attributes

HBU - Historically Black Universities

HE- Higher Education

HEI(s) - Higher Education Institution(s)

HEQC- Higher Education Quality Council

HR- Human Resource

IAO- Institutional Advance Office

IPO- Institutional Planning Office

IPS- Inter-Personal Skills

IOP - Institutional Operation Plan

MCQs- Multiple-Choice Questions

MG1- Module Guide for first year level

MG2- Module Guide for second year level

MG3- Module Guide for third year level

MG4- Module Guide for fourth year level



NCHE- National Commissioner Quality Education

NEs- Nurse Educators

NEI- Nursing Education Institution

NHS- National Health System

NQF- National Quality Framework

OBE- Outcome Based Education

OSCE- Objective Based Clinical Examination

PBL- Problem-Based Learning

PBU- Previously-Black Universities

PG- Postgraduate

POs- Programme Outcomes

RN- Registered Nurse

SA- South Africa

SANC- South African Nursing Council

SAQA- South African Quality Authority

SL- Service Learning

SimLAB- Simulation Laboratory

SO- Specific Outcome

SOAD- Specific Outcomes Associated with Degree

SoN- School of Nursing

TLC- Tender Loving Care

TLU- Teaching-Learning Unit

TOP- Termination of Pregnancy

UG- Undergraduate

UWC- University of the Western Cape

WIL- Work Integrated Learning

WHO- World Health Organisation

Note: Abbreviations for identification codes for the module guides are not included in this list but these are explained in relevant sections to enhance their purposeful use.



CHAPTER 1: **OVERVIEW OF THE STUDY**

1.1 INTRODUCTION

This chapter introduces the reader to the background and rationale for conducting the study on teaching-learning of spiritual care in the undergraduate nursing curriculum. The study was focused on how spiritual care is currently taught and learnt in the undergraduate nursing programme at a higher education institution in the Western Cape. A further discussion on the research problem, research question, research objectives, the aim and significance of the study will be provided. Lastly, ethical considerations and measures that were applied to ensure rigour will also be discussed. A layout of the thesis will be provided at the end of the chapter.

1.2 BACKGROUND AND RATIONALE FOR THE STUDY

The background and rationale provides relevant arguments regarding specific issues that were identified from literature. Each identified issue is argued to show the current status of teaching-learning of spiritual care, ideally, how the situation should be and lastly what measures are necessary to address the issues that were identified. These issues include the following; changing conceptualisation of the term “health”; developments and varied definitions of the concept of nursing; challenges in conceptualisation of the term spirituality and consequently spiritual care; challenges in teaching-learning of spiritual care as well as the lack of a practice theory for teaching-learning of spiritual care.

1.2.1 Changing conceptualisation of the term “health”

The World Health Organization’s (WHO’s) traditional definition of health is “a complete state of physical, mental, social well-being and not merely the absence of disease” (WHO, 1978). This definition was not only received globally but it also guided the health professions’ education and practice for many decades. However, due to mutable nature of the concept “health” its understanding has evolved in the recent past leading to the revision of the definition of the term. The need to re-define “health” has been evident in the World Health Organization’s (WHO’s, 1998) assertion to include the “*spiritual dimension*” in their definition of health. The concept of health is not only central to nursing practice but it also relates to patients’ health and well-being. Mohan, Mohan and Roy (2004) attest to a shift from an understanding of the concept of health from a narrow illness-centred model to a broader multi-dimensional model that embraces spiritual well-being in its essence and scope. Nursing, like other health professions that regard health as their core business, was also obligated to revisit its definition to encompass the spiritual dimension. Hence worldwide, efforts to integrate spiritual care in teaching and practice of

nursing are in progress (Burkhart & Schmidt, 2012). The concept of health is not only central to nursing practice but it also relates to patients' health and well-being. The current study did not only conceive the concept of health as central to nursing practice but also acknowledging its impact on patients' health and well-being. This view in turn influences how nursing is defined. Notably, is the move towards a definition of nursing that incorporates the spiritual aspect of human well-being. This view suggests resurgence of spiritual care in the practice of nursing which undergirds the bases of the current study. The next paragraph below shows how different authors have defined nursing with special emphasis on caring activities between the nurse and patient.

1.2.2 Defining nursing

WHO (2015) defines nursing as a process that encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all health settings. It includes the promotion of health, the prevention of illness, and care of the ill, disabled and dying people. Other authors define nursing as a practice-based profession that is directed to assist the patient through the process of restoring good health and quality life, reducing suffering and pain and allowing the patient to die with dignity and without pain where death is inevitable (Wallace, Campbell, Grossman, Shea, Lange, & Quell, 2008). Burkhart and Hogan (2008) attest that nursing assists the patient from the state of being helpless to being self-sufficient while Florence Nightingale argued that nursing is an interface of "caring activities" which are directed to achieve similar goals through caring for the whole person including the spirit of the person (Burkhart & Hogan, 2008, 929). Geyer, Mogotlane, and Young (2009: 10) defines nursing as a provision of care to physical, emotional, social and spiritual needs of the patients. Definition of nursing would be incomplete without spiritual component. It is therefore argued in this study that "spiritual care" and "spirituality" should remain central to nursing practice which can best achieved by formal preparation of nursing students on how to provide spiritual care within the context of the nursing practice.

1.2.3 Spiritual care and spirituality within the nursing context

"Spiritual care" refers to caring actions that are triggered by the patients' need for meaning and understanding of illness and suffering; the need for hope when experiencing adversity or calamity (Burkhardt, 1989). Lowry and Conco (2002: 388); Hsiao, Chiang, and Chien (2010, p.386) view "spiritual care" as an aspect of holistic care which is designed to reach the invisible,

deep human needs that are important for good health such as the search for meaning, hope, inner strength and peace. Furthermore, authors including Mackinlay and Trevitt (2007) agree that experiences such as motivation, aspiration, purpose in life and meaningfulness are human qualities that flow from the inner invisible components of “Being Human” and are linked to a patients’ spirituality. Remarkably, should these inner qualities not be nurtured, they translate into negative emotions that deplete the patient’s energy. Therefore, failure of nursing to provide spiritual care to patients does not only degrade the “humane” aspect of “human beings” but it also increases the risk of reducing humans to objects (Sawatzky & Pesut, 2005: 24). Carr (2010) perceives such an approach to nursing as “skill-intensive” in contrast to “caring”. Based on this view, patient’s needs should not only be viewed as a collection of health needs that can objectively be measured and routinely managed.

Gita (2006) and McSherry (2004, 43) on the other hand alert that spiritual care does not, and should not replace the physical aspect of care. They propose a balance between nursing interventions that address the physical needs and those that address the invisible components of patients’ needs. Whilst this alert is aimed at ensuring that “spiritual care” does not remain at the periphery of nursing interventions; it also promotes integration of human-centred care. Authors including Grosvenor (2000), Ross (1992) and Bradshaw (1997) argue that the holistic care approach in the absence of spiritual care becomes ‘less’ holistic. Spiritual care is not only widely accepted by some individuals who demonstrate interest in spiritual matters (De La Porte, 2014) but, it is a vital aspect of health which Delaune and Ladner (2006) view as an “all-in-one” in caring for the whole person. Literature presents spiritual care as dependent on a person’s spirituality. This means that nurses should understand spirituality and how it relates to the spiritual care they provide (van Leuween 2008). Narayanasamy (1999b); Wright (2002); McSherry, Cash & Ross (2004); Baldachinno, and Draper (2001,836) and Mahlunulu, and Uys (2004) concur with this view by stating that spirituality is the foundation on which spiritual care is “given” or “received”. Burkhardt and Hogan (2002) view spirituality as a paradigm of activities that promote and optimise health, particularly in response to illness.

Spirituality is defined as an experience and expression of one’s spirit in a unique and dynamic event often reflecting faith in God or a Supreme Being. It also refers to connectedness with one’s self, others, nature or God. The word “*spirituality*” is derived from the primary root word “SPIRIT” that comes from the Latin word “SPIRITUS” which means to “breathe”, “blow”, “courage” or “vigor the soul life”. According to the American English On-line Dictionary (2015) spirituality means to “inspire”, “expire” or “respire” and it is equivalent to the Greek word

“pnuema” which means “to breathe”. It is therefore, critical to understand spirituality in relation to “caring nature” in order to understand how it relates to “spiritual care”. Acknowledging that “spiritual care” and spirituality” are both attributes of “caring” is an acceptable notion; because they both correlate with the “humane” aspects of being human by allowing “deep connection” with the spiritual realm. Burkhart and Hogan (2002); Mahlunqulu and Uys (2004) agree that spirituality is not only an “intrinsic nature” but it is a very important aspect of “being human”.

In a South African-context “spirituality” is viewed as person-to-person or a person-to-God relationship, also relating to “*seeking*” a relationship with God, the Superior Being or a relationship with other people in order to reach out to God. This relationship is sought through belief, faith, and or religious practices (Mahlunqulu & Uys, 2004). Dossey, Keegan and Guzzetta (2004) conceive “spirituality” as the essence of human-being, which permeates one’s living and infuses unfolding awareness of who and what a person really is, one’s purpose in life, and one’s inner resources that are crucial in one’s life journey. Apart from the fact that patients expect that their spiritual health should be taken care of by the nurses and other health care workers, Wright (2002) affirms that nurses do have a moral obligation to take an active role in addressing the spiritual needs of the patient.

Spiritual need is defined as “a need or an expectation that all human beings have to find meaning, purpose and value in life” (Murray, Kendall, Boyd & Benton, 2009). Spiritual needs become more pronounced when the individual’s inner strength to cope with life challenges is depleted by ill-health and other life crises (Agrimson & Taft 2009: 456). When the patient’s spiritual needs are not met, it does not only deprive the patient from receiving esteemed care, but, it also negates and subtracts good effects of nursing interventions. Spiritual needs become more important when a person is facing a life threatening circumstance or life issues that negatively challenge a person’s inner peace and deplete inner strength. Spiritual needs evoke spiritual discomfort or crisis in severe cases resulting in the inability to cope with physical and mental functioning. The loss of coping power can be fatal when a person is already stricken down by physical and or mental ill-health. Agrimson and Taft (2009) define spiritual crisis as a turbulent period of spiritual opening and transformation caused by illness, hospitalization separation from usual support, and personal source of comfort which are burdensome and may trigger spiritual needs. Therefore, nurse’s open-mindedness about spiritual matters in nursing beyond possible limitations is advocated for by Agrimson and Taft (2009). Teaching and learning platforms are hence important vehicles for advocacy for spiritual care.

1.2.4 Spiritual care and spirituality in teaching and learning of nursing

Despite teaching-learning of spiritual care being increasingly welcomed (Coyle, 2001; Burris, Brechting, Salsman, & Carlson, 2009; McSherry, Gretton, Draper & Watson 2008; Shores, 2010) there are challenges concerning the lack of universal understanding of spirituality and spiritual care in the nursing field. Helming (2009) does not only argue that published work on spiritual care in nursing practice is very sparse; but acknowledges that dearth of knowledge in spiritual care is as a precursor to lack of teaching-learning and practice in nursing. Despite the South African Nursing Council (SANC) espoused holistic approach to nursing, it does not provide details with clarity of what its conceptualisation of “holistic nursing” is and how spiritual care comes into play. This lack of clarity has led to inadequate guidelines on teaching and practice of spiritual care. Consequently, spiritual care is not taught and practiced with intention. Bloemhard (2006) attests that lack of inclusion of spiritual care in the nursing curriculum has led to lack of teaching-learning and practice of spiritual care.

In spite of effective good nursing education programmes worldwide in an attempt to address the “human needs”, this gap has not closed starting from the teaching to practice platform. Some of the reasons for lack of implementation of spiritual care in the nursing curriculum and in practice do not only relate to lack of understanding of the concepts for spirituality, but to issues that arise from the perception that spirituality is a sensitive and personal matter. This sensitive notion does not only create detrimental effects on nursing practice but it exacerbates challenges and fears from nurse educators and nursing students who at all cost avoid confrontations with self-reflection and introspection. Consequent to these challenges, a state of incompetence in teaching and provision of spiritual care has been reported (Burkhart & Schmidt, 2012; Burkhart & Hogan, 2008; Cavendish, Luise, Russo, Mitzeliotis, Bauer, Mcpartlan, Medefindt, 2004; Fletcher, 2004; McSherry, Gretton, Draper, & Watson, 2008) pointing to the slow uptake of spiritual care in formal pedagogical education of nurses as a call for concern. Curriculum challenges do not only relate to lack of shared definition of spirituality (Treolar, 2000) which poses difficulties in teaching-learning of spiritual care; but also the lack of clarity in the curriculum outcomes.

Teaching can be defined as a process whereby the students are assisted to manage their learning by creating a conducive environment that facilitates learning. It also entails instructing someone or a process of leading someone to discover truth in the form of knowledge. Learning is often defined in the light of the two broad education psychologist’s perspectives namely cognitivist and behaviourist. The cognitivists view learning as an active process through which the adult

learner is engaged in construction of new knowledge which is interpreted rather than memorisation of data (Klopper, 2009). The behaviourists view learning as a permanent change in one's behavior as evidenced in Watson's, Skinner's and Pavlov's theories of learning (Slavin, 2012).

In the United States of America (USA) the American Nursing Association (ANA) (2004) has openly and formally embraced the notion of spiritual care in nursing education and practice as a critical component of health. A similar trend is noted in Canada (CNA, 2010) and Australia Winslow & Wehtje-Wislow 2007). The International Code of Nurses (2000) and Malta Code of Nurses (1997) alludes that nurses are expected to create a caring environment which promotes spiritual care among other human values like human rights, values, customs and cultural belief needs. Yet, the health care personnel are still not confident in providing spiritual care due to inadequately educational preparation (McSherry, Cash, & Ross, 2004; and Taylor & Mamier, 2005). The lack of training of nurses regarding their own and their patients' spirituality poses challenges in addressing the patient's spiritual matters (Monareng, 2012: 14). In South Africa, most nursing schools have not explicitly adopted a curriculum with a strong component of spiritual care. However, awareness campaigns about spiritual care in health and healing are in progress; as evidenced by the Watson Caring Science Institute which conducted the first South Africa International Caritas Consortium Conference in Sept 2015 (<http://watsoncaringscience.org/event-registration/?ee=57>).

The lack of clarity of the term spirituality which has come over time requires the nurse educators to assume a deliberate posture to address this issue in nursing education (Ross, 1992; Reed, 1992). It is, therefore, argued in this study that issues around teaching-learning of spiritual can be addressed by providing a practice theory that will guide both the nurse educator and nursing student on how to engage with spiritual care subject and the patient's spiritual matters. Dickoff, James and Wiedenbach (1968) state that if a theory is generated based on empirical evidence it guides practice. Hence it was imperative to generate a practice theory that would guide and assist the nurse educators and nursing students in teaching-learning of spiritual care; hence this study was pursued (Martsof & Mickley, 1998; Grossvenor, 2000). A detailed discussion on the rationale for generating the practice theory is provided as the basis for theory-generative research in chapter two (2).

1.3 PROBLEM STATEMENT

Despite nursing education programmes being commended for keeping pace with the rapid advances in disease management, spiritual care has received far less attention in nursing curricula

worldwide (Keefe, 2005). No studies in nursing conducted on spiritual care in South Africa were found at the time when this study was conducted. This indicates the dearth of knowledge and skills in spiritual care in nursing practice. There are challenges in teaching-learning of spiritual care in nursing programmes which are not unique to the South African context, but have been reported worldwide (Pesut, 2002; Baldachinno, 2006). Bloemhard (2008: 2) identifies omission of spirituality in education as major gap that emanates from lack of its visibility within the curricula worldwide (Carr, 2010: 1380; Wallace, Campbell, Grossman, Shea, Lange, & Quell, 2008: 2). Existing difficulty in integration and application of spiritual care in the undergraduate nursing curricula (Pesut, 2002: 128; Baldacchino, 2006) is assumed to be due to the abstract, nebulous, intricate, vague, enigmatic nature of the concept of spirituality from which spiritual care emanates. Additionally, the lack of knowledge of the nurse's own spirituality contributes strongly to the issues of lack of participation in patient's spiritual matters.

The problems that are pertinent to the South African context as reported by Mahlangu and Uys (2004) query the nurse educator's claim of teaching holistic care where the spiritual component is not an integral part of holistic care. Currently in South Africa (SA), the National Undergraduate Nursing Curriculum does not clearly and effectively address the teaching and practice of spiritual care. Tjale and Bruce (2007: 46) argue that the lack of clear practice guidelines from the (SANC regarding holistic nursing, which do not include spiritual aspects in the education of nurses, produces challenges where the teaching-learning of holistic nursing covertly addresses or excludes spiritual care. Despite some studies being conducted in SA, these studies do not address in-depth the pedagogical inquiry to question how teaching-learning of spiritual care is or should be done in nursing education. This implies that there are neither guidelines nor theories designed to address how spiritual care should be incorporated in the nursing curriculum. Hence a need for the current study which aimed to generate a practice theory for teaching-learning of spiritual care in the undergraduate nursing programme at a higher education institution in the Western Cape.

1.4 RESEARCH QUESTION

In line with the problem as presented above, the study attempted to answer the following research questions which were formulated to obtain information that could provide relevant solutions to the research problem. The main research question was "*how can a practice theory for teaching-learning of spiritual care in the undergraduate nursing programme at a Higher Education Institution in the Western Cape be generated ?* To answer this research question the following sub-questions were posed:

1.4.1 What is the understanding of nurse educators and clinical supervisors of the concept of spiritual care in the undergraduate nursing programme at a Higher Education Institution in the Western Cape?

1.4.2 What are students' opinions of teaching-learning of spiritual care in the undergraduate nursing programme at a Higher Education Institution in the Western Cape?

1.4.3 What are the spiritual care elements embedded in the undergraduate nursing curriculum for nurses at a Higher Education Institution in the Western Cape?

1.4.4 How can a conceptual framework (CF) for teaching-learning of spiritual care in the undergraduate nursing programme be developed and described?

1.4.5 How can a practice theory for teaching-learning of spiritual care in the undergraduate nursing programme be generated?

1.5 RESEARCH AIM AND OBJECTIVES

Based on the research problem and questions posed above, the main aim of this research was to generate a practice theory for teaching-learning of spiritual care in the undergraduate nursing programme at a Higher Education Institution in the Western Cape. In order for this aim to be achieved, the following objectives were employed:

1.5.1 To explore and describe the understanding of nurse educators and clinical supervisors of the concept of spiritual care in the undergraduate nursing programme at a Higher Education Institution in the Western Cape.

1.5.2 To explore and describe students' opinions of teaching-learning of spiritual care in the undergraduate nursing programme at a Higher Education Institution in the Western Cape.

1.5.3 To conduct a descriptive content analysis to identify what spiritual care elements are embedded in the undergraduate nursing curriculum for nurses at a Higher Education Institution in the Western Cape.

1.5.4 To develop and describe a conceptual framework for teaching- learning of spiritual care in the undergraduate nursing programme at a Higher Education Institution in the Western Cape.

1.5.5 To generate a practice theory for teaching-learning of spiritual care in the undergraduate nursing programme at a Higher Education Institution in the Western Cape.

1.6 SIGNIFICANCE OF THE STUDY

Firstly, the study contributed knowledge on how spiritual care in nursing is understood from the perspective of nurse educators, clinical supervisors and students in a South African context. *Secondly*, the study provided clarity on how the teaching-learning process of spiritual care in nursing is currently practiced. *Thirdly*, the current status of spiritual care competencies were ascertained, thus providing useful context-based information to supplement pedagogical strategies for teaching-learning of spiritual care. *Fourthly*, the study made a significant contribution in understanding how nursing students can be formally prepared to provide spiritual care to patients that is believed will bring into completion the meaning of 'holistic care' which is fundamental in nursing practice. *Fifthly*, practice theory for teaching-learning of spiritual care will assist the nurse educator in the facilitation of learning and guide nursing students in the process of learning of spiritual care. *Sixthly*, the development of practice theory might influence SANC not only to overtly include spiritual care in the education of pre-nursing education but to also develop guiding policies and procedures regarding implementation of spiritual care in nursing as well as developing competencies according to the South African context.

1.7 CENTRAL THEORETICAL STATEMENT

The insight gained from the empirical study on participant's understanding, knowledge and experiences pertaining to teaching-learning of spiritual care in the undergraduate nursing programme as well as information from reviewed academic documents will inform the generation of a practice theory on teaching-learning of spiritual care in the undergraduate nursing programme in a higher education institution in the Western Cape.

1.8 ASSUMPTIONS OF THE RESEARCHER

The researcher's assumptions are described based on the meta-theoretical, theoretical and methodological perspectives adopted in this study.

1.8.1 Meta-theoretical assumptions

Meta-theoretical assumptions are non-epistemic statements that are not intended to be tested (Mouton & Marais, 2012). However, they provide a basis for understanding a person's point of departure thus making it imperative for researchers to state them in their work. In this study, the researcher's philosophical viewpoint about humans is founded on the Judeo Christian view. This

implies that the researcher's view of human beings as a species is founded on the belief that humans are created by and formed in the image of God. The four dimensions namely physical, psychological, emotional and spiritual are unique characteristics only found in humans. Therefore, the researcher believes that humans as God's creation are "spiritual beings" which is not only their strongest nature but also an influential dimension of their being. The researcher believes that if this dimension is not aligned with other humane dimensions, a person loses balance in life. The loss of balance creates disequilibrium between the human and their relationships with God, inner being and others. Based on these beliefs, the researcher described own view of human, health, nursing and environment concepts in the context of this study as follows:

Human

A Biblical fact that supports the researcher's belief is the view that *human* is God's creation. A human is a 'spiritual being' possessing a soul and embodied in the physical body. A *human* should be handled with the understanding of this Biblical knowledge, especially the claim that the spiritual component of man is the core, which is influential to the other aspects, namely body and soul. In this study a human primarily refers to the nursing student and nurse educator, clinical supervisors and nursing students who are conceived as spiritual beings made in the image of God. However, it is also acknowledged that the patients and health clients are end users of nursing practice and therefore; are potentially humans who might receive spiritual care from the nursing students in one point in time.

Health

As a researcher and *health* care professional, the researcher's belief regarding health is founded on the view that health relates to the attainment of a state of equilibrium across all human dimensions; spiritual, psychological, physical and social; and the ability to live life as determined by God. When a *human's health* is tarnished, his spirit too may be fractured or bruised, resulting in ill-health to the body and soul. When a human is in a state of *ill-health*, the need for spiritual care is heightened. This can happen when the human's needs for religious practices and or affiliation are not met. Hence in this study health refers to God's given conducive state of being and a relationship with self as well as the relationship with others; for an example the relationship between the nursing students, nurse educators and clinical supervisors. Such relationships and

interactions are believed to promote spiritual health as an important component of health and well-being.

Environment

Human is viewed as being inseparable from his society which forms his *environment* in which he exists. Therefore, it is vital to ensure that the social context in which she or he is immersed holds meaning and provides a good living for his existence in all the dimensions, particularly the spiritual dimension. The environment should therefore be in such a way that it ushers peaceful living in line with the perspective of *love your brother as thy self* which is aimed at maintaining peace between humans. The environment in this study refers to physical, psychological, social and spiritual climate within the context in which the nurse educator, clinical supervisor and nursing students, as role players in teaching-learning and practice of spiritual care, is situated. The environment can be the institution of higher learning or health care institution that facilitates human's engagement with religious practices or rituals and accepts spiritual care tenets.

Nursing

In this study, nursing is viewed as an art and science through which the nursing students, nurse educators and clinical supervisors perpetually endeavour to serve humankind, by assisting the patient in the process of restoring good health, eradicating pain and suffering, and allowing humankind to die with dignity where death is inevitable. Within the parameters of nursing philosophy and ethics, it is concerned with the development of knowledge for the nursing diagnosis, treatment and personalised care of persons exposed to suffering, or recovering from physical, mental and spiritual ill health. In this study nursing is viewed not only as a patient-nurse relation in the process of providing health care to the patient; but it also refers to the nurse's conscious decision to interact with the patient in an ethically, socially and spiritually acceptable manner based on the patient's presenting needs.

1.8.2 Theoretical assumptions

Theoretical assumptions include models and theories that are used in this research, as well as the definitions of concepts. The researcher, as a pragmatist, integrated several theories to ground and guide this study. The three models used as theoretical points of departure are:

1.8.2.1 Klopfer's (2009) model of constructivist learning. The model will guide teaching-learning process in an active and engaging manner.

1.8.2.2 Ross's (1996) model for teaching spiritual care through the scientific strategy for nursing. This model will facilitate the practical application of spiritual care.

1.8.2.3 Burkhardt's and Hogan's (2008) theory of spirituality which aided the development of the data extraction checklist by using broad spiritual components and spiritual attributes to guide data extraction in the document review process.

1.8.3 Definition of concepts

A concept is a complex mental formulation of an object, property or event that is derived from the individual per caption and experience (Chinn & Kramer, 2011: 158). Concepts may denote underpinning philosophical views and beliefs on which the study is founded and they promote unified understanding of the study by the readers.

1.8.3.1 Spirituality

Spirituality is derived from the Latin word *spiritus* or spirit, the essential part of the person which controls the mind; and the mind controls the body (Baldacchino & Draper, 2001). Spirituality refers to a complex of values, attitudes and hopes linked to the transcendent that guides and directs a person's life (Chinn & Kramer, 2011: 132).

The researcher's belief about the wholeness nature of the individual and holistic approach to nursing accepts the notion of spirituality from different perspectives through which the concept has been extensively explored. These perspectives are derived from different disciplines which include theology, psychology, and sociology. Theology describes spirituality as one's belief in God which can be manifested through religious beliefs and practices. Psychological views denote spirituality as an expression of one's internal motives and desires with focus on self in search of meaning and purpose in life rather than focus on supreme intelligence. The sociological view acknowledges strong people's influence on other people; this view focuses on spiritual practices and rituals of groups of people and social morality within individuals (Meraviglia, 1999).

In this study, spirituality is regarded as a state of being conscious, cautious and willingness of the nurse educators, clinical supervisors and nursing students not only to teach and be taught respectively and learn about the patients' spiritual matters which are influenced by presenting human-needs or the patient's health-needs but who also willingness to participate in the delivery of spiritual care.

1.8.3.2 Spiritual Care

Spiritual care can be viewed as an aspect of holistic care (Lowry & Conco, 2002; Hsiao; Chiang & Chien, 2010) which is designed to reach the invisible, deep human needs which are important for good health, such as inner strength and peace.

Spiritual care in this study is applied as willingness by the nursing student, nurse educator and clinical supervisor to actively engage in an interactive-caring-relationship based on the patient's communicated quest for spiritual care whether verbally or in gesture. The aim should be directed not only to the cultural, religious or personal respect but more importantly to be grounded on the understanding of the value of spiritual care in health and healing.

1.8.3.3 Spiritual Nursing Care

Although the term "spiritual nursing care" can be used interchangeably with "spiritual nursing", in this study spiritual nursing refers to an intuitive, interpersonal, selfless, and integrative expression that is dependent on the nurse's awareness of the transcendent dimension of life that reflects the patient's reality. At its foundational level, spiritual nursing care is an expression of self (Sawatzky & Pesut, 2005: 4). The researcher conceives "spiritual nursing care" as an approach to nursing science and art that is designed to reach the invisible human components that are equally important for good health by responding to existential questions of meaning, need for hope and faith-based or religious-based activities.

1.8.3.4 Spiritual care in Nursing

Spiritual care in nursing refers to the acknowledgement of the spiritual role of a nurse in meeting the patient's spiritual needs. The role includes, among others, a relationship with the patient or client; companionship; acceptance of the patient or client and their condition; and loving them and promoting their autonomy by supporting their decision making and taking responsibility of their own suffering or condition (Burkhardt, 1989). In this study, application of spiritual care in nursing meant the state whereby the nursing student is informed about spiritual care and their disposition that reveals readiness to engage in the patient's spiritual matters.

1.8.3.5 Care

Care can be defined as means to reach out to something or someone other than the self (Paulson, 2011). It is therefore viewed as neither self-referring nor self-absorbing. Care can be conceived as both practice and a disposition which characterises a single activity or a process (Paulsen, 2011). Care can be executed in four different levels namely (i) Caring about where the nurse is

or being attentive about the patient's need; (ii) Taking care of assuming responsibility and (iii) *Care giving* is when the nursing student embarks on the required action to meet the patient's needs which is considered as a central moral activity. Therefore, this requires planning of action to meet the patient's needs accordingly. Adequate resources and willingness to participate in ethical accountability is pivotal. (iv) Lastly, care receiving which requires responsiveness as an essential activity between care givers and care receivers in order for good health to be in place. All four dimensions of care must fit into an integrated whole with all interlinking ethical elements (Paulsen, 2011). In this study, care was assumed as a state of willingness and readiness to attend to patient's inclined needs whether human or health in nature.

1.8.3.6 Caring

Caring can be defined as an ongoing activity, a character or trait about concern of living through which a human actively engages in the processes of everyday living. According Paulson (2015) it is an affective component of one's commitment to the welfare of another. The researcher conceived caring as an intervention through which the nurse helps the patient to deal with and or accept the challenges related to ill-health and be motivated to partake in the management of own health condition.

1.8.3.7 Theory

A theory is a coherent group of tested general propositions, commonly regarded as correct, that can be used as principles of explanation and prediction for a class of phenomena (Walker & Avant, 2011). The researcher conceived theory as an assertion taken as truth until proven otherwise.

1.8.3.8 Practice Theory

Is a goal-directed and prescription of the required actions that are necessary to produce the required outcome(s), progressing through four phases: factor isolating, factor relating, situating-relating and situation-producing (Dickoff, James & Wiedenbach, 1968a). According to Dickoff *et al.*, (1968a) if a practice theory is developed based on empiric evidence, it guides practice. The researcher conceived practice theory as a framework through which spiritual care can be implemented in the undergraduate nursing programme at a higher education institution in the Western Cape.

1.8.3.9 Model

A model is defined as a representation of an empirical experience in the form of words, pictorial graphic diagram, mathematical notations or physical material, such as a model airplane (Chinn & Kramer, 2011: 192). In this study, a model is conceptualised as a structural design consisting of organised and related concepts representing reality. Although it is not a reality in itself, it assists users to visualise the reality that is represented.

1.8.3.10 Undergraduate Nursing Curriculum

Undergraduate nursing curriculum refers to a systematic process that contains theoretical and practical content and educational programmes through which teaching-learning and evaluation interventions are undertaken as prescribed by the South African Nursing Council (SANC), the governing body for the nursing profession as gazetted in SANC Regulation R425 of 1985, as amended (SANC, 2005: 2). In this study, the undergraduate nursing curriculum is regarded as an approved academic document, teaching-learning content, technique and processes that facilitate learning and attainment of learning objectives by the student.

1.8.3.11 Undergraduate Nursing Programme

Is a four-year degree programme intended to prepare student nurses for practice as professional nurses according to the SANC Regulation R425 of 1985, as amended (SANC, 2005: 2).

1.8.3.12 Student

Is a person who is following a course of study as in a school, college or university (On-line British Dictionary, 2014). In this study, a student is a person who is registered to engage in the learning process at the university's school of nursing. Student is used synonymously with "learner nurse" as defined by the South African Nursing Council (SANC, 2005: 4). However, in this study, the researcher used the term student.

1.8.3.13 Nurse Educator

According to the Nursing Act No. 33 of 2005 a Nurse educator can work or function as a lecturer, clinical educator, education manager, researcher, and specialist in accordance to on-line the Nursing Act 33 of 2005 (SANC, 2015). In this study, nurse educator refers to a registered nurse who is employed by the university and whose name is on the SANC register for Professional Nurses and practising nurse educator in the R425 programme in the year in which the study was conducted.

1.8.3.14 Clinical Supervisor

A clinical supervisor is a professional nurse working in a clinical setting who supports and develops nurses, including students, in the unit team to optimise their professional functioning and is employed by the health service authority (The Nursing Education Stakeholders, 2012).

In this study, a clinical supervisor is a person who is employed by the university who is also registered with the SANC as a practising nurse practitioner whose role is to support and develop student nurses in the clinical setting to optimise their professional development and functioning.

1.8.4 Methodological assumptions

Methodological assumptions refer to fundamental truths, means and ways that guide the researcher in arriving at the study's answers. Methodological assumptions also refer to aspects of good science of research (Crotty, 2003: 10). Methodological assumptions promote systematic and organized ways in finding the answers to the research question regarding the phenomenon under investigation. Based on the above, the researcher applied credible research methods to enhance the merits and rigour of the study. Table 1.1 below depicts how the research process unfolded. A brief description of the research design is given on the sections that follow while a detailed description of the research design and methods is provided in Chapter two (2)

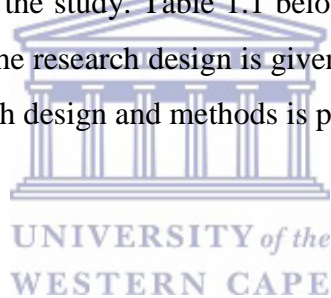



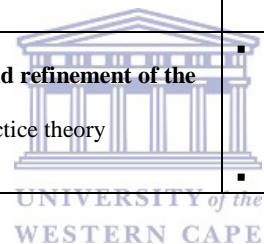
Table 1.1 SUMMARY OF THE RESEARCH PROCESS

	POPULATION, SAMPLE AND SAMPLING	DATA COLLECTION	DATA ANALYSIS	RIGOUR
PHASE 1: CONCEPT IDENTIFICATION, CLASSIFICATION AND DESCRIPTION				
OBJECTIVE 1: TO EXPLORE AND DESCRIBE THE UNDERSTANDING OF NURSE EDUCATORS AND CLINICAL SUPERVISORS OF THE CONCEPT OF SPIRITUAL CARE IN THE UNDERGRADUATE NURSING PROGRAMME AT A HIGHER EDUCATION INSTITUTION IN THE WESTERN CAPE.				
CHAPTER 3	Population: (N =18) <i>All nurse educators involved in R425 undergraduate nursing programme</i> Sample: (n=10) Sampling: purposive sampling	Step 1(a): Individual interviews Face-to-face, individual in-depth interviews.	AtlasTi7 Tesch method (1990)	<ul style="list-style-type: none"> ▪ Trustworthiness: ▪ Reflexivity ▪ Member checking ▪ Thick descriptions ▪ Triangulation ▪ Prolonged engagement ▪ Independent Coder
	Population: (N=25) <i>All clinical supervisors involved in R425 undergraduate nursing programme</i> Sample: (n=9) Sampling: purposive sampling	Step 1(b): Individual interviews: Face-to -face, individual in-depth interviews	AtlasTi7 Tesch method (1990)	<ul style="list-style-type: none"> ▪ Trustworthiness: ▪ Reflexivity ▪ Member checking ▪ Thick descriptions ▪ Triangulation ▪ Prolonged engagement ▪ Independent Coder
OBJECTIVE 2: TO EXPLORE AND DESCRIBE STUDENTS' OPINIONS OF TEACHING-LEARNING OF SPIRITUAL CARE IN THE UNDERGRADUATE NURSING PROGRAMME AT A HIGHER EDUCATION INSTITUTION IN THE WESTERN CAPE.				
CHAPTER 4:	Population: (N=1009) <i>All undergraduate nursing students from year levels 1-4 involved in R425 undergraduate nursing programme</i> Sample: (n=90) Sampling method: purposive, cluster	Step 2: Focus group (FG) discussions	AtlasTi7 Tesch method (1990)	<ul style="list-style-type: none"> ▪ Trustworthiness: ▪ Reflexivity ▪ Member checking ▪ Thick descriptions ▪ Triangulation ▪ Independent Coder

	POPULATION, SAMPLE AND SAMPLING	DATA COLLECTION	DATA ANALYSIS	RIGOUR
OBJECTIVE 3: TO CONDUCT A DESCRIPTIVE CONTENT ANALYSIS TO DETERMINE WHAT SPIRITUAL CARE ELEMENTS ARE EMBEDDED IN THE UNDERGRADUATE NURSING CURRICULUM FOR NURSES AT A HIGHER EDUCATION INSTITUTION IN THE WESTERN CAPE.				
CHAPTER 5	Population: (N=129) <i>All selected documents used in R425 undergraduate nursing programme</i> Population breakdown: <ul style="list-style-type: none"> ▪ Curriculum (N=1) ▪ Module Guides (N=32) ▪ Assessments (N=96) Sample: (n=73) Sample breakdown: <ul style="list-style-type: none"> ▪ Curriculum (n=1) ▪ Module Guides (n=18) ▪ Assessments (n=54) 	Step 3: Review protocol Checklist	AtlasTi7 Content analysis	Trustworthiness: <ul style="list-style-type: none"> ▪ Review protocol ▪ Checklist ▪ Triangulation ▪ Purposive sample ▪ Audit trail
 UNIVERSITY of the				
PHASE 2: THEORY-GENERATION				
OBJECTIVE 4: 4 TO DEVELOP AND DESCRIBE A CONCEPTUAL FRAMEWORK FOR TEACHING- LEARNING OF SPIRITUAL CARE AT A HIGHER EDUCATION INSTITUTION IN THE WESTERN CAPE.				
CHAPTER 6:	Population: Empirical data from phase 1 step 1 to 3 Sample: Core and related concepts identified from phase 1 step 1- 3 from all four data sources. Sampling: Purposive Available National and International sources	Step 1(a) Concepts identification: From conclusive statements derived from emerging themes in phase 1 steps 1-3.	Inductive-deductive approach to concept identification	Trustworthiness: <ul style="list-style-type: none"> • Synthesis reasoning strategies • Purposive sample • Audit trail • Reflexivity

	POPULATION, SAMPLE AND SAMPLING	DATA COLLECTION	DATA ANALYSIS	RIGOUR
	<p>Population: Core & related concepts</p> <p>Sample: concepts from the previous step of phase 2 placed and arranged in their relationship</p> <p>Sampling: Identified concepts synthesized into statements</p>	<p>Conceptualization process Creation of conceptual meaning and structuring. Contextualisation of theory</p>	<p>Concepts and statement synthesis</p>	<p>Trustworthiness:</p> <ul style="list-style-type: none"> • Synthesis reasoning strategies • Audit trail • Reflexivity
	<p>Population: Identified concepts</p> <p>Sampling: Application of the survey list of Dickoff, James and Wiedenbach (1968).</p> <p>Sample: Identified concepts</p>	<p>Step 1(b) Concept classification: Synthesis of concepts and statements from the conceptual framework</p>	<p>Survey list of Dickoff, James and Wiedenbach:</p> <ul style="list-style-type: none"> ▪ <i>Agent</i> ▪ <i>Procedure</i> ▪ <i>Context</i> ▪ <i>Goal</i> ▪ <i>Dynamic</i> 	<p>Trustworthiness:</p> <ul style="list-style-type: none"> • Synthesis and reasoning strategies • Supervision Co-checking • Reflexivity
	<p>Population: National and international books and journal articles</p> <p>Sampling: Purposive sampling</p> <p>Sample: Multiple electronic databases and hard copy</p>	<p>Step 1(c) Concept Description: Concepts and statements that were synthesized to form a conceptual framework in the previous step 2</p> <ul style="list-style-type: none"> ▪ Literature control ▪ Use dictionaries 	<p>Integrated discussion of literature Synthesis reasoning strategies</p>	<p>Analytic reasoning strategy</p>
<p>OBJECTIVE 5: TO GENERATE A PRACTICE THEORY FOR TEACHING-LEARNING OF SPIRITUAL CARE IN THE UNDERGRADUATE NURSING PROGRAMME AT A HIGHER EDUCATION INSTITUTION IN THE WESTERN CAPE</p>				
CHAPTER 7	<p>Population: Concepts, variables and statements from phase 2 step 1-3</p> <p>Sampling: Purposive</p> <p>Sample: Concepts, variables and statements from phase 2 step 1-3</p>	<p>Step 2(a): Description of the conceptual framework Conceptual framework Coherent relationship of statements and interpretation. Literature review</p>	<p>Theory construction questions:</p> <ul style="list-style-type: none"> ▪ What is the purpose? ▪ What are the concepts forming the model? ▪ What is the nature and structure of the model? ▪ How are the concepts defined? 	<p>Trustworthiness:</p> <ul style="list-style-type: none"> ▪ Synthesis reasoning strategies ▪ Audit trail ▪ Reflexivity

	POPULATION, SAMPLE AND SAMPLING	DATA COLLECTION	DATA ANALYSIS	RIGOUR
	<p>Population: Core and related concepts</p> <p>Sampling: purposive</p> <p>Sample: Concepts</p>	<p>Step 2(b) Construction of relational meaning between core and related concepts Core and related concepts</p>	Description of the model	Synthesis reasoning strategies
	<p>Population: Model description</p> <p>Sampling: Purposive sampling</p> <p>Sample: Literature and thesaurus</p>	<p>Step 2(c) Description of elements that constitute the model as a whole Results of Phase 2 step 4 From empirical knowledge Model description in phase 2 level 2, step3</p>	<p>Inductive-deductive logic Structure and process description Conclusions, deductions and recommendation.</p>	<p>Trustworthiness: Synthesis reasoning strategies Survey list</p>
CHAPTER 8	<p>Model constituents i.e. model :</p> <ul style="list-style-type: none"> ▪ Development ▪ Description ▪ Guidelines and ▪ Evaluation 	<p>Step 3: Evaluation and refinement of the model Generated practice theory</p>	<ul style="list-style-type: none"> ▪ Criteria for model evaluation i.e. ultimate aim and credibility of the model evaluate the contents of the model ▪ Critical reflection on the model 	Evaluation of integrated knowledge using rigorous structure of tentative purposeful and systematic review of the phenomena of spiritual care.



1.9 RESEARCH DESIGN

According to Burns and Grove (2009) a research design is a blue print for conducting a research. Research design can be described as a systematic, rigorous methodological plan that guides the researcher when conducting an empirical enquiry. Polit and Becker (2008: 765) define research design as the overall plan for addressing the research question, including specifications for enhancing the study integrity. Whilst Creswell (2009: 5) defines research design as the plan or proposal to conduct research which involves the intersection of philosophy, strategies of inquiry and specific methods. In this study, a theory-generative, qualitative, explorative, descriptive and contextual design was implemented in two phases. The intention was to obtain the truth and knowledge about the phenomenon under study from the participant's emic perspectives. Thus the design used the participants'emic viewpoint which acknowledges the insider's views and values the participant's opinions as vital (Holloway, 2010). The philosophy that undergirds this research design is the postmodernism and constructivists in in nature.

In phase one (1) theory-generative design was used to explore and describe the understanding of nursing educators, clinical supervisors and opinions of nursing students about teaching-learning of spiritual care. Also, to conduct a descriptive analysis to determine what spiritual care components were embedded in the undergraduate nursing curriculum. This approach was ideal due to its relevance and capability to retrieving data that other methods could not. For an example, in this study the qualitative approach enhanced collection of rich data from participants who possessed the knowledge that was needed regarding the phenomenon under study (Guba & Lincoln, 1985). Furthermore, triangulation of data collection through review of the academic records complemented the information obtained from the participants.

In phase two (2) the design was used to develop and describe the conceptual framework pertaining to teaching-learning of spiritual care as well as generation of a practice theory that would guide the nurse educators and nursing students in the teaching-learning process of spiritual care. Furthermore, this phase was used to generate, describe and evaluate a practice theory for teaching-learning of spiritual care in the undergraduate nursing programme. As it has been highlighted above, Table 1.1 provides a summary of the research process that was followed in this study.

1.10 RIGOUR

Rigour refers to strategies applied by the researcher throughout the research process to enhance the quality and integrity of the study (Polit and Beck, 2008: 536). This means that the researcher applies specific strategies through all the phases of the study from planning to implementation as well as reporting the findings. The researcher's philosophical and methodological insights often play a valuable role in ensuring research integrity. In this study, rigour was maintained through application of measures to ensure trustworthiness according to four criteria by Guba (1981).

1.10.1 Measures to Ensure Trustworthiness

Trustworthiness can be defined as a means to establish quality and soundness of qualitative research (Krefting, 1991: 215, Schwandt, 2007: 299, Polit & Beck 2008: 71, Holloway & Wheeler, 2010: 297, Marshall & Rossman, 2011: 251). These authors also agree with the criteria of trustworthiness by Lincoln and Guba (1985: 290), which is aimed at promoting merits and authenticity of qualitative studies (Guba & Lincoln 1989: 233). In this study, a model of trustworthiness by Guba (1981: 74-91) was used to ensure credibility. The model depicts four aspects of trustworthiness that relate to qualitative research namely; truth value, applicability, consistence and neutrality (Klopper, 2008).

1.10.1.1 *The criterion of truth value*

Truth value refers to the criterion that explains how the researcher established and maintained confidence in the study findings (Klopper, 2008). The findings are regarded as credible if scientific strategies or methods were employed. Credibility was ensured through various research interventions including triangulation, prolonged engagement and alternative interviewer. Each of these strategies are discussed below to show how they were applied and why they were used. Triangulation was implemented through diverse data collection methods and data sources. This strategy increased the study's worth because of use of several data collection methods such as in-depth interview, focus interview and review of documents which brought a better view of the phenomenon being studied. Hence, these diverse data collection methods did not only increase the strength of the study by yielding uniting findings (Krefting, 1991: p.219); but also increased the understanding of the phenomenon under study from different meanings. The convergent of multiple perspectives ensured wide questioning about the phenomenon under enquiry. Furthermore, triangulation allowed the researcher to identify inconsistencies among participants which were redressed by follow-up questions. Prolonged engagement avoided a potential halo-effect as most participants had met the researcher on the premises prior to data collection.

Prolonged engagement increased rapport through close interaction with participants and thus allowed that researcher to uncover hidden facts. The understanding of the participants' shared perceptions and opinions by the researcher due to the interviews were adequately long. Reflexivity and bracketing were applied in order to avoid contaminating obtained data whilst the participants shared their understanding, perceptions and opinions which in turn positively influenced the credibility of the study findings. preconceived ideas and thoughts. The researcher was submerged in data during the analysis phase (Krefting, 1991: 217). The use of a neutral interviewer was aimed at ensuring participants' comfort in case there were those who would not be willing to be interviewed by the researcher, for diverse reasons.

1.10.1.2 The criterion of applicability

According to Krefting (1991: 216) applicability refers to the degree to which the findings can be applied to another context, setting or group. Klopper and Knobloch (2008) refer to applicability as the extent to which the findings can be generalised to a larger community using the strategy of transferability. Applicability considers the usefulness of the findings from one context to another similar context or setting. This strategy implies the principle of generalisation of findings. However, qualitative studies do not aim at generalizing the findings but they aim to discover human experiences as lived and perceived by participants within a specific context (Krefting, 1991: 215; Lincoln and Guba, 1985; Guba, 1981). In line with this view, the findings of this study cannot be generalised to other settings; however thick description of the participants' responses and descriptive data might enhance the transferability of the findings to other similar South African contexts. Therefore, transferability would only be possible based on the extent to similarity or goodness of fit between the context of the current study and that to which the findings are to be transferred to (Krefting, 1991: 216; Lincoln and Guba. 1985; Guba, 1981).

1.10.1.3 The criterion of consistency

Consistency refers to an assumption that when the study is replicated by different people on the same participants in similar context the findings will be the same (Krefting, 1991: 216; Lincoln & Guba, 1985; Guba, 1981). A degree of consistency denotes the stability of the study and credibility of the findings. Tight description of the research design, procedures and research methods that were used were intended to safeguard the value of “*repeatability*” or “*replicability*”. However, challenges can be experienced in fulfilment of this criterion based on the fact that qualitative studies are not only primarily designed to learn from the participants and not to control them as it is the case with quantitative studies (Krefting, 1991: 216); but more

importantly qualitative studies emphasise uniqueness of human experience. Therefore, variation in the experience is often sought than identical occurrences.

Furthermore, consistency can be defined in terms of dependability (Kretfing, 1991: 216); which Guba (1985) acknowledges as trackable and it increases the researcher's insight and understanding of the phenomenon that is being studied. Triangulation was attained by the use of multiple sources from which the conclusions were drawn from (Polit & Beck 2008:196). The dependability of the findings was ensured through thick description of the research methodology, step-wise replication of the research method and code-recode procedure of data analysis. In addition to detailed description of participants' experiences and use of excerpts to describe the findings of the study. The reporting of the study findings was not based only on the description participants' experiences but also used their own words. Dependability focuses on the process of inquiry in relation to the researcher's responsibility to ensure not only paper trail for the research process but more importantly to keep accurate, adequate and traceable analytic and decision-making processes in scientific activity.

1.10.1.4 The criterion of neutrality

Neutrality refers to freedom from bias during the entire research process (Kretfing, 1991: 216). Scientific analysis and interpretations of data and audit trail or decision trail to facilitate the judgment of data were employed. The scientific research methods, procedures, audit trail and interpretation of data were therefore used in a manner that enhanced objectivity. Reflexivity, bracketing and member checking were measures used to enhance conformability of the findings. Furthermore, codes, summaries and themes and an Independent Coder promoted conformability of the study findings.

1.11 ETHICAL CONSIDERATIONS

Ethical consideration in research refers to a deliberate ethical stance that is taken by the researcher to ensure that the research is conducted ethically. It ensures that the research practice is free from unprofessional and harmful research practice. Increased awareness about the fact that human beings are the objects of study in social research does not only bring unique ethical challenges for the researcher; but it means that data should not be obtained at the expense of human lives. De Vos, Strydom, Fouche, and Delport, (2011) point to a need to handle ethical aspects in a manner that promotes good practice and research. This can be achieved through mutual trust, acceptance and cooperation between the researcher and participants.

Approval for the study by the ethical committees of the institution where the study was conducted was sought to ensure that the study was conducted ethically. The proposal was presented at the school of nursing for input from colleagues. After which it was submitted to the faculty's research committee for scrutiny so as to determine if it was written according to the ethical requirements and standards before it could be submitted to the Senate Research Committee of the university where the study was approved by issuing Research Certificate no. 13/4/22 (See appendix no.1).

Furthermore, the Code of Ethics as agreed by Beauchamp and Childress (2009) was followed in fulfilling the research ethics requirements including approval by ethical committees. Beauchamp's and Childress's (2009) ethical framework which is as fundamental in social science was used. In addition to the principle of respect for autonomy beneficence; non-maleficence and justice that are pillars including other pillars such as right to privacy, other. These principles are essential to protecting participants from unwarranted physical or mental discomfort, distress, harm, danger or deprivation of all kinds that may emanate from the research encounter. The ethical aspects that were applied in this study are discussed below.

1.11.1 Approval by Ethical Committees

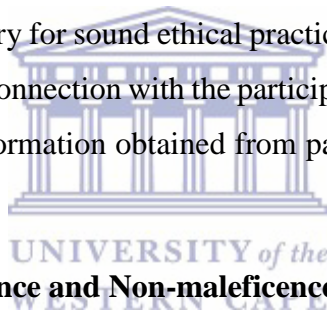
Authorisation for the study was sought to ensure that the study was conducted ethically. The proposal was presented at the school of nursing for input from colleagues. After which it was submitted to the faculty's research committee for scrutiny so as to determine if it was written according to the ethical requirements and standards before it could be submitted to the Senate Research Committee of the university where the study was approved by issuing Research Certificate no. 13/4/22 (See appendix no.1).

1.11.2 Principle of Respect for autonomy

The principle of respect acknowledges a person's right to self-determination; right to making choices, to holding views, and to taking action based on personal values and beliefs. It entails acknowledging the participant's autonomy to decide to participate or not to participate in the study. Clarifications and explanations about the study were provided. The participants were free to ask the researcher questions for the purpose of clarity and decision-making on whether or not to participate; their questions were answered as per individual need(s). The researcher avoided coercion but explained and answered questions in a language understood by participants. Furthermore, the participants were informed that they have the right to withdraw from the research at any stage, and that there would not be penalized, punished or receive prejudicial treatment should they decide to withdraw (Brink, 2006).

1.11.3 The right to Privacy, Anonymity and Confidentiality

Safety measures that were taken include the use of a familiar, comfortable environment for data collection from the participants to avoid psychological trauma. Participants were free to select a preferred place where they were interviewed. The participants' choice of a place where they would be interviewed enhanced emotional stability as their privacy was conveniently catered for. Privacy, confidentiality and anonymity were ensured to prevent harm to participants (Brink, 2006: 40-42). Privacy of the participants was ensured at all levels in handling data. All study participants were kept anonymous through-out the data collection process, data analysis process and beyond. This meant that under no circumstance were the names of the participants divulged. The participants' real names were not used throughout the study; from data collection to reporting the study findings. The participants in the focus group discussion only related to each other by use of numbers instead of real names. During the interviews, the participants were not addressed by their real names. Furthermore, participants' names never appeared on the study documents but only codes used as pseudonyms. Only the researcher knew the true identity of the participants. This was necessary for sound ethical practice where confidentiality ensured that no other person could detect any connection with the participants based on available information. All the documents containing information obtained from participants were kept under lock and key.



1.11.4 Principles of Beneficence and Non-maleficence

Several measures were applied to ensure that all potential forms of errors and negligence in relation to research activities were avoided. Respect for autonomy was enhanced through an information sheet (see Appendix no.3) and informed consent (see Appendix no. 4) which were given to participants to read at their own time after they had been explained by the researcher. The information sheet contained the contact details of the researcher. A special binding form (see Appendix no.5) was signed by all focus group participants to ensure they did not divulge what was discussed in the focus groups to non-participating individual. Participants were informed and explained to about their expected role in the study. The contact details of the researcher were made available to all participants in case they needed to access the researcher for any study related needs.

1.11.5 Scientific Honesty

The principle of justice entails moral obligation to conduct the research process with integrity and acceptable standards. Reflexivity was maintained through abstinence from plagiarism by providing full citation and reference list of sources used. This was to observe the copyright and

intellectual property rights regarding the authors' work. This was not only exercising the fundamental ethical principles but also as a sign of respect for authors' of information sources and databases that were consulted (Brink, 2006: 40-43). The researcher shared the results with the scientific community in a respectful manner and observed the ethical requirements of the accredited journal where the findings were distributed. The other authors, whose literatures were used to support the arguments and findings of the study, were acknowledged to ensure that no plagiarism was committed. Papers published from this study were intended to share the researcher's experiences about the research process and reporting the study findings acknowledged all the authors whose works were used in the study. The researcher adhered to this aspect by ensuring that all the information that was reported was accurate and that no data was falsified.

1.11.6 Principle of Justice

According to Polit and Beck (2008: 173) the principle of justice refers to fairness and equity that is applied when handling humans. It entails participant's right to fair treatment and their right to privacy. Researchers have a responsibility to protect the rights and interests of participants and ensure that participants are not exploited for the advancement of knowledge. This means that participants should freely and willingly participate in the research. They should be treated in a non-prejudicial manner if they drop-out from participating even after having agreed to participate. The researcher must honour all promises made to the participants and provide courteous and tactful treatment to participants at all times (Polit & Beck, 2008: 173-174). In this study, the principle of justice was applied through a fair selection and treatment of the participants using a scientific process ensured that all participants were fairly selected and included. Participants were purposefully selected on the basis of their knowledge and experience of the study topic. Their participation might have been compromised because most of them were known to the researcher. Furthermore, the researcher ensured that participants were neither exploited nor compromised in their engagement.

1.12 THESIS CHAPTERS

The following outline provides the structure and organisation of the thesis chapters. Each chapter is designated to specifically address an aspect relevant to the study process and the findings.

Chapter 1: Overview of the study

Chapter 2: Research design and research methods

Chapter 3: Results from in depth interviews with nurse educators and clinical supervisors.

Chapter 4: Results from focus group discussion with the nursing students.

Chapter 5: Results from document review of the academic records.

Chapter 6: Conceptual framework for teaching-learning of spiritual care.

Chapter 7: Practice theory for teaching-learning of spiritual care in the undergraduate nursing programme at a higher education institution in the Western Cape.

Chapter 8: Evaluation of research study, limitations and recommendations for education, practice and research.

Chapter 9: References

1.13 CHAPTER SUMMARY

This chapter outlined the overview of the study in which the aim and objectives of the study and the problem statement were presented. Assumptions of the study were discussed. Definitions for concepts were provided. The research design and -methods as well as data management were also addressed as well as measures to maintain rigour, ethical consideration, and trustworthiness were also addressed.



CHAPTER 2: RESEARCH DESIGN AND RESEARCH METHODS

2.1 INTRODUCTION

This chapter presents a discussion on the research design that was used in this study. It also provides a discussion on the research methods, procedures and techniques that were applied to select the sample from the targeted population, collection and analysis of data. Measures that were employed to enhance trustworthiness and ensure quality as well as ethical integrity of the study were discussed in detail in Chapter one (1).

2.2 RESEARCH DESIGN

Research design refers to a plan and procedures essential to undertake a research. This study employed a theory-generative design which was undertaken in two phases comprising of data generation process on which the theory is based followed by a theory-generative process where relationships concerning spiritual phenomenon were clarified and described resulting in the generation of a practice theory and its evaluation. Post-modern and constructivist philosophies of science were used as foundation to the research design. These philosophical assumptions of science guided and shaped the researcher's decisions from broad assumptions to detailed methods of data collection, analysis and interpretation (Creswell, 2009: 3). The theory-generative design will be presented under the respective sub-headings unfolding the process that was followed.

2.2.1 Theory-Generative Research Design

According to Chinn and Kramer (2011), theory-generating research design aims not only to clarify and describe the relationships concerning a phenomenon under study; but it is an inductive approach to generate data on which the theory is based. Furthermore, Chinn and Kramer (2011), affirm that theory-generative design assists in establishing how close the theory portrays the relationships between its constituents. In the current study, theory-generative design was used to generate a practice theory for teaching-learning of spiritual care in the undergraduate nursing programme at a higher education institution in the Western Cape. The process followed the application of qualitative research approach using exploratory, generative, qualitative, explorative, descriptive and contextual designs. The participant's beliefs, experiences and perceptions were explored using their emic perspective to collect data. Thus the theory generative design was chosen as an appropriate design to achieve the aim of the

study as it allowed the researcher to draw the meanings of the phenomenon under study from the participants' views. Ritchie and Lewis (2003: 7) emphasise that qualitative research focuses on the value of human experience and interpretation of knowledge about the social world. Therefore, the use of the participants' emic perspective was founded on its value in accessing the participants' insights. Each of the elements of the design will now be discussed.

2.2.1.1 Qualitative Approach

The qualitative research approach is defined as the process of data gathering that focuses on meanings, narrations, expressions of human experience rather than numerical values (Burns & Grove, 2009). The qualitative research approach enhanced the gathering of rich data regarding the phenomenon under study while taking into account the context from which data was being extracted (Darlington & Scott, 2002: 50; Maxwell, 2005: 24). Hence this approach allowed the participants to share their understanding and opinions whilst attaching their own meaning about the phenomenon of teaching and learning of spiritual care in the undergraduate nursing programme. This emic data contributed to the generation the practice theory through its structuring into expressions of a formal description of a phenomenon (Chinn and Kramer, 2011: 153).

2.2.1.2 Exploratory design

The explorative design allowed the research to delve deeper into the matter, although without any intention to generalise the findings Burns and Grove (2009). According to Curry, Nembhard and Bradley (2009: 1442) qualitative studies are often exploratory and seek to generate a novelty of insights through inductive processes. In-depth inquiry enhanced exploratory questioning by the researcher whilst allowing participants to narrate the experiences in their own words. Thus, the exploratory design enhanced the production of rich data by taking into account the in-depth insights of the participants as they explored their own meanings. Darlington and Scott (2002: 50) and Maxwell (2005: 24) recognise that the participants' role of giving their understanding and opinions regarding the phenomena under inquiry, which was teaching-learning of spiritual care in this case, is critical in explorative design.

2.2.1.3 Descriptive design

The descriptive design provided a better understanding of how the phenomenon of teaching-learning of spiritual care is viewed and understood by the participants. The researcher described

obtained data using the participants' own words (Corbin & Strauss, 2008). Therefore, participants' voices were central in identifying and describing what spiritual care meant to the participants. The recorded units of speech were utilised to form thick descriptions of the participants' voice in the study (Guba & Lincoln, 1985). These descriptions meaningfully contributed to the process of generating the practice theory for teaching-learning of spiritual care.

2.2.1.4 Contextual design

Contextual design provided a detailed description of the study setting (Burns & Grove, 2009) which was aimed at providing an understanding of the setting and context about the school of nursing at a university in the Western Cape Province where the study was conducted. The context of the study was significant to expand the participant's description of experiences which further heightened trustworthiness and credibility of the study findings. The setting is discussed in detail in section 2.4 below.

2.2.2 Basis for Theory-Generative Design

The aim of the theory-generative design was to develop a practice theory. This was achieved by finding the answer to the research question "*how can a practice theory for teaching-learning of spiritual care be facilitated in the undergraduate nursing programme?*" According to Dickoff, James and Weidenbach (1968) theory-generative research design often connects the contextual factors that are in play with the phenomenon under study. Furthermore, Dickoff, James and Wiedenbach (1968a: 416) argue that theory-generative research is best placed within the levels of theory generation. These levels are provided below in sections 2.2.2.1; 2.2.2.2; 2.2.2.3 and 2.2.2.4. In justifying the use of theory-generative design that aims to describe a practice theory for teaching-learning of spiritual care, authors including Rodgers (2005: 12), George (2011: 27) concur with Dickoff *et al.*, (1968a) assertion concerning the value of the levels of theory development. Authors including Chinn and Kramer (2011: 40); Walker and Avant (2011: 5) viewed theory-generation design as a directive for developing nursing as an autonomous profession. The design is also viewed as a mechanism that can provide the profession with an organized and distinguished body of specialised knowledge on which the practice of nursing education is reinforced. Chinn and Kramer (2011: 229), also assert that theory-linked research provides the profession of nursing education with the opportunity to refine concepts and theoretic relationships, and thereby providing an empirical evidence to

support practice. However, the authors further argue that if empirical evidence does not support concepts and theoretic relationships, the constructs within a theory cannot be sustained.

Chinn and Kramer (2011: 41) define theory as an expression of knowledge that is derived from empirical evidence, whereby creative and rigorous structuring of ideas is projected to represent tentative, purposeful, and systematic view of phenomena. Despite existence of different definitions of a theory and ways through which theory is constructed, each definition often depicts a stance and philosophical belief about that particular theorist (Chinn and Kramer, 2011: p.185). These authors further state how the theorist defines the process of theory generation, and becomes a critical and guiding factor in the development of theory. Hence definition of a theory reflects the values that underpin the theorist’s beliefs.

Furthermore, theory is classified accordingly to different levels which are in line with the intended use of the theory by the theorist (Fawcett 2005: 19; Rodgers, 2005: 19; Meleis, 2007: 43; Chinn & Kramer, 2011: 178; George, 2011; Walker & Avant, 2011: 5). The purpose of articulating the levels of theory is to position the development and description of a theory being developed (Chinn & Kramer, 2011: 41; Walker & Avant, 2011: 6) accordingly. The levels include the following: (i) meta-theory, (ii) grand theory, (iii) middle-range theory and (vi) practice theory. The levels of theory development are presented in figure 2.1 below to show interrelatedness of theory levels (Walker & Avant, 2011: 20). Each level is briefly described below and depicted in figure 2.1.

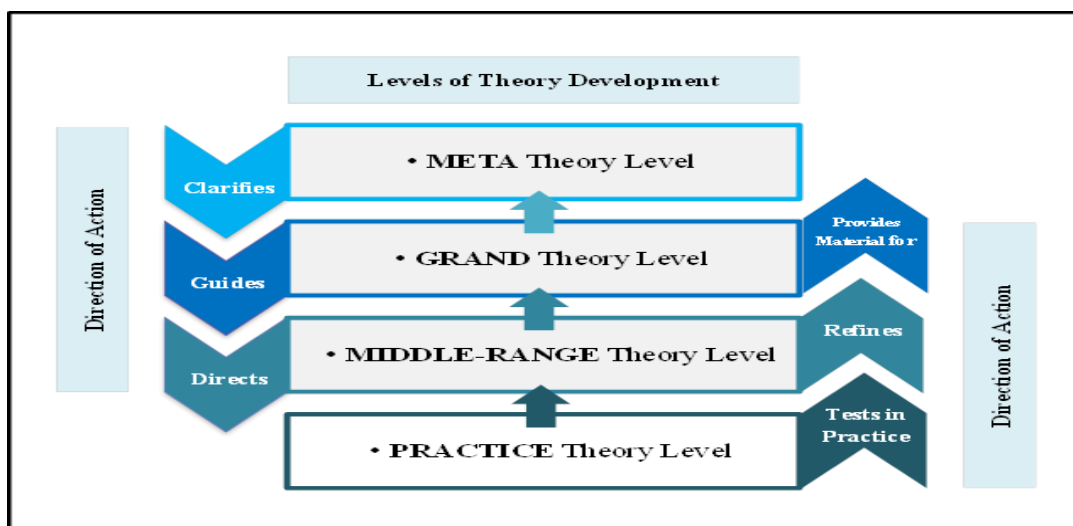


Figure 2.1 Levels of theory generation adapted from Walker and Avant (2011).

2.2.2.1 Meta-Theory

At this level, Walker and Avant (2011: 7) maintain that broad universal issues are debated without producing grand, middle-range, or practice theories. Examples of issues at this level include: (i) analysis of the kinds and purposes of theories in nursing, (ii) review, recommendation and critique of the sources and methods of theory development in nursing, and (iii) advancing appropriate criteria to evaluate theory in nursing. They contend that a common theme throughout the meta-theoretical literature is recurring reviews of the meaning of nursing as a practice discipline, namely nursing as both a science and a profession. In their description, Chinn and Kramer (2011: 45,) allude to the work of Dickoff *et al.*, (1968) value-laden nature of theory in nursing where the goal is indicated in the goal-content. Additionally, Chinn and Kramer (2011: 4) regard meta-theory as writings that explicate on what the essential and fundamental qualities of a theory should be, and the processes for developing theory.

2.2.2.2 Grand-Theory

At this level of theory, Chinn and Kramer (2011: 188) and Walker and Avant (2011: 12) regard the aim as expounding on a worldview in nursing that gives a global perspective of the goals and structures of nursing practice. Walker and Avant (2011: 12) provide an important function of grand theory as contributing to the conceptual distinction between the practice of nursing versus the practice of other health care disciplines by illustrating the nursing-defining perspectives of practice in a healthcare setting.

2.2.2.3 Middle-Range Theories

This level of theory development focuses on areas of substantive concerns in nursing practice or concepts of interest and related phenomena (Chinn & Kramer, 2011: 48). Middle range theory provides sufficient specificity for research and practice, and is therefore useful for inquiry between grand theory and practice theory. Walker and Avant (2011: 16) consider this level of theory as useful and testable in nursing research because of its limited scope and fewer variables compared to grand theories, yet retaining its scientific value in theory development.

2.2.2.4 Practice-Theory

Chinn and Kramer (2008: 58) and Walker and Avant (2011: 18) advise that this level of theory has at its core a particular goal and directions for actions to accomplish the goal. Dickoff *et al.*, (1968) attest that the primary aim of practice theory is to improve practice. This view is

supported by Meleis's (2007) stance that practice theory focuses on explaining the nursing concepts that are founded on practice of nursing. This denotes goal-oriented nature of a practice theory through with specific actions that are necessary to produce the required outcome(s) are prescribed. Walker and Avant (2011: 18) acknowledge the practice theory as "nursing-in-action" that has become distinguished as a particular type of theory within the context of nursing as a practice discipline. Walker and Avant (2010:18) point to Dickoff *et al.*, (1968a: 415-435, Dickoff *et al.*, 1968b: 545-554) seminal work on practice oriented theory whenever they discuss practice theory. The aim of the current research was to generate a practice theory in teaching-learning of spiritual care in the undergraduate nursing programme at a higher education institution in the Western Cape; South Africa. Practice theory is generated through the following process: (i) factor-isolating theories; (ii) factor-relating theories; (iii) situation-relating theories and (iv) situation-producing theories or prescriptive theories. Practice theory which is a "situation-producing" theory or "prescriptive" theory is the level of theory where this study was undertaken to accomplish its aim. Dickoff *et al.*, (1968a: 421) point to the three (3) components that are essential for situation-producing theory; these include:

- (i) **Goal content** that is specified based on the **aim** of the activity. In this study, the goal was to integrate spiritual care in the undergraduate nursing programme through development of a practice theory for teaching-learning of spiritual care in the undergraduate nursing programme at a higher education institution in the Western Cape.
- (ii) **Prescription** for the activity which ensures the realisation of the goal content. In this study, the prescriptions of integration of spiritual care in the undergraduate nurse programme at a higher education institution in the Western Cape would be enhanced by implementation of practice theory for teaching-learning of spiritual care.
- (iii) **A survey list** that serves to classify the prescriptions for future applications of the theory so that the prescriptions are carried out in a manner that promotes attainment of the goal content. The survey list of Dickoff *et al.*, (1968a) was used in Chapter six (6) to facilitate concept classification after concept identification from empirical data was obtained from participants.

Table 2.1 below presents the process of development of a practice theory according to Dickoff *et al.*, (1968: 420).

Table 2.1 Practice theory generation process

Levels of practice theory by Dickoff, James & Wiedenbach (1968a: 420)	Application to practice theory development in this study
i. Factor-isolating	Concept identification Concept classification
ii. Factor-relating	Conceptual framework Relational statement
iii. Situation-relating	Description of practice theory
iv. Situation producing	Evaluation of practice theory

According to Walker and Avant (2011: 58) there are three fundamental elements in theory generation, they include; concepts, statements, and theory. A concept is a mental image that represents an idea, phenomenon, or a construct about something or an action. It is a foundation on which the theory is built. According to Walker and Avant (2011: 20), ideally, concepts are not necessarily tangible objects or actions, but they are mental representations of what they stand for. Concepts assist in categorising and organising the environmental stimuli which facilitates communication. Furthermore, Walker and Avant (2011: 59) assert that language is the means by which humans express themselves through concepts; however, the terminology that is used to communicate these concepts simply conveys the expression of a created mental picture because the terminology itself is not the concept. In this manner, concepts contribute to new learning by identifying how human experiences are similar or dissimilar. The types of concepts include; primitive, concrete and abstract concepts and provide examples of different meaning or conceptualisation. Each type is briefly described below to depict its use.

Primitive concepts are those concepts that all persons can identify such as that the “sky is clear”, “blue” or “cloudy” as this observation would be a universally shared mental image. *Concrete concepts*, are those concepts that exist in time and space. Concrete concepts can be shared universal mental images as it is the case with primitive concepts. However, concrete concepts are observable and definitive in the real space such as the “car”. *Abstract concepts* differ from the primitive and concrete concepts in that they are independent of time and space such as “temperature” or “wind”. These type of concepts are not discussed in detail but were only pointed out as their role became critical as theory constructs. Thus their skilful use to describe meanings of experiences can assist in the development of theory through articulation of relationships between concepts and statements depicting a higher level of usefulness

concepts. Statements are essential prerequisite segments for building scientific argument. Statements are body of knowledge which are generated before explanations or predictions are made. In reference to theory development, statements can be relational or non-relational. Relational statements therefore denote a relationship or association between two or more concepts, and non-relational statements denote independent existence, or are defined by a concept. The definitional statements can either be theoretical or operational in that the former has abstract defining characteristics and the latter has a degree of measurable characteristics. In theory generation, relational and non-relational statements are crucial as they serve as a means of testing and validating theories in real settings. A preliminary discussion and description of a theory was provided in chapter one (1) under background and rationale to introduce the study. A diagrammatic presentation of an overview of theory-design is provided below in figure 2.2 below.



Diagrammatic presentation of an overview of theory-design

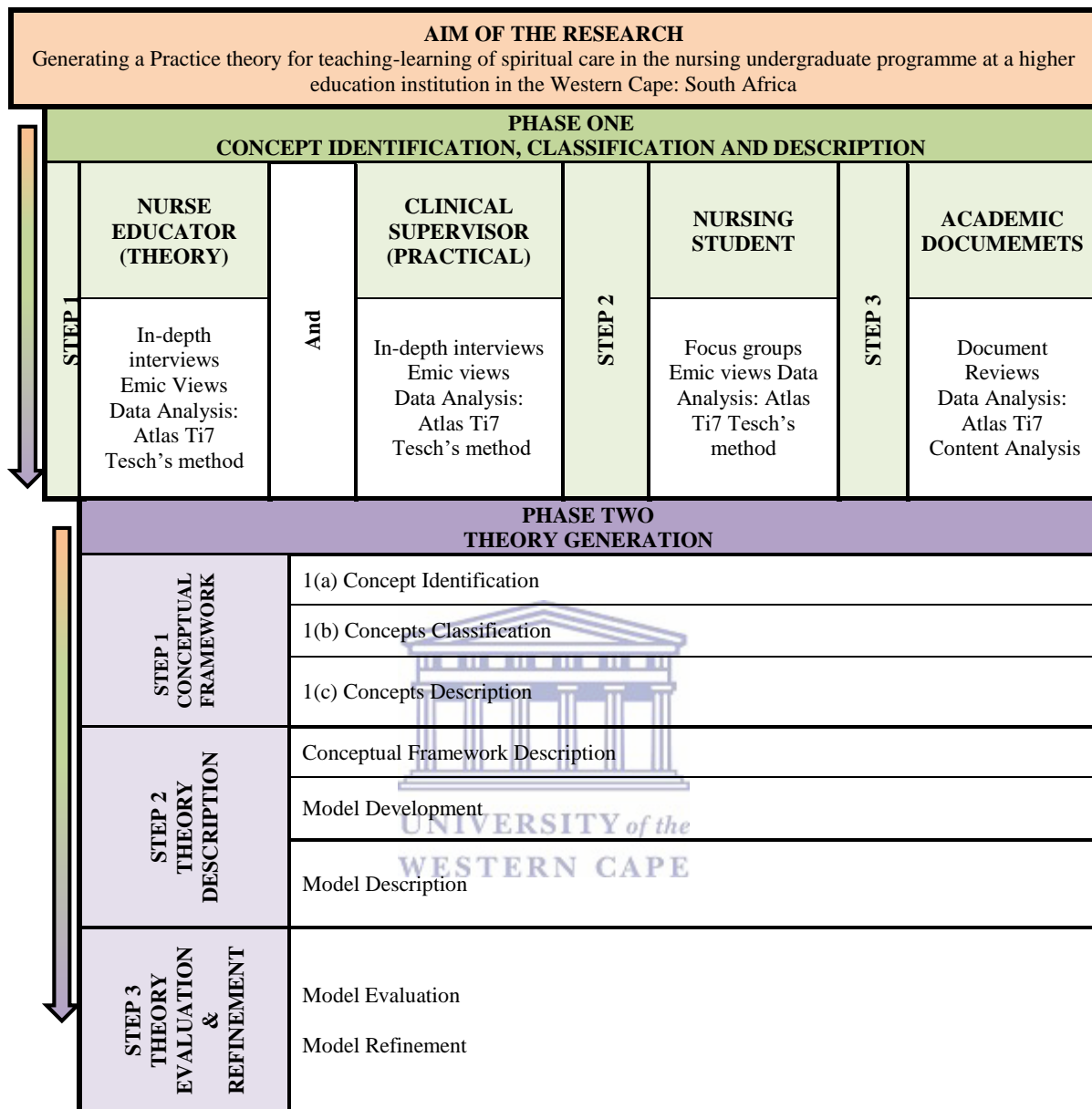


Figure 2.2 An overview of the research-design

2.3 STUDY SETTING

A particular school of nursing at a university in the Western Cape was identified as an ideal setting for the study. The description of the study context is discussed below under the following sub-headings: (i) geographic settings of the study context. (ii) The university context in relation to the faculty in which the school of nursing is situated (iii) lastly, the context of the school of nursing in relation to the programmes that are offered at the school.

2.3.1 Geographic setting

The university in which the study was conducted is among the four universities in the Western Cape Province. The map below provides a special geographical location of all the universities in the Western Cape as demarcated in Figure 2.3 below by the respective institution's logo.

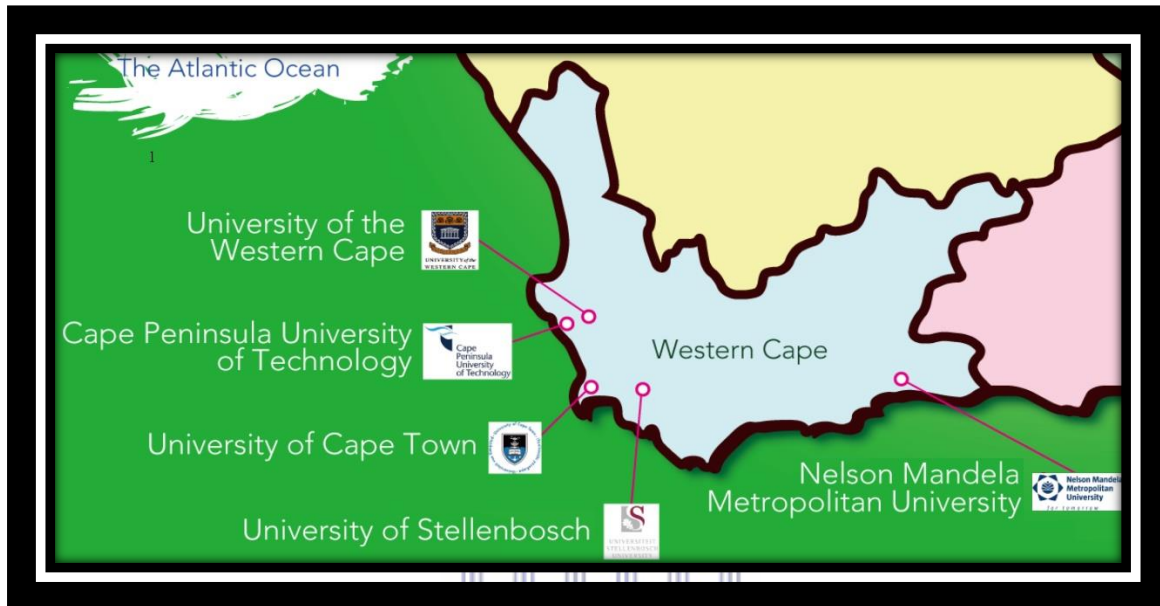


Figure 2.3 The universities in the Western Cape Province

(Embassy of the Republic of South Africa in Tokyo JAPAN (2015) <http://www.dst.tokyo/study-sa.html>)

2.3.2 The university context

The university context in which the study was conducted is comprised of various faculties and disciplines of which the faculty of Community and Health Sciences is one of them. Each faculty is comprised of several schools, departments and centers of learning scholarship wherein they offer undergraduate, post graduate and certificate level programmes. The school of nursing is governed under the Faculty of Community and Health Sciences (University Calendar, 2015).

2.3.3 The context of the school

The school of nursing in which the study participants were drawn is part of a higher education institution in one of the universities in the Western Cape. The school offers both undergraduate and postgraduate programmes with different specialties. The undergraduate programme in which the study was conducted is a four-year Bachelor's Degree that is offered under R425 as governed by the Nursing Act No. 33 of 2005 (SANC, 2014).

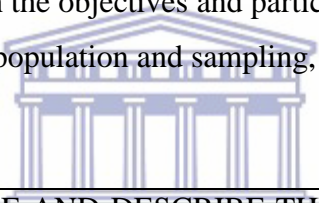
2.4 RESEARCH METHODS

Research methods refer to the techniques and procedures that were followed to identify a population, select a sample, collect and analyse data. Burns and Grove (2009) define research methods as a means of obtaining, organising and analysing data. The use of the research methods was purposed at finding answers to the research questions, and solutions to problems. These methods can be used to develop models and theories that reflect the truth about the existence of a particular phenomenon. The methods section will be discussed according to phases, steps and related objectives for ease of comprehension on how the process unfolded.

2.4.1 Phase 1: data generation

In phase one (1) the qualitative research approach was undertaken as part of a theory-generative process using an eclectic approach to collect data from the study participants. The first three objectives as outlined in chapter 1 were addressed in sequential steps 1-3. The phase one (1) steps will be discussed in line with the objectives and particular research methods which were used. The discussion will include population and sampling, data collection and data analysis.

2.4.1.1 Objective one: Step 1



OBJECTIVE 1: TO EXPLORE AND DESCRIBE THE UNDERSTANDING OF NURSE EDUCATORS AND CLINICAL SUPERVISORS OF THE CONCEPT OF SPIRITUAL CARE AT A HIGHER EDUCATION INSTITUTION IN THE WESTERN CAPE

2.4.1.1.1 Population

Population refers to the entire set of individuals, elements or objects having some common characteristics (Polit and Beck, 2008: 761). These authors define target population as the entire population in which the researcher is interested and to which the researcher would like to generalise the study results (Polit & Beck, 2008: 767). Accessible population comprised all potential participants or elements that were available for data collection if they met the inclusion criteria. The population for objective one comprised of nurse educators and clinical supervisors as the target population. The target population for nurse educators was eighteen (18) whereas that of clinical supervisors was twenty-five (25). The inclusion and exclusion criteria were as follows;

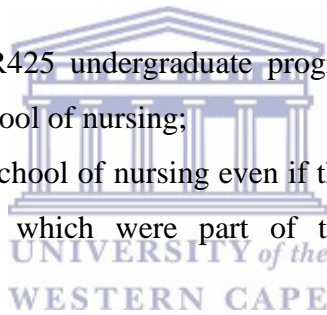
Inclusion criteria:

Participants must;

- (i) be employed at the school of nursing whether as contract-full time or permanent staff;
- (ii) be a nurse educator who has been teaching in the R425 Nursing Programme at least for twelve months or two semesters prior to data collection; or
- (iii) be a clinical supervisor who has been teaching, supervising and accompanying nursing students in the R425 Nursing Programme at the clinical laboratory and clinical facilities;
- (iv) have signed a written consent for participation.

Exclusion criteria:

- (i) not involved in the R425 undergraduate programme even if they taught other programmes at the school of nursing;
- (ii) not employed by the school of nursing even if they taught the nursing students on non-nursing modules which were part of the R425 undergraduate nursing programme;
- (iii) not signed the written consent.

***2.4.1.1.2 Sample, sampling technique and sample size***

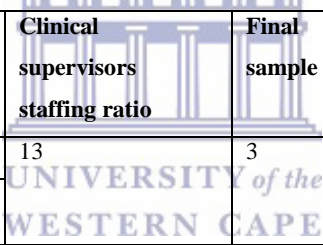
The sample refers to a subset of the population elements. The element is the most basic unit through which information is collected (Polit & Beck, 2008: 339). Purposive sampling (Brink, 2011: 102) was used to select both the nurse educators and clinical supervisors for participation in the study. Ten (10) nurse educators and nine (9) clinical supervisors participated after data saturation was reached which implied no new data was forthcoming. However, due to the multiple levels that the undergraduate programme is comprised of, representation was ensured so that the views from different levels come to the fore. For the nurse educator, the sample was not only guided by different nursing disciplines in which the nurse educators taught specific subjects; but, varied factors such as different nursing modules in different year levels was considered as indicated in Table 2.2 below.

Table 2.2 Nurse Educators sampling

BN Undergraduate Nursing Programme Year Level	Nurse Educators staffing ratio	Actual sample	Nursing Disciplines
Year level 1	6	3	Fundamentals of Nursing
Year level 2	5	2	General Nursing Science and Art
Year level 3	4	3 (*2;**1)	*Midwifery and **Community Health Nursing
Year level 4	3	3(*2;**1)	*Psychiatry and **Gender Based Violence
Totals	18	10	

On the other hand, for clinical supervisor representation was ensured by inclusion from different year levels and disciplines as indicated in Table 2.3 below. However, it is important to note that the clinical supervisors in the first and second year levels were represented by the same individuals as per their job description requirement.

Table 2.3 Clinical supervisors sampling



BN Undergraduate Nursing Programme Year Level	Clinical supervisors staffing ratio	Final sample	Nursing Disciplines
Year level 1	13	3	Fundamentals of Nursing
Year level 2			General Nursing Science and Art
Year level 3	6	3	2 Midwifery discipline and Community Health Nursing)
Year level 4	6	3	Psychiatry and Gender Based Violence
Total	25	9	

2.4.1.1.3 Recruitment Plan

Recruitment of the nurse educator (NEs) for participation was undertaken concurrently with recruitment of the clinical supervisor (CSs). Email was used as a primary source to recruit the participants however, where an opportunity presented itself during the staff meetings or any academic gatherings; an invitation for participation was extended verbally and followed by a request letter (appendix no.9).

2.4.1.1.4 Data Collection

This section will discuss the process of data collection followed by description of the field notes.

- **Data collection procedure**

According to Burns and Grove (2009) there are different types of tools and methods used to collect data. Data collection refers to a systematic approach to gather and measure information from variety of sources to get a complete and accurate picture of an area of interest. Data collection allows the researcher to obtain answers to relevant questions, evaluate outcomes and make predictions about circumstances and future probabilities and trends. However, for the specific population of this study, in-depth interviews were used. In-depth interviews as an unobtrusive method were used based on their nature which promotes close working range between the researcher and participants. Interviews support rapport and improve probing or follow up questions for clarification of any unclear phenomenon (De Vos, Strydom, Fouche & Delpont, 2011).

The interviews were conducted by the researcher and the participants were asked one open ended question *“What is your understanding of the concept of spiritual care in nursing?”* This question was followed by probing to stimulate participants to produce more information without injection and interjection (Darlington & Scott, 2002). Different probes and cues used included echo probes such as “uh, huh,” “yes, I see,” “right, uh-huh”. Silent probes were used when the researcher remained silent and waited for participants to continue talking. Non-verbal prompts such as head-nodding, frowning and head shaking were at times appropriate to rekindle interest of participants which helped to keep sound communication and motivated the spirit in participants to continue talking and keeping the discussion vibrant and engaging. The participants were asked to “tell more”, “explain”, or describe what was being discussed as the researcher listened and showed interest. Probing was to ensure that the researcher understood the details by seeking clarification and confirmation on unit of speech where participants were not clear or had paraphrased words.

Interviews were conducted in English but participants were allowed to express themselves in the language they are comfortable with such as Afrikaans or Xhosa, both of which the researcher is familiar with. However, participants were conversant and comfortable in communicating in English. Interviews were held in different places as determined by the participants. These included their offices, the researcher’s office and other available spaces in the university campus. All interviews were audio recorded with the permission of the participants to ensure that no important information was lost in the process. Interviews lasted

about 45 minutes to an hour and thirty minutes on average. Audio recorded files were labeled accordingly to ensure anonymity before being given to a professional transcriber. It is important to note that the original method planned to collect data from the clinical supervisors was focus group interviews but this was changed to in-depth interviews due to challenges pertaining to getting the groups together.

- **Field notes**

Field notes refer to additional information obtained from interaction with the participants during an interview that can be useful in making sense of empirical data obtained. According to Polit and Beck (2008: 405) field notes refer to unstructured ways to collect data through observing the participants. In this study, the researcher took field notes including descriptive and reflective notes. Descriptive notes described the geographical and demographical set up as transpired while reflectively capturing the researcher's thoughts and experiences during the interviews. Reflective notes such as methodological, theoretical and personal notes were kept by the journaling of important events or incidents which occurred. The reflective notes were compiled from observed participant's reactions such as staring and frowning were jotted down (Malley & Hawkins, 2016). In addition, the reflective were also taken to keep track of the researcher's thoughts and feelings that transpired during interviews. The researcher jotted notes during and immediately after data collection sections were completed. In addition, theoretical notes were made with the intention to make sense and find meaning of what was being discussed and observed whilst personal notes were comments on the researcher's feelings and attitude in the field (Polit & Beck, 2008: 406 - 408).

2.4.1.2 Objective two: Step 2

<p>OBJECTIVE 2: TO EXPLORE AND DESCRIBE STUDENTS' OPINIONS OF TEACHING-LEARNING OF SPIRITUAL CARE IN THE UNDERGRADUATE NURSING PROGRAMME AT A HIGHER EDUCATION INSTITUTION IN THE WESTERN CAPE</p>

2.4.1.2.1 Population

The population in step two included nursing students who were registered (N=1009) for the undergraduate programme as regulated by SANC in the R425 at the university where the study

was conducted during the time of the study. The inclusion and exclusion criteria were applied as provided below.

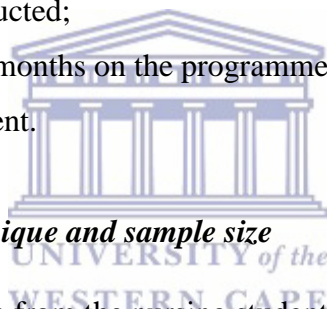
Inclusion criteria:

Participants must:

- (i) be registered at the school of nursing and the university where the study was conducted;
- (ii) be more than six months at the school of nursing;
- (iii) be involved or registered in the R425 Nursing Programme as regulated by the Nursing Act No. 33 of 2005; and lastly,
- (iv) have signed a written consent for participation.

Exclusion criteria:

- (i) not studying under R425 Nursing Programme in the School of Nursing at the university where the study was conducted;
- (ii) not to be less than six (6) months on the programme at the time of data collection;
- (iii) not signed a written consent.



2.4.1.2.2 Sample, sampling technique and sample size

A strata sample (n=90) was drawn from the nursing students as according to the year levels of the programme in which they were enrolled. The sample size was not predetermined; however, it was based on the target population as shown in Table 2.4 below. A total of nine (9) focus groups were anticipated whereby there would be three (3) focus groups each from year levels 1 and 2 and two (2) focus groups each from year levels 3 and 4, potentially resulting in data saturation (Polit & Beck, 2008: 357). Strata were created based on the year levels to ensure representation and all students who met the criteria were invited to participate. A total number of ninety (90) students volunteered as depicted in table 2.4.

Table 2.4 Nursing students sampling

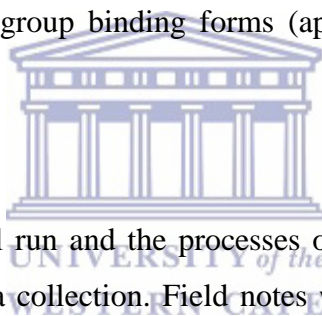
BN Undergraduate Nursing Programme Year Level	Nursing students' ratios	Final sample	Number of FGs	Nursing Disciplines
Year level 1	304	25	3	Fundamentals of Nursing
Year level 2	260	28	3	General Nursing Science and Art

Year level 3	177	27	2	1 Midwifery discipline and 1 Community Health Nursing
Year level 4	245	10	1	Psychiatry and Gender Based Violence
Totals	1009	90	9	

Focus group

2.4.1.2.3 Recruitment Plan

After the permission to conduct the study was received from the University Research Ethics Committee and the Head of School of Nursing, the nursing students were approached from their respective classes. They were informed about the nature of the study and the processes they would be expected to comply with should they be involved in the study. A participation schedule (appendix 7) was provided for students to submit their names if they were willing to participate in the study. Documentation such as information sheet (appendix 3), informed consent (appendix 4) and focus group binding forms (appendix no.5) were signed by the nursing students.



2.4.1.2.4 Data Collection

This section will discuss the trial run and the processes on data collection followed by the description of the process of data collection. Field notes were similar to those in Step 1 as discussed above.

Trial run of data collection

A trial run is a small scale version of data collection process which is done in preparation of the major study (Polit & Beck, 8008: 761). Before the main data collection process commenced, a trial run was conducted which was not only aimed at testing soundness and clarity of questions; but it was also to ensure that appropriate information was collected which consequently promoted credibility of the findings. Furthermore, the testing of the interview process was necessary to identify required changes that would bring more clarity on how the grand tour (i.e. open-ended) question would gather the required information that would ensure that the research question was answered and objectives were met. Answers from the trial interview are not included in the findings of the study.

Focus group interviews:

Focus group interview refers to a purposive discussion by a group of people who are purposively selected to engage discussion on a specific topic based on their common understanding and interest on the subject matter (De Vos *et al.*, 2001). Krueger and Casey, (2009) define focus group interviews as “carefully planned series of discussions designed to obtain perceptions on a defined area of interest in a permissive, nonthreatening environment”. Focus groups interviews were audio recorded (Polit & Beck 2008:386). The focus group interviews were aimed at allowing the participants to explore their experiences with regard to teaching-learning of spiritual care in the undergraduate nursing programme while the researcher gathered information (Krueger, 2002: 7; Litoselitti, 2003; Polit & Beck, 2008). The choice to use focused group discussions was based on its capability to collect complex data from fewer individuals within a short span of time (Kroll, Barbour & Harris, 2007). Focus groups were heterogenic comprising of seven (7) to ten (10) individuals per group. They lasted between 45 to 60 minutes (Krueger, 2002; Litoselitti, 2003).

The focus group interviews were conducted by the researcher who initiated the discussion by posing the following open-ended question “*What is your opinion about teaching-learning of spiritual care in the undergraduate nursing programme?*” These interviews allowed nursing students to share their experiences especially from their social interactions. They expressed, talked and verbalized their opinions within a safe and non-threatening environment (Krueger, 2002). Probing through cues and prompts was used to delve deeper where participants were shallow or not clear.

The researcher managed the discussion time by moderating the interviews discussion process whereby all the participants were appropriately involved in the discussion which resulted in a vibrant and interesting discussion. In depth discussions provide unique interaction among participants which also provided support to each participant. The focus group interviews did not only allow the researcher to appreciate the participants’ perceptions with regard to how they saw their own reality; there was also a friendly atmosphere and supportive atmosphere provided through collective power of collective conversation (Kamberelis, & Dimitriadis, 2013). Interviews were closed and or terminated smoothly.

2.4.1.2.5 Data analysis for objective 1 and 2

Data analysis is defined as the process of examining and evaluating empirical data using analytical and logic reasoning (Polit & Beck, 2008). It also refers to the systematic organisation and synthesis of research data (Polit & Beck, 2008: 751). Qualitative data analysis can follow an inductive analytical process that focuses on the interpreting, explaining or describing of textual data rather than numbers. Data analysis for both nurse educators and clinical supervisors was conducted similarly. The process of extraction of spiritual elements from empirical data was actualised by identification relevant and related concepts using Tesch's (1992) thematic data analysis process. The purpose was to determine the meaning of a particular element as identified.


The process of managing data included transcription of the interviews, and numbering of typed pages of the transcripts. Transcription of data was conducted by a professional transcriber (Burns & Grove 2009). Data were cleaned and transcripts arranged according to data sources or the groupings of participants, which in this study included the nurse educators, clinical supervisors and students and documents. The interviews were transcribed verbatim. Each page was identified with markers such as the participants' pseudo name, date, time, and venue of the interview. Transcripts were checked and moderated by the researcher after repeatedly listening to the tapes. This was to ensure that transcribed information reflected what was shared during the interview. Spelling errors and information resulting from language barriers were validated and corrected.

The data that were collected in all the three (3) steps of phase one (1) were analysed using Tesch's (1992) data analysis strategy. This data analysis method required the researcher to restrain preconceived ideas through bracketing and reflexivity to prevent potential biases towards the researcher which might influence interpretation of data (Brink, *et al.*, 2012). The eight steps of qualitative data analysis were used not only to organise qualitative collected data but also to guide the analysis process (Tesch, 1992: 142-145). The researcher read carefully through all the transcripts to get a sense of the whole. Each transcript was looked into to figure out what it was about based on identified topics. These topics were then written on the right (R) side margin of the transcript. Each identified topic was placed in a sheet under a designated column per data source. The topics were compared across the columns for similarities and differences. Topics were coded with abbreviated names of the data source and a number as topic codes. The researcher went back to the transcripts and wrote these codes next to the

appropriate segments of the text. New categories and codes emerging at this stage were considered and written down on analytic memos. All topics were descriptively labelled and categorised. Topics were further reduced by grouping related topics into new categories and subcategories which were recoded with some codes falling into more than one category. A structure of categories was devised where data belonging to same category were put together. After which the researcher examined one category at a time focusing on the content of each category. At this point, the research question was closely reflected and where necessary, the existing data was recoded and irrelevant data discarded.

This data analysis process was applied to analysis of phase one (1) step one (1) to three (3) of the research process. However, in step 2 in particular, data were analysed separately according to the year levels (Malley & Hawkins, 2016). Whereby, the information, opinions and experiences expressed by the nursing students were treated as one voice for the purpose of interpretation of empirical data.

2.4.1.3 Objective three: step 3



OBJECTIVE 3: TO CONDUCT A DESCRIPTIVE CONTENT ANALYSIS TO DETERMINE WHAT SPIRITUAL CARE ELEMENTS ARE EMBEDDED IN THE UNDERGRADUATE NURSING CURRICULUM FOR NURSES AT A HIGHER EDUCATION INSTITUTION IN THE WESTERN CAPE

In this section, the research methods that were used to review the academic records are discussed under the following sub-heading: population, selection, criteria, sampling, sample and sample size, inclusion and exclusion, data collection and data analysis.

2.4.1.3.1 Population

The population in this section included the academic record such as; curriculum, module guides and assessments papers. The total available documents for review were one hundred and twenty-nine (N=129) which was comprised of: (i) one curriculum document (N=1) for undergraduate nursing Programme 8311 as provided under the SANC regulation R425 as gazetted (ii) thirty-two (N=32) nursing module guides and descriptors from all the year levels and (iii) ninety-six (N=96) formative and summative assessments papers.

2.4.1.3.2 Sample, sampling technique and sample size

Purposive sampling technique was used to select the sample (Polit & Beck, 2008: 363). The final sample for step 3 which was selected from the total population was (n=73) (Polit & Beck, 2008: 765). The sample breakdown comprised of curriculum (n=1), nursing module guides (n=18) and assessments papers (n=54) from year levels one (1) to four (4) from all the nursing disciplines as well as the interdisciplinary modules. The documents were sampled to increase representativeness of the sample across various nursing disciplines and subjects. Table 2.5 below depicts the sampling frame that was used to sample the documents.

Table 2.5 Documents sampling frame

Type or category	No. of Total docs	No. of sampled docs	Description of documents
Curriculum document	1	1	R 425 curriculum for B NURSE programme
Module guides	32	18	Module guides for the BNURSE programme for both semester one (1) and two (2) across four year levels. This includes interdisciplinary modules.
Assessment documents (test assignments and final exams)	96	54	At least two (2) formative and one (1) summative assessments are conducted each year.
	129	73	

2.4.1.3.3 Inclusion and exclusion criteria

Inclusion criteria:

Must:

- (i) be active nursing modules as depicted in the university calendar of the year the data collection was conducted;
- (ii) be part of the teaching-learning contents from the undergraduate nursing programme 8311,

(iii) be prescribed documents for the undergraduate nursing programme 8311 and used by nurse educators and clinical supervisors for teaching-learning purposes,

(iv) be interdisciplinary modules undertaken as part of the undergraduate nursing programme 8311.

Exclusion criteria:

- (i) Alternative nursing modules which were offered for alternate groups within a semester as they contained synonymous contents.
- (ii) Non-nursing modules even though they were part of the undergraduate nursing programme 8311.
- (iii) Assessment papers for re-evaluation, supplementary and special or senate discretion assessment exams.

Alternative nursing modules which were mainly in the third year level were excluded on the basis of clash group's status. Clash groups are groups of students in the same year level who alternate similar modules within the same academic term. These groups would alternate class attendance and clinical placements; however, they write the same assessments at the same time with exam papers demarcated with different codes. The clash groups affected the Midwifery and Community Health Nursing Science modules in the third year level of the undergraduate nursing programme. These were excluded on the basis that they contained similar contents with the alternate group.

2.4.1.3.4 Description of selected documents as data sources

These documents were accessed through the year level co-ordinators after a written permission from the University Research Ethics Committee, the Registrar and the Head of the School of Nursing were obtained. Each document is briefly described below in the sequence through which they were analysed.

▪ **Curriculum**

The curriculum was regarded as a main document because it contained the programme outcomes from which all the teaching-learning activities were founded. The curriculum document was conceived as an official document because it contained the signatures of the Head of School and the representative member of the South African Nursing Council; which is the standard generating body for nursing in South Africa. The significance of the signatures

indicates the legal process that was followed by the school to offer the undergraduate nursing programme.

- **Module guides**

The nursing modules are designed and developed by Nurse Educators (NEs) in collaboration with Clinical Supervisors (CSs). At the end of each semester, the two groups come together to reflect, give feedback and share on how the modules were delivered in relation to how students experienced the modules as reflected on module evaluations by the students. During these short term reflections and module inspections, only minimal restricted changes can be made where consensus is obtained within respective year level teaching teams. The suggested changes are presented to the head of the undergraduate programme for approval and noting. After which the changes are presented to the school's management committee for final approval. The changes are only implemented in the following academic semester or year only after they are approved by the school's management committee.

- **Assessments**

Formative and summative assessments were considered for review. Assessments are often intended to test the student's knowledge on the prescribed learning content. Assessments including tests, assignments, group projects and clinical skills were variably conducted based on the individual module descriptor for a particular year level in the undergraduate nursing programme. Based on the number of credits which varied between fifteen (15) and twenty (20) per module, a minimum of two (2) formative assessments and one (1) final assessment per module was a norm.

2.4.1.3.5 Data collection

The academic documents were reviewed to collect information that would provide evidence or existence or non-existence of spiritual elements in the R425 programme. The data extraction checklist (appendix 21) was used to aid the process of data extraction. The data extraction was based on identification of "*spiritual*" and or "*spiritual care*" elements embedded in the curriculum for the undergraduate nursing programme.

- **Need for data extraction tool**

Empirical studies use rigorous structured methods and procedures to collect data. Therefore, the purpose for using the tool was to ensure the credibility of the study findings. Polit and Beck (2008: 66 & 751) refer to such tools as an intervention protocol through which the researcher

uses as a guide to collect data in a standardised fashion. Therefore, the use of the data-extraction checklist in this study was intended to prevent potential procedural haphazard actions which may affect or jeopardise the credibility of the findings. Literally, the process of data extraction from the academic records required a checklist; hence the researcher developed the “*data-extraction checklist*” also referred to as “*data-extraction tool*”. The data extraction checklist or data extraction tool will be briefly described below to provide some insight as to how it was constructed to aid the process of extracting the “*spiritual*” or “*spiritual care*” elements from the empirical data.

- **Composition of data-extraction checklist**

The data extraction checklist was adapted from the Experiential Theory of Spiritual Care in Nursing Practice (Burkhart & Hogan, 2008). The constituents of the checklist are discussed to show how it was crafted to extract the spiritual elements in the documents. Notably, the Experiential Theory of Spiritual Care in Nursing Practice was not only empirically generated; but it was generated through a grounded theory within the nursing context (Burkhart & Hogan, 2008). This depicts relevance to the current study in the sense that both the nursing context and theory generation process are applicable. The taxonomy or domains of the Experiential Theory of Spiritual Care in Nursing Practice were reinforced by the use of criteria items describing elements and or components of spirituality to enhance extraction of the spiritual elements. The seven domains of the taxonomy of the Experiential Theory are comparable to the seven categories of the checklist as they were named after the Experiential Theory of Spiritual Care taxonomy domains. They were placed in the first column of the data-extraction checklist as the basis on which the criteria items or components of spirituality were founded (Burkhart & Hogan, 2008: 928). The seven experiential domains were used to provide grounding and support element identification process whilst the criteria items guided actual data extraction. The second column of the data-extraction checklist comprised twenty-five (25) criteria items that describe spiritual occurrences or events. These criteria are extracts from different spiritual connotations from authors including Larson, Larson and Koenig (2001) and La Pierre (1994). The checklist criteria items were aligned with the Experiential Theory of Spirituality in Nursing Practice of Burkhart and Hogan (2008) accordingly. This alignment was not only to guide the data extraction process; but also to maintain the understanding and meaning of extracted spiritual elements.

All twenty-five (25) criteria-items do not explicitly signify any specific spiritual phenomenon; however, they provide broad predictions of connotative and denotative meanings of spirituality and spiritual care. The use of these “*criteria items*” was motivated by the all-inclusive Burkhardt’s (1989) “spirituality”. Burkhardt’s spirituality is comprehensive to “*humanity needs*” or “*spiritual needs*” outside the confinement of religion or denominational-based practice. Therefore, Burkhardt’s (1989) spirituality was presumed as best to represent all human spiritualities. In addition to Burkhardt’s (1989) theory of spirituality other spiritualities such as Larson’s (1994) and La Pierre’s (1994) were considered when compiling the checklist criteria items. The purpose of using the various theories was to ensure a wide coverage of spirituality and relevance to most people to whom the theory will be used. By so doing the diverse social-cultural spiritualities would be catered for which is appropriate to serve the multi-rainbow South African nation.

- **Preparation for data extraction process**

Hard copies and electronic versions of the review documents were accessible, however the electronic copies were mostly preferred as they were easy to handle. The data extraction process was therefore conducted mainly from electronic versions of the academic records. A copy of a data-extraction checklist was prepared for each academic document reviewed. The data-extraction checklist is provided as appendix 21.

- **Data extraction process**

The data-extraction criteria items were practical in the extraction of the teaching-learning experiences and understanding of how the participants engaged with the spiritual phenomenon. The review of documents commenced by analysing the curriculum followed by modules guides and lastly assessments. This sequencing of documents was vitally important to keep track of how the spiritual elements unfolded from the curriculum programme outcomes through associated assessment criteria and assessment criteria respectively. The data extraction checklist was used to plot the spiritual elements as they were identified from the documents. Thus, the use of data extraction checklist ensured clarity of the structure and process through which the document review was conducted. The review process was conducted through searching for spiritual elements including words, terms or sentences as depicted in the document. These elements were first extracted from the academic records and temporarily copied and pasted on a blank A4 page. In cases where the elements were found lying in between

sentences or paragraphs which in essence did not relate to spirituality, such elements were “italicised” for easy identification.

The seven categories of the Experiential Theory of Spiritual Care in nursing practice of Burkhardt and Hogan (2008) were used to provide the basis on which extracted elements were could be framed. The checklist categories which are based on Burkhardt’s and Hogan (2008) theory include the following seven domains; (i) cue from patient, (ii) decision to engage or not to engage in spiritual encounter, (iii) spiritual care interventions, (iv) immediate emotional response, (v) searching for meaning, (vi) formation of spiritual memory and lastly, (vii) nurse-spiritual well-being were used to guide the data analysis process. The electronic documents were uploaded on an Atlas Ti7 computerized data analysis tool which allowed the researcher to identify families of data while creating memos and codes. This activity was useful not only in managing data but more importantly in reducing the bulk of data from the academic documents. The materialization of the process is presented in Chapter five (5).

2.4.2 Phase 2: Practice theory generation

Phase 2 of the theory-generative process was conducted through the three (3) steps namely: (i) development of the conceptual framework, (ii) theory generation and description (iii) theory evaluation and refinement. These steps were undertaken to generate a practice theory for teaching-learning of spiritual care in the undergraduate nursing programme. The step on conceptual framework was used to respond to objective four (4). The step on theory generation and description, evaluation and refinement was used to respond to research objective five (5). Each of the steps that was used to achieve the study objectives four (4) and five (5) are discussed below to show how these were applied to generate the practice theory for teaching learning of spiritual care in the undergraduate nursing programme at a university in the Western Cape. The processes of phase two (2) are narrated below to show how each step happened.

2.4.2.1 Objective 4: Step 1

<p>OBJECTIVE 4: TO DEVELOP AND DESCRIBE A CONCEPTUAL FRAMEWORK FOR TEACHING-LEARNING OF SPIRITUAL CARE IN THE UNDERGRADUATE NURSING PROGRAMME AT A HIGHER EDUCATION INSTITUTION IN THE WESTERN CAPE.</p>

The process of developing the Conceptual Framework marked the beginning of phase 2 of the theory generation process (Chinn & Kramer, 2011). The process towards the development of a Conceptual Framework is addressed below to show how the development of the conceptual development occurred. The Conceptual Framework was developed through the following processes (i) Concept Identification, (ii) Concepts Classification and (iii) Concepts Description which all formed steps 1(a), 1 (b) and 1(c) of phase two (2) respectively.

2.4.2.1.1 Concept identification

Concept identification is the process of choosing concepts on which the generated theory was founded. In this study, the concepts were identified from the empirical data that were collected and analysed in phase one (1) of the research process. Conclusion statements (Table 6.1) that had emerged from steps 1 to 3 of phase 1 were systematically reviewed and re-arranged to arrive at the meaning and relevance to the practice theory that was being generated to ensure rigour (Walker & Avant, 2010). The concepts were **inductively identified** from the conclusion statements and core and related concepts identified from the empirical data were used to develop the conceptual framework.

Concept identification procedure was achieved by the use of analysed empirical data that were retrieved from phase 1 steps 1 to 3 of the objectives 1, 2 and 3 to inform the conceptual framework. Data were analysed through **deducted-inductive reasoning approach** (Tesch, 1990). Core and related statements that were derived from the empirical data from all data sources in phase 1 steps 1 to 3; that is from the interviews and document review, were synthesized into statements through **deductive-inductive reasoning**. After which a tentative list of concepts was generated which then was followed by searching for key concepts. Key concepts were identified according to their denotative and connotative meanings which supported categorisation of concepts as shown in last column in Table 6.1. Jabareen's (2009) probability and classical view were instrumental in actualizing this concepts identification process. Concepts that had been derived in phase 1 steps 1 to 3 were placed in their relationships. The process of concept identification involved (i) selection of concepts; (ii) developing relational statements and (iii) placing statements in their hierarchical order. The concepts were then mapped to depict their strength and nature of emerging conceptual framework.

Conclusion statements were subjected to further **deductive-inductive analysis** with an aim to identify main concepts on which the conceptual framework was founded. The process of sorting concepts, generating a list of concepts from which the key concepts were identified using connotative and denotative meanings is described in detail in Chapter six (6). Concepts were therefore, selected based on their relatedness, meaning and relevance to emerging theory rather than just being handpicked. Rigour was maintained through synthesis and reasoning strategies as described by Guba (1885) and Guba (2001). These strategies were applied as measures to ensure trustworthiness for the study. They include the following criteria: credibility, dependability, transferability and conformability. These criteria and their strategies were discussed in depth in Chapter two (2) Table 2.6. The purpose and criteria for their use in the study were also provided.

2.4.2.1.2 Concept classification

Concept classification was step 1(b) which followed concept identification as a process to develop the conceptual framework. Concepts that were identified in phase 2 step 1(a) were now used as population in the process of classification of concepts. Identified concepts were thought to be relevant to inform the conceptual framework and model because they were empirically derived. **Deductive-inductive reasoning** and literature control processes were used to validate the strength of these concepts as they constituted the generated theory. Concepts identified in phase 2 step 1(a) were purposively selected to constitute the sample for concepts classification process. Dickoff *et al.*, (1968) survey list was technically employed to categorize the selected concepts. The process of classification of the concepts is described in detail in Chapter six (6) under section 6.4 and was depicted in figure 6.1. Data collection was achieved through synthesis of identified concepts and statements from the conceptual framework. The analysis process was achieved by placing and arranging the concepts from phase 2 step 1(a), into their relationships. After which they were classified using Dickoff, James and Wiedenbach (1968) survey list. The survey list used, portrait how the concepts were classified also promoted an understanding of intended use of each concept in the generated theory. Classification of concepts also enhanced effective communication (Melodie, 2011) based on the functionality of each concept as classified. The literature control was used to affirm credibility of the resulting concepts. This process was also to contextualize the generated theory which was achieved by conceptualisation and creation of meaning and structure of the concepts (Chinn & Kramer, 2011).

2.4.2.1.3 Concept description

Concept description was undertaken as step 1(c) of the conceptual development process. After concepts were classified (Dickoff *et al.*, 1968) they were described using literature. The use of literature was to affirm the empirical stance of the concepts and compare them with the existing knowledge that is already known about the phenomenon of spiritual care. Furthermore, it was to ensure rigour. Concepts that had been identified and classified were described using multiple electronic databases and hard copy searches of national and international sources, including dictionaries, books, journals and other literatures (Walker & Avant, 2010). Conclusions on main and related concepts were made followed by an integrated discussion using literature and synthesis and reasoning strategies. This was undertaken to support arguments claimed on relational statements of the emergent practice theory for teaching-learning of spirituality in nursing. This process is described in detail in Chapter 6.

2.4.2.2 Objective 5:

OBJECTIVE 5:
TO DEVELOP A PRACTICE THEORY FOR TEACHING-LEARNING OF
SPIRITUAL CARE IN THE UNDERGRADUATE NURSING PROGRAMME AT A
HIGHER EDUCATION INSTITUTION IN THE WESTERN CAPE

Two steps were undertaken under objective 5 accounting to steps 2 and 3 of the theory generation process.

Step 2: Theory generation

In this stage, the core and related concepts which were used in conceptual development were considered as the basis on which the theory was generated. In addition, the theory was described in relation to constituents or elements which constituted the model as a whole. Theory was then described through application of structure and process description which was followed by generation of conclusions, deductions and recommendation as deemed fit. A detailed description of this step is discussed in Chapter seven (7).

The conceptual framework which was determined in phase two (2) through step one (1) to three (3) was considered as a sample in step two (2). Concepts identified, classified and described in phase 1 steps 1 (a) to (c) were now arranged into their relationships in step 2 of phase 2. The researcher purposefully selected core and related concepts which were then driven by a process

of synthesis and reasoning strategies in crafting them into a conceptual model. These statements were further synthesized to form coherent, related statements with meanings through use of literature, dictionary and thesaurus. Thus, theory generation was enhanced through use of synthesised statements derived from inferred core and relational statements. This treatment was aimed to establish how the phenomena of spiritual care was perceived and understood by the participants and how it was validated through literature.

Analysis of concepts identified in phase one (1) steps one (1) to three (3) were described in relation to each other within the framework. The model was described using various elements that constituted the model as a whole. This was achieved through application of the following questions to enhance the process of theory generation. (i) what the purpose of the model was? (ii) what were the emerging concepts that informed the model (iii) what was the nature and the structure of the emerging model and lastly, (iv) how were the concepts defined? The relationships were determined by making prescriptive, descriptive and explanatory nature of the associations of emerging theory (Walker & Avant, 2005). A survey list of Dickoff et al., (1968) technically enhanced the functionality of the theory by providing a distinct role to each aspect of the practice theory. The emerging theory did not only depict the relation between the agent and recipient but it further indicated the context and the dynamics under which they engage to achieve the goal; as well as the how teaching-learning procedure should be conducted. By determining the nature of the relationships, it was aimed at enhancing the generation of knowledge from concepts. A literature review was conducted as a control measure during the data analysis process. Concepts from phase 1 step one (1) to three (3) were considered as a sample for this step. In this process, rigour was maintained by the application of synthesis and reasoning strategies through which measures for trustworthiness as advocated, by Guba and Lincoln (2001), were employed. Strategies such as credibility, dependability, transferability and confirmability and survey list were useful in this process.

Step 3: Theory evaluation and refinement

This step was on theory evaluation and refinement of model constituents. The generated theory and formed model were used as the population in this step. Hence, the constituents of the developed model and its description were utilised not only to evaluate generated theory; but also to ascertain the strength of the generated theory. The sampling technique was carried out through the use of different criteria as set out by Chinn and Kramer (2011) and Fawcett (2005). The developed model was purposefully selected as a sample in this step. The developed model

was also used as data for evaluation and refinement. Data analysis strategies including various criteria and critical reflection on the model were aimed at ensuring credibility of the generated practice theory for teaching-learning of spiritual care in the undergraduate nursing programme. The criteria for theory evaluation were necessary to affirm the ultimate use of the generated theory and credibility of its structure.

A critical reflection on generated theory was therefore a vital step for the researcher to ensure that the generated theory was acceptable. Evaluation and refinement of the theory was done not only to compare its content with certain criteria, but it was also to ensure credibility of emerged practice theory. This was necessary to determine the theory's appropriateness and fitness for use (Fawcett, 2005: 53). The process of theory evaluation and refinement involved different strategies and criteria (Chinn and Kramer, 2011; Fawcett, 2005). These criteria are described in detail in Chapter seven (7), hence only referenced in this section. Each author's criteria and questions provoked the researcher's critical reflection on the emerged theory. The process of evaluation was conducted to establish the credibility of the research findings. The researcher sought evidence and feedback through literature control and member checking (Burns & Grove 2009). The process of theory evaluation is described in Chapter seven (7).

Rigour was maintained through evaluation of integrated knowledge using rigorous structure of tentative purposeful and systematic review of the phenomenon of spiritual care as conducted. The process to evaluate the theory was ensured through application of measures for trustworthiness; use of Chinn and Kramer (2011) criteria for evaluating theory as well as use of Fawcett (2005) theory critique approach. These criteria strategies were used together because they complemented each other which was perceived as good for the study credence. The developed model was scrutinized for alignment and congruency with emerging theory.

2.5 BASIS FOR DATA ANALYSIS PROCESS

The dimension of science philosophy specifically relates to qualitative research in crafting constructivism within naturalistic methodologies in nursing inquiry (Cutcliffe & McKenna (2002: 611). According to these authors, a question of when a person knows that he/she knows, is critical in qualitative research. This question suggests that qualitative researchers should use the process of scientific inquiry in an enabling manner to provide a fully comprehensive report on research design and research methods as an encounter in the early phases of the research journey. The process of qualitative inquiry that culminated in a

practice model for teaching-learning of spiritual care in the undergraduate nursing programme in the institution of higher learning was employed. This process required dexterity and congruence in the use of combinations of these skills when executing research activities and strategies. The process included the use of unique methodological practices, empirical materials, perspectives and observational field notes. Including measures such as bracketing that were applied to maintain rigour. The use of the participant's own words extending the credibility of the process allowed the analysis process to construct the report on the understanding of the nurse educators' and clinical supervisors' conceptualisation of spiritual care in the undergraduate nursing programme; opinions and experiences of nursing students regarding teaching-learning of spiritual care in the undergraduate nursing programme as well identification of elements of spiritual care embedded in the undergraduate nursing curriculum through the exploration of the academic documents. The reasoning strategies that are the foundations to the study inquiry were applied as measures to maintain rigour and combat possible biasness. Deductive process of reasoning may progress from one or more general statements regarding what is known in order to reach logical conclusion or conclusions about a certain phenomenon. Both deductive and inductive logic reasoning processes were used in this study, whereby the conclusion statements from diverse data sources were deductively and logically used to inform the developed model. Subsequent to deductive logic reasoning the constructs of the phenomenon under enquiry were further evaluated through theory evaluation process as a measure to validate general propositions of the developed theory and subsequently assisted in describing the generated theory.

The process of paradigm scientific criteria which was supplemented with practical strategies to maintain rigour, is discussed below under the following heading: value-based claim, knowledge-based claims, sociological, methodological, ethical and teleological.

2.5.1 Value-Based Claim

The value-based claims were regarded as specific aspects of the reality through which the participants were to respond to the question "what is this?" The process was accomplished by exploratory and contextual research approaches on understanding the conception of spiritual care by the nurse educators', clinical supervisors' and nursing students' perceptions and experiences of teaching-learning of spiritual care in the undergraduate nursing programme at a higher education institution in the Western Cape, South Africa.

2.5.2 Knowledge-Based Claims

Knowledge-Based Claims were a quest for truth that provided valid and reliable judgements and answers regarding what could be learnt. The knowledge-based claim was addressed by the researcher's reflexivity related to prolong exposure and relationship to the setting as accounted for. The process of concept identification and concept classification informed the conceptual framework, and the description on teaching-learning of spiritual care in the undergraduate nursing programme at a higher education institution in the Western Cape was context-based.

2.5.3 Sociological

The sociological aspect involved collaborative activity to reflect on the nature of the discipline and to consider impact by society on scientific activity. This was directed at finding answers of who is involved? And who is influenced? The developed relational statements that portray links between concepts were provided. Interactions between the goal content and the activity on integration of spiritual care in the undergraduate nursing curriculum, as an end product of the study, was demonstrated in theory generation and description. The nurse educator and or clinical supervisor who are the agents, the nursing students who is the recipient; the spiritual care subject contents, teaching methods and techniques for spiritual care; dynamic active commitment from all parties respectively were all explained as to how they interact within the generated theory. All the research participants fulfilled the requirements for inclusion criteria and were purposively sampled and included in the study

2.5.4 Methodological

The planning, structure and implementation of procedures and processes as well as methods to answer the question how to conduct the study were addressed through scientific methods of data collection and model development. Data collection methods that were used included in-depth interviews, focus group discussions, and document review. Frameworks and model development processes that utilised empirical data derived from the participants were used.

2.5.5 Ethical

Concerns around morality, reasoning and human involvement and purpose to answers who and why of participation were addressed by attaining consent and permission for site research, ethical clearance certificate from the university to conduct the study as well as attaining informed consent from the research participants, as well as by attaining institutional consent for dissemination and publication of the study findings.

2.5.6 Teleological

Awareness and focus on intentions and outcomes that are goal-directed meant that the overall purpose of the study was upheld as criteria-driven. The critique of the practice theory developed in this study were undertaken to maintain research ethical requirement. Operationalisation guidelines for implementation of the developed model for teaching-learning of spiritual care in the undergraduate nursing programme at an institution of higher education in the Western Cape were thought of, however these will be further developed as a postdoctoral project.

2.6 REASONING STRATEGIES

Induction and deduction logic reasoning strategies were applied in accordance with Walker and Avant's theory on development and construction sculpture (Walker & Avant, 2011: 66). According to these authors, there is no single reasoning strategy that surpasses the other but every strategy is useful not only for the manner in which theory is developed in practice and purpose for use; but also by taking into consideration the way through which an iterative process between deductive and inductive reasoning strategies is appreciated as a creative process when generating theory (Walker & Avant, 2011: 67). Chinn and Kramer (2011) concur with Walker and Avant's (2011) view by acknowledging that "deductive" and "induction" strategies are forms of logic reasoning that portray an understanding of relational statements between concepts as they are formulated. Many authors regard deductive logic as reasoning from the general to the specific, whereby the starting point embodies two or more concepts that are categorised in relation to one another in broad terms or descriptions with a conclusion that contains specific concepts or data on the relationship (Rossouw, 2003: 39; Schwandt, 2007: 147; & Chinn & Kramer, 2011). In generating deductive arguments one begins with a general or universal statement and moves through inference by stating a specific case of the argument with a statement in the conclusion that contains specific data.

The strength and weakness of conclusion statements from an inductive process may vary in support of empirical data which influences the strength and weakness of developed theory. Schwandt (2007: 147) and Chinn and Kramer (2011) are congruent that deductive logic and inductive logic are useful in the qualitative research process of inquiry. In this study, deductive logic was used extensively, particularly with the conclusion statements derived from results in making convincing arguments as shown in Table 6.1 in Chapter six (6). Empirical data that was generated from the in-depth interviews, focus groups discussions and document review was used to develop the conceptual framework on which the practice theory is founded.

“Inductive” logic was used in this study in the process of model development and description. The essence of reasoning strategies whether deductive or inductive logic, were useful in approaching activities of qualitative research inquiry in a systematic and consistent manner. These two (2) reasoning strategies were also applied at other levels of the research process such as analysis of empirical data in the development of conceptual framework in a manner that allowed the researcher to generate plausible relational statements and showed linkages in the data at different phases of the research process to arrive at the conclusive statements that embrace the empirical reality.

2.7 TRUSTWORTHINESS

Krefting (1991: 215) defines the trustworthiness as a means to establish quality and soundness of qualitative research. Table 2.6 below indicates how trustworthiness was maintained in this study in accordance with a full discussion in Chapter One (1).

Table 2.6 Criteria and strategies for trustworthiness

Criteria	Strategy	Measure for trustworthiness in the study
Credibility (truth value)	Trial run of data collection	Trial run of data collection was undertaken with the nursing students’ category of participants as a measure to ensure that the grand tour interview question was <i>clear</i> and <i>understandable</i> by the participants.
	Reflexivity	<i>Field notes</i> from data collection sessions and <i>methodological notes</i> from qualitative inductive and deducting reasoning and outcomes of reflective sessions were used as insights to inform model development. <i>Bracketing technique</i> was used to enhance reflection as a researcher worked with the empirical data. <i>Memoing</i> was used through AtlasTi7 computer programme which was accessible to the researcher for cross referencing while engaging with empirical data and analysis process. <i>Feedback from the supervisors</i> assisted the researcher to assume more critical and effective ways to present the findings. This strategy was more useful in Chapter five (5) in presenting the results of document review. <i>Rigour</i>

		was maintained by use of protocol to guide the review process as well as by application of measures to ensure trustworthiness.
	Prolonged engagement	The researcher, by being part of the institutional establishment, had prior first-hand experience of the setting, context and institutional procedures. But also had an opportunity to be immersed in the research setting whilst exposed to participants throughout the research process especially data collection process. This promoted sound relationship with the participants.
	Member checking	Emerging themes depicting the experiences of participants were checked with participants in <i>member checking</i> sessions. This process was a measure to validate the emerged themes for accuracy.
	Structural coherence	Discussions of findings were supported by <i>literature from published sources</i> to control authenticity and evidence in the literature. <i>Implementation of Burkhardt (1989) spirituality assisted to eradicate potential errors</i> associated with adapted checklist which had not been tested prior to its use. Despite the checklist not being tested for suitability and fitness for purpose prior to actual use in the study; the researcher's confidence was based on the structural constituent items which were derived from Burkhardt's (1989) conceptualisation of spiritual theory. This aided to eliminate possible spiritual misinterpretations that could otherwise weakened the trustworthiness of the study.
	Scientific honesty	Audio cassettes were labelled with codes which ensured confidentiality and anonymity of the participants.
Transferability (applicability)	Purposive sample	Purposive sampling was used. The study's sample constituents including nurse educators, clinical supervisors, nursing students and academic documents were purposively sampled from the individuals who were

		involved in the undergraduate nursing programme as regulated by the Government Notice No. R425. Dense description of demographics of the participants was provided as a measure to enhance transferability.
	Defined contextual setting	The <i>research setting</i> was defined as specific in terms geographical, university and school of nursing contexts. Model <i>contextualisation</i> was described at provincial and local levels and institutional context levels with regards to higher education in SA. A <i>reference to international standards</i> was made as a referenced point and bench marking of how SA is performing in terms of moving forward in the practice of nursing.
	Thick description	Participants' reported data was <i>densely described</i> , thus all information from participants were clearly and sufficiently described to give good grasp of the understanding, opinions and experiences of participants in responding to the research question.

<p>Dependability (consistency)</p>	<p>Inquiry / process audit</p>	<p>Substantial evidence is provided through <i>appendices</i> regarding the process of the study from proposal registration to thesis submission for a vivid portrayal of qualitative research. <i>Supervisions</i> assisted with the process of data analysis and provided a specimen to be followed where applicable. <i>Co-checking</i> of emergent themes and eventually findings was done with the supervisor to improve rigour and the coherence structured system of memoing, reporting and integrated discussion to support and refute the study findings. The researcher took time out from her routine academic commitment and activities and was <i>submerged in the process of data analysis</i>. Dense description of research methodology was also provided. The purpose was to ensure continuity of thought processes in the data analysis phase.</p>
	<p>Saturation of data</p>	<p><i>Saturation</i> of data themes and categories denote that no new concepts or dimensions were identified. In essence, saturation indicates that despite the fact that all data were being analysed, there was no emergence of new or unique categories and themes from the excerpts.</p>
<p>Confirmability (neutrality)</p>	<p>Paper trail (reflexivity)</p>	<p>A comprehensive list of <i>appendices</i> that illustrate the activities in the research process, and substantial referencing were provided for all published and unpublished sources and literature that were used in the study. Reflection-on-action and reflection-in-action enhanced the researcher's reflexivity; especially during inductive-deductive reasoning process when the researcher was developing the conceptual framework and creating the model. The researcher also consulted with the supervisors with regard to transpired findings, for affirmation.</p>

(Source: Krefting, 1991)

2.8 CHAPTER SUMMARY

This chapter began by providing the justification for the research design. An outline on how the theory-generation methodology was applied in conducting the research process was provided. The components of the design, both the qualitative research and theory-generative processes, were discussed. The research methods were described in connection to their chronological application in the research study and the science philosophy underpinnings were described. Sampling of the research population and data analysis were outlined prior to the ethical aspects that pertain specifically to the research methods. Detailed application and materialisation of the research methods used, the analysis of collected data, empirical data and literature control as well as the results from each data source will be provided in each the following chapters; three (3), four (4) and five (5) respectively.



CHAPTER 3: RESULTS FROM IN-DEPTH INTERVIEWS: NURSE EDUCATORS AND CLINICAL SUPERVISORS

3.1 INTRODUCTION

The chapter presents the findings from analysed empirical data that were collected from Nurse Educators (NEs) and the Clinical Supervisors (CSs). The NEs are teachers who teach the theory component of the nursing subject. The CSs are registered nurses who teach the practical component of the nursing subject. The chapter further presents how the sample, sampling technique, data collection and data analysis processes for each category materialised. For clarity purposes, the findings from the NEs and CSs will be presented separately. The conclusion statements from the NEs and CSs will also be presented as per each data source.

3.2 MATERIALISATION OF DATA COLLECTION

Despite the fact that both NEs and CSs were asked the same question in their interviews, the interview methods were planned differently. In-depth interviews were intended to collect data from the NEs and focus group interviews for CSs. The purpose of distinct methods was not only to triangulate data collection per se; but more importantly focus group interviews were ideal to obtain data from CSs who use a team teaching model to facilitate students' Work Integrated Learning (WIL). Ten (10) NEs out of eighteen (18) and nine (9) CSs out of twenty-five (25) participated in the study. The clinical supervisors work in teams in different nursing disciplines and year levels as shown in Table 2.3. The team teaching model was different from the nurse educators' teaching approach where each NE is assigned to teach specific class within a specific year level of the programme. In this case the NEs teaching style, it was not necessarily challenged with competition because all students were exposed to the same teaching at any given time. Hence individual interviews were considered relevant for NEs. At the time when data collection from CSs commenced, there were three outstanding interviews with NEs which were then completed concurrently with interviews with CSs. In-depth interviews were used with this category as well to collect data through which they responded to the same questions as NEs. Despite some differences of responses from both categories, the findings confirmed similarities in their understanding of the phenomena of interest.

Challenges that were encountered with the planned method of data collection with supervisors and how these were resolved will be briefly presented below. There was a challenge in getting all the CSs together for focus group discussions. Their lack of availability was based on work

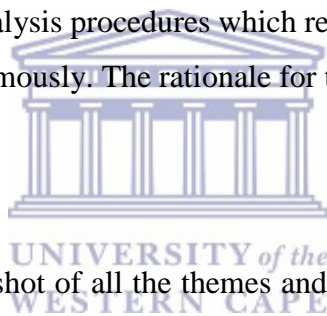
schedule, not only because they were responsible for first and second year nursing students concurrently but also because they were assigned in different clinical sites making their schedule tight. The third year CSs were divided into alternative groups which are called clash groups and this arrangement made it difficult to get them together for data collection. Consequent to this challenge, the CSs could not be interviewed in focused groups as it was initially planned. Thus all CSs were interviewed individually. This meant that the proposed plan to use focus group discussions to collect data from the CSs did not materialise. The change of data collection method from focus group interviews to individual interviews affected the number of participants. Nine (9) CSs were accessible for interviews in contrast to twenty-five (25) who would have participated in four focus groups, one per year level.

Nurse Educators (NEs) and Clinical Supervisors (CSs) were recruited through a phone call, email or informed by the researcher face-to-face to participate in the study. After participants had responded to the researcher's request, interviews were scheduled and conducted accordingly. Participants were given privileges to choose the venue in which they would want to be interviewed, as well as an option to be interviewed by a neutral researcher should they feel uncomfortable to be interviewed by the researcher who is also a colleague. Participants had to make the request ahead of time so that the neutral interviewer could be booked for the day. All participants were interviewed by the researcher as they were comfortable with that arrangement, so the neutral interviewer was not utilised in any of the data collection sessions in accordance with the contingency plan.

In-depth interviews (Kvale, 1996, also see Kvale & Brinkman, 2009) were held with individual nurse educators and clinical supervisors. All interviews were conducted in private venues as preferred by participants to ensure anonymity. In addition, they were tape recorded. Most interviews lasted for about one (1) hour with one longest interview which took one (1) hour and fifty (50) minutes. Before the recorder was switched on, participants were given an opportunity to ask any questions for clarity. This was also to make them feel comfortable and at ease during the interview. No problems were encountered from the researcher's and participants' side. The interviews were conducted according to data collection plan and process as presented in Chapter two (2). Whilst conducting individual interviews, the researcher observed non-verbal cues and gestures from the participants which the researcher documented during and immediately after interviews were conducted.

3.3 DATA ANALYSIS

The traditional steps of qualitative data analysis as discussed in Chapter 2 under section 2.4.1.2.5 were employed. Thick description of participants' expressed views will be provided in the following sections where applicable with direct quotations and para-phrasing to ensure clarity. Each theme and sub-themes were then presented in a table. Presenting the results using the tables is intended to frame the idea under discussion. After-which, a full description of the participants' responses was provided using themes and sub-themes and supplemented with excerpts and quotations. An integrated discussion was provided after which conclusive statements derived from the findings and integrated discussions were also presented. Lastly, a summary to recapitulate on what was discussed in the chapter will be presented. Despite the fact that the Nurse Educators (NEs) and the Clinical Supervisors (CSs) were asked the same interview question, the findings from each category are treated separately but both are presented in this chapter. This distinction in data analysis is intended to cater for the credibility of the empirical processes and analysis procedures which require that raw data is analysed and interpreted separately and autonomously. The rationale for this separation serves as a measure for rigour.



3.4 RESULTS

Table 3.1 below presents a snap shot of all the themes and subthemes that emerged from the nurse educators and clinical supervisors. These themes and sub-themes are further discussed under each data source category.

Table 3.1 Comprehensive themes for all data sources for objective one

Themes from the Nurse Educators	
Themes	Sub-Themes
3.4.1.1 Defining Spirituality	3.4.1.1.1 Spirituality as connectedness
	3.4.1.1.2 Spirituality as an inherent-virtue in human beings
	3.4.1.1.3 Understanding the concept of spiritual care
	3.4.1.1.4 The caring nature of humans
	3.4.1.1.5 Lack of visibility of spiritual care subject matter
3.4.1.2 Spiritual care as a missing component in the curriculum	3.4.1.2.1 Lack of visibility of spiritual care
	3.4.1.2.2 Teaching-learning of spiritual care
3.4.1.3 Challenges with teaching and learning	3.4.1.3.1 Concerns about myths and conflicting ideas and beliefs
	3.4.1.3.2 Lack of role models
Themes from the clinical supervisors	
3.4.2.1. Defining Spiritual care	3.4.2.1.1 Spirituality as a concept
	3.4.2.1.2 Spirituality as an inherent value in humanity dimension

3.4.2.2 Spiritual care in teaching and learning	3.4.2.2.1 Current status of teaching and learning of spiritual care
	3.4.2.2.2 Constraints in implementation of teaching & learning
	3.4.2.2.3 Awareness, willingness and desire for spiritual care
3.4.2.3 Benefits of spiritual care	3.4.2.3.1 Benefits to the patient
	3.4.2.3.2 Benefits to the nursing students
3.4.2.4 Need for spiritual care	3.4.2.4.1 Essentials of spiritual care
	3.4.2.4.2 Communication
	3.4.2.4.3 Patient's felt needs

3.4.1 Results from the nurse educators

Table 3.2 below presents comprehensive themes and sub-themes from the nurse educators. Thereafter each theme and sub-themes will be presented followed by a narrated description and explanation of the participants' responses. This arrangement provides the reader with a comprehensive understanding on the findings' context from in depth interviews with NEs. The Nurse Educators (NEs) shared their views on what their understanding of spiritual care in nursing is. The responses that were received from the NE category were significantly varied in contrast to clinical supervisors. As it was indicated before, the NE participants' point of departure on their discussion was to first reflect on their own spirituality and what it meant to them prior to seeking its relevance within the context of nursing. Below is a presentation of themes which emerged from individual interviews with the nurse educators. A table below presents comprehensive themes and sub-themes from the NEs.

Table 3.2 Comprehensive themes from the NEs

Themes	Sub-Themes
3.4.1.1 Defining Spirituality	3.4.1.1.1 Spirituality as connectedness
	3.4.1.1.2 Spirituality as an inherent-virtue in human Beings
	3.4.1.1.3 Understanding the concept of spiritual care
	3.4.1.1.4 The caring nature of humans
3.4.1.2 Spiritual care as a missing component in the curriculum	3.4.1.2.1 Lack of visibility of spiritual care
	3.4.1.2.2 Teaching-learning of spiritual care
3.4.1.3 Challenges with teaching and learning	3.4.1.3.1 Concerns about myths and conflicting ideas and beliefs
	3.4.1.3.2 Lack of role models

Theme one on the definition of spirituality is provided below.

3.4.1.1 Theme One: Defining Spirituality

The process of defining spirituality happened as a mental activity through which the participants sharpened their understanding of spiritual care within the nursing context. They defined spirituality as an attachment to something significant; and God which was the most common and familiar form of attachment.

Table 3.3 Theme one: Defining spirituality

Themes	Sub-Themes
3.4.1.1 Defining Spirituality	3.4.1.1.1 Spirituality as connectedness
	3.4.1.1.2 Spirituality as an inherent-virtue in human Beings
	3.4.1.1.3 Understanding the concept of spiritual care
	3.4.1.1.4 The caring nature of humans

The four sub-themes are sequentially provided in context to theme one under which they emanate.

3.4.1.1.1 Sub-Theme 1: Spirituality as connectedness

Spirituality was conceived as referring to being attached to something significant. The most form of attachment presented was attachment to a Higher Being or God through belief. Although other forms of attachment were acknowledged, attachment to God was the most type that NEs could relate to. They informed the researcher that spirituality in essence is about belief and believing which may include believing in other things; if those things are regarded as important or significant to the person. Their understanding of spiritual care depicted a close link to God as an influential source of spirituality in one's belief. "...*Spirituality relates to believing in God or Higher Power...*"; "... *People have relationship with God or the Superior Power or anything that is important to them*". In this view, spirituality was regarded as a denominator or precursor for spiritual care which in most cases coexist. Spirituality was therefore seen as more than just a religion but as something beyond religious limitations. The participants' example of this understanding included the following observation: "*When a person is sick, in my experience, people always cry out to God, it doesn't matter if you are a Christian or a Muslim or a Hindu*". Although the Nurse Educators (NEs) could describe the concept of spirituality in view to spiritual care, they admitted that they did not know how to differentiate spirituality from religion and vice versa. This is what was expressed: "*I may not be familiar with the difference between religion and spiritual care but spirituality is something*

that is in you, it is within you. It's there, in your background, it is in your values when you grow up”

3.4.1.1.2 Sub-Theme Two: Spirituality as an inherent virtue in human beings

Participants presented that spirituality resides in human beings. The NEs viewed spirituality as something that is always within a human and that which can always be tapped into and accessed especially when teaching students on the subject of morality. A reference was made to the Nurse's Oath as a measure that the profession of nursing applies to cultivate a desirable conscience on nurses. Through own spirituality, the nurse can capture the essence of what the Oath requires of them. They said that: *“it is to bind the nurse's conscious with moral obligations of the profession which guides interaction with the patient”*; *“...it [the Oath] binds the nurse to say that regardless of race, colour or culture, they will treat the person [patient] as a human being that as valued by God”*. With the same breath of expression of what their understanding is about spiritual care, they also alerted about a potential threat to a situation where untoward reactions may manifest. This warning was related to issues that may result from the interface of cultural diversities and differences in human beings. Different beliefs and understandings were presented as possible points of contention. For instance, “calming the mind” was explained as not referring to or being same thing as God's peace. *“...So it depends where you [i.e. person] come[s] from, that is your [his/her] background...”*; *“So peace can mean different things it will be based on where you come from, who is influencing you as a person and so forth.”* Generally, the NEs assume that every student in the programme should have some prior exposure to spirituality or spiritual care from their family background. However, this was not the case as NEs acknowledged being challenged with the need to change the student's unpleasant [bad] moral behaviour that they bring along when they enter the nursing profession. This is what the lecturer said: *“It is hard to separate students with values of where they come from”*; *“The challenge is to change a person's morals they have before entering the programme”*. This denotes a view that spirituality is closely related to good moral behaviour and values. The NEs embraced the notion of spiritual care, however they admitted that it was just an espoused wish.

3.4.1.1.3 Sub-Theme Three: Understanding of the concept of spiritual care

The participants made it clear that before narrating their understanding of spiritual care, they had to first demonstrate how spirituality is applied in their normal life. The impression from the NEs concurs with that of other study participants who also approached the discussion of

spiritual care in nursing by first unpacking it from a personal meaning of spirituality. Spirituality was viewed as part of human existence which is open to different interpretations. They reported that: *“They viewed spirituality as part of the people which reflects who or what they [people] believe “...all humans are spiritual but experiences are different and opened to different interpretations”*. The lecturer’s conception of spirituality was associated with a different dimension of being human. The participants viewed spirituality as part of a structural make-up of human beings that holds strong beliefs in a higher being. This is what they said: *“Truly, it is more than a religion, denominations or something of that sort, but it is about beliefs that are there, out there [in people]”*

However, there was consensus amongst the nurse educators on the understanding that a person’s spirit has nothing to do with religion. They indicated that when people talk about somebody’s spirit as being high or low, this has no reference to religion. They further explained that when a person’s spirit is high, it simply means that the person is alive, energetic and full of life. They expressed this notion by saying: *“A person’s spirit may be low but a person’s spirit has nothing to do with religion. And when a person’s spirit is high it means that the person is full of life”*. On the contrary when a person is said to have a low spirit, it means that the person is having the feelings of hopelessness, dullness, and demotivation among other negative emotions.



They posed the question *where does the spirit go when a person dies?* This question was in a way to show the complexity of the topic of spirituality as not fully understood or comprehended. This was their comment: *“Where does the spirit go when a person dies? The science has not answered this question on human existence”*. The NEs believed that spirituality has to do with a belief system and what a person believes. Despite their acknowledgment that the human spirit has nothing to do with religion; they agreed that spirituality does touch closely to religion yet it is not the same with religion. Another argument was about the confusion between spiritual beliefs, personal beliefs and cultural beliefs. However, the confusion was resolved by them realising that all beliefs are within the person so the nurse should only respond to the patient’s expressed needs without necessarily distinguishing the source or nature in an attempt to find out which one is which. Their views on what spirituality is were expressed as follows: *“What a person does is influenced by what they believe in”*; *“Spirituality has to do with how you speak and manner of approach to life and how you do things”*. The NEs’ understanding of spiritual care also demonstrated that they view it as a means to meet every patient’s needs under the umbrella of holistic care. Regarding beliefs, the NEs did not provide

detailed discussion on this topic; however, they mentioned that beliefs are important to a believing person [the believer] therefore they should be treated as such. *“Beliefs refer to values that one aspires in life and they must be respected”*. According to the nurse educators, nurses must be able to identify patient’s beliefs needs so that nursing can offer harmonious care.

3.4.1.1.4 Sub-theme four: The caring nature of humans

The NEs spoke at large about the caring nature of humans and how the student is expected to care for the patient. Literally speaking, NEs appeared aloof from daily interactions with the spiritual needs of patients. Their discussion was restricted with regard to current practical evidences to demonstrate how they apply caring in their daily practice as nurse educators. This notion was further demonstrated by their diverse ways of responding to different challenging situations they encounter while interacting with students. The NEs also spoke a lot about spontaneous nature of human beings to care. These are examples that they gave: *“...I mean the natural carers, those young children who care for others”*. Surprisingly, no credibility was awarded to nursing students regarding the caring attributes or caring nature as human. This lack of acknowledging caring attitude in nursing students is a worry emanating from the fact that they are in a caring profession, and are expected to be carers. This is what the NEs said: *“...Despite students being taught nursing in all nursing modules from first to last year of training they [nursing students] are [remain] tasked-oriented or focussed and not caring per se”*. This comment concurs with what the student participants reported that they are not taught how to care for patients in spite that the programme that they are studying is a degree in “caring”. Based on the NEs comments, they teach nursing but they don’t make reference to care or caring in particular. This arouses a suspicion that NEs do not acknowledge the essence of caring as a dimension beyond nursing activities, tasks or procedures.

On the other hand, the nurse educators made a reference to a case study in a midwifery module where students do not understand the gist of caring. They said: *“...they [students] can’t connect the dots as they [students often are too young to use their intuition in their nursing interventions”*. Despite the NEs acknowledging that caring is an important virtue in nursing, they could not give accounts on how they ensure its implementation. It was not clear whose responsibility it is to teach caring skills. There seems to be a shortfall in the teaching aspect of caring values in nursing. The NEs appeared to be unaware of the caring content as this was a gap because they could not realise how they may possibly have been contributing to lack of caring skills and attitudes in nursing students. However, NEs made reference to a possibility

of lack of caring skills based on different backgrounds that each student comes from. To bring more clarity on the issue, they made an example of different meanings about the concept of peace. They said: “...*What peace means to you as a person] may not be same with what peace is for me [or another]*”; “...*I don’t have to be religious in-order to have peace*”. However, nurse educators agreed that they subscribe to care and according to them it entails: “*A caring attitude, meaning to pay attention to details, show concern to patient interest and act on behalf of the patient*”.

Contrary to an acknowledgement about the need to care for students, instead the nurse educators accepted that they often do not show a caring attitude towards students. Another view on this was presented by the NE for mental health nursing modules who said sharing herself with students is an exception rather than a rule. She informed that she does not let students penetrate her personal space; by this she did not mean that she does not care for another person but she attributed it as a different way to cope whilst she is caring for another human being. She said caring can be shown in varied ways including: “*Being with the person...I am comfortable with silence and I can sit with the person for an hour or so, not saying anything but being present. I can offer person water or tissues, wait until the person/patient is ready to talk.*” She explained the notion of silence in detail from a mental health perspective pointing to cases of gender based violence where victims are often not ready to divulge their crisis. She attested to intuition where she would go by gut feelings and the principle of interference and counter-interference as guiding her interventions with mental health patients. She attested that she learned this through her years of experience in mental health nursing. She said: “*I have learnt through reflection that interjection disturbs the patient’s line of thoughts which they need in order to take control of their lives*”. The implied gut feelings and intuition concurs with what a midwifery clinical supervisor said that she sometimes prefers to keep labour as natural as possible which promotes emotional feelings and physical safety and body strength of a labouring woman. What is common with these two instances is that they are instinctively driven by nursing intervention where both participants claim to be well experienced in the area of their specialisation. However, they emphasised that intuition should be followed within the parameters of scientific nursing. This is what they said: “...*it means that the nurse must be watchful and alert about potential complications or problems that may arise whilst they follow their intuitive skills*”. If students were to be taught to use their gut feelings (which they probably do use without being taught), it should strictly be allowed under specific guidelines. Patients may also want to embark on different routes to receive care. She made an example that some

patients would want to give birth while on the floor, others may want to consult ancestors as their chosen religion; they must be allowed unless it endangers their life and others'. "Caring for a person or patient means to be at the core of the person's or patient's needs". The NEs, just like the students, affirmed that being called to nursing means that caring comes naturally. Nurses as carers do not only assist the patient to go through the process of illness but they make the patient feel cared for. Caring requires a good nurse who can pay genuine attention to the patient. Nurse educators were asked about attributes of a good nurse, this is what they said: "A good nurse is sympathetic, takes actions to find out more about what is happening with the patient. Has an ability to identify patient's needs... Allows the person/patient to cry with you [nurse & patient], she attempts to meet every patient's need in an attempt to provide holistic care. Nurse educators emphasized that they allow their intuition within the parameters of scientific nursing. This means that they would be watchful and alert about potential complications or problems which may arise whilst they solely follow their intuitive skills. They mentioned that if students were to be taught to follow their gut feelings and intuition, it should strictly be taught under specific guidelines.

The second theme that emerged from the nurse educators is presented below. The theme depicts a diagnosis on the current teaching learning status at the school of nursing where spiritual care was identified as missing. The table below presents the second theme that emerged from the nurse educator participants.

3.4.1.2 Theme 2: Spiritual care as a missing component

The table below presents the second theme on spiritual care.

Table 3.4 Theme two on spiritual care as a missing component

Theme:	Sub-themes
3.4.1.2 Theme 2: Spiritual care as a missing component in the curriculum	3.4.1.2.1: Lack of visibility of spiritual care in the Curriculum
	3.4.1.2.2: Teaching-learning of spiritual care

The following two sub-themes presented below support how the participants' views on spiritual care as a missing component were constituted.

3.4.1.2.1: Sub-Theme One: Lack of visibility of spiritual care in the curriculum

Despite the NEs' acknowledgement that they do not teach spiritual care per se; they admitted that they do teach, to a certain extent, different religious requirements as a means to sensitise

students about the different faiths and religious requirements. Religions including but limited to Rastafarian, Muslim and Christianity were pointed out as means to provide practical application of religious content. The basic understanding on religion was perceived as having same meaning as spirituality. They said: *"...so if students are sensitised about different religions they will remember to attend to patient's religious needs, which assist the patient to connect to God"*. The nurse educators, when asked about their views on teaching of spiritual care in the nursing programme, responded by showing that they were unclear not only as to where teaching of spiritual care gets lost in the process but were more puzzled as to who should teach it. Factors for them not teaching spiritually-based content was awarded to lack of visibility of spiritual care content and subjects in the curriculum; also them being unsure on how to assess competence of spiritual care skills.

Whilst the NEs admitted that spiritual care is not taught as it should, they explicitly voiced the need to contextualise it in the nursing curriculum. This notion was also related to geographical and political needs of the community they serve. Such a view was deepened by awareness of patient's spiritual needs which are hardly considered when providing nursing care. Politically speaking, human rights for both the patients and nurses should be aligned in accordance with the over-arching national values of the South African Government. Nurse educators admitted that they neither teach nor assess the spiritual care subject matter. Furthermore, they commented that unless it [spiritual care] is clearly put in the curriculum and the objectives well specified, it will always vanish. The educators' views about teaching of spiritual care subjects within the practice of nursing were that: *"...it [spiritual care] is not adopted as the subject matter into the curriculum..."*; *"We do not teach it and we do not assess it"*. *"Despite the fact that spiritual care subject is not overtly incorporated in the UG curriculum nursing by its virtue it can be closely linked nursing"*. The nurse educator who teaches General Nursing also said: *"... and again I must be honest there's no specific time set apart where we particularly focus on this [meaning spiritual care], neither is there an integration of it during our sessions"*; *"Again, it is there but it is also not there"*. *"It's there but it's not taught... it doesn't stand out like the rest, like the other knowledge and skills"*

The NEs agreed that currently teaching of spiritual care is not visible as it should which was expressed as a concern. This is how the concern was expressed: *"Again, you just hope that it will be there, it will be applied but yet those are some of the things that are very [much] neglected"*. *"...and that's why we have a type of students ..., we are in the state that we are experiencing unprofessional behaviours with the types of students that we have. They don't*

have those basic interpersonal skills, basic communication, basic professionalism, the basic aspects of care, you know, you don't see it".

They said: *"...lack of the visibility of spiritual care subject matter in the curriculum contributes to it not being attended to in UG nursing programme".* Another nurse educator who was concerned about the lack of a guiding theory for teaching nursing at that school said: *"We don't know what is the school's philosophy and theory that underpins the UG curriculum"*

The NE for Mental Health Nursing also emphasised the need for a guiding theory on which the curriculum should be based. She argued that teaching of spiritual care should be guided and supported by a philosophy and theory because it is a sensitive subject. This is what she said: *"The school must show high regard for its beliefs and values that are expected to translate to student's learning and graduate attributes or characteristics"* *"As nurses we need to have our own theories and not borrowed ones"*; *"A real stand would be necessary for the school to implement the practice of spiritual care in health care or in nursing"* Among other things that the curriculum needs to provide is direction and distinction on certain concepts including emotional needs, spiritual needs, cultural needs, professional needs and nursing needs. The NE actually criticised the lack of clarity as caused by lack of a nursing philosophical stance, which according to her was evidenced by use of philosophies that borrow from other disciplines and are implemented in nursing without scrutiny. A case of the existentialist's view contradicts with Christian spirituality assumptions because it only acknowledges power within human beings or persons and nothing further and beyond. The NEs pointed out that: *"Existentialism actually negates spiritualism"*; In contrast to this view on the existentialism philosophy the same NE said *"Christianity is branded as something that is not to be mentioned overtly"*; *"...because people want to be politically correct and do not questions things"*

The next sub-theme discussed is on teaching-learning of spiritual care.

3.4.1.2.2: Sub-Theme Two: Teaching-learning of spiritual care

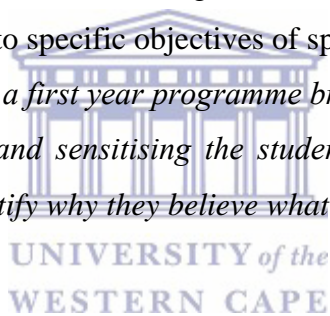
A need for clarity on differences between religion and spirituality was pointed out as a dire necessity. Participants believed this would assist students to realise that whatever religion that a person belongs to should be acceptable; but more importantly is awareness about the need to meet the patients' deeper personalised or personhood needs which enhance their relationship with God. It was also recommended that clinical teaching and or student accompaniment should be guided by whatever the educator finds the student doing without necessarily having to assess the student on the spiritual subject matter. For an example: *"... "An educator [i.e. a*

clinical supervisor or lecturer] may see a student for one to two hours in the clinical placement without an intention to assess the student”

Nurse Educators made reference to different things that they blame for lack of spiritual care including lack of good role models. In contrast, educators acknowledged that they do not teach anything that can round-off the students’ professional character until something wrong happens, then do they see the need. She said: “... it is only when a student has done something wrong and unprofessional behaviour that we sit with the student and try to correct the student”; “...But, we don’t deliberately include it in the routine teaching”

They then suggested that: “...The curriculum must provide clarity on differences between religion and spirituality because it is confusing”.

Teaching process: Nurse Educators suggested that a breakdown of the teaching content across each year level objectives towards holistic nursing would be ideal. Additionally, the year level objectives could then be reduced to specific objectives of spiritual care at that particular level. They said for an example: “...for a first year programme broad objectives may be directed to awareness about spiritual care and sensitising the students through discussion in class”; “Educator should let students justify why they believe what they believe and or not believe as part of the learning process.”



Nurse Educators admitted that spiritual care in the undergraduate programme is not given the attention it deserves but it is only hoped that somehow students will get spiritual skills. This was evidenced in what the Nurse Educators said: “...we don’t teach students what will shape their character and ground them into a competent-professional nurse; instead we [nurse educators] only address such issues when a matter has arisen”

Teaching method: Regarding the method of teaching the spiritual care subject, all participants suggested case based education. Case based teaching or learning method was considered a more valuable method with potential benefits in addressing spiritual care subject matter. The use of cases was mostly preferred because it offers a variety of learning opportunities to students. This is what they said: “The case base method is an analytic way of learning, affording the students with detailed learning, peer and social learning. Case base education (CBE) allows a rich discussion on the subject matter”. “...case base content is well handled by students in their learning. Thus the cases and scenarios on spiritual care subject would be ideal as their use in nursing modules to teach students”.

Teaching content: A list of spiritual care components unfolded as participants shared their understanding and opinions regarding spiritual care in the nursing programme. These included empathy, sympathy and compassion, Tender-Loving-Care (TLC), talking to patients, praying with or for the patient, giving the patient what he or she wants, and many more. Additional elements were suggested as relevant. They include awareness about spiritual needs, sacrifice, kindness, love, openness, readiness for intervention and observing the body language as part of communication, solemnity care which is the nurse's inward declaration to the patient that *I'm here for you*. Value of humbleness trusting, support and respect for each other; all these were discerned as associated with spirituality. This is what one NE said *"...each one of these elements are in a way got to do with spiritual things"*

Relationship building through communication and emotional support were mentioned as fundamental to prioritised caring. Basic interpersonal skills, basic communication, basic professionalism were all viewed as basic aspects of care. The NEs attested that the subject of interpersonal skills is well addressed in the first year level in comparison to the entire programme. They said: *"...There are specific interactive sessions assigned to it [communication]"*. Lecturers associated spiritual care in nursing with the appropriate use of basic communication, interpersonal (IPS) and relationship skills that demonstrate caring. These include how a person approaches people; how the person speaks to people. One lecturer said: *I think that it is where your spirituality comes from*. She said: *"...It [spiritual care] determines how you interact with [the] patients, talking to your patient, listening to your patient. "...We do it [spiritual care] by caring, by being supportive"*

Nurse educators acknowledged that the purpose of spiritual care is to care for the patients in a more holistic way. One lecturer affirmed that that she can deal with anxiety, depression and all of that because of the counselling skills that I have acquired over the years. She acknowledged that the purpose it is to make the patients feel better. This is how they put it: *"If I [patient] feel(s) that you [the nurse] understand me [the patient], already you [the nurse] are sorting something inside me, you increasing my hope, you increasing my strength, my resilience"; "...you make the person feel I understand, I'm empathetic"*

One of the ideas that could be considered regarding assessment of the student's competence on spiritual care was the need to move away from assessing it in a formal manner. The other notion was that if the school goes with formal assessment of spiritual care there would definitely be a need to revise existing assessment tools. This was expressed as follows: *"All the assessment*

instruments will need to be revised to cater for assessment of spiritual care". They suggested that an assessment of spiritual care can probably be conducted in an Objective Structured Clinical Examination (OSCE) type of assessment where a clinical station could be presented to the students to intervene and address the patients' ethical issue(s). Nurse Educators also indicated that the assessment could focus on diversity and differences amongst the individuals in a manner that assists students to make sense in appreciation of prevailing patients' scenario or whole picture.

Nurse Educators admitted that currently they use the Multiple Choice Questions (MCQs) to assess the students' religious knowledge. However, they have never taken it further to assess the spiritual relevance of that religious knowledge as taught. An example of what the lecturer meant is provided below: *"I [academic] have actually never thought about what happens if the religious expectations of the patients are not met because the MCQs choices focus on religious requirements but never relate to spirituality angle"*; *"MCQs assessments are used to assess the student's knowledge on diet for a Muslim patient that will require the student to select the correct option..."*; *"The student chooses something to feed a Muslim patient and will not choose bacon"*.

The third theme presents the nurse educator participants' arguments regarding challenges they face in attempting to teach spiritual care.

3.4.1.3 Theme Three: Challenges with teaching and learning

In theme three participants addressed relevant issues on teaching and learning.

Table 3.5 Theme three: Challenges with teaching and learning

Theme:	Sub-themes
3.4.1.3 Challenges with teaching and learning	3.4.1.3.1: Concerns about myths and conflicting ideas and beliefs
	3.4.1.3.2: Lack of role models

The participants' challenges and concerns that were raised comprised of myths and conflicting ideas about nursing principles versus spiritual principles as well as the lack of role models in the nursing profession.

3.4.1.3.1: Sub-Theme one: Concerns about myths and conflicting ideas and beliefs

Different beliefs and believing was the main source and cause for concern about potential conflicting ideas and beliefs. Participants discussed how provision of spiritual care can easily

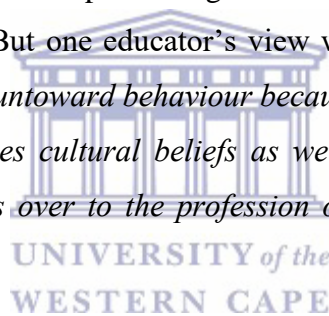
be taken outside nursing confinements which was of paramount importance. In view of the fact that in South Africa there are many different races and tribes, one would have to tread with care when addressing this matter. A concern was expressed where an individual [a nurse or a patient] may hold a conflicting view that spiritual matters are private and personal. A lecturer said a patient may give an indication that: *“You must not trespass..., you must be cautious not to trespass”*. *“There is a need to be cautious how to deal with spiritual matters”*; *“Spiritual care should not force one’s view on a client”*. Another concern was in regard to unacceptable practices that are claimed to be religious beliefs for some individuals. In response to this concern, educators suggested that teaching and provision of spiritual care will have to be guided by the universal ethical principles and be grounded on great parameters of the universal principles for humanity, Spirit of Ubuntu and basic principles of ethics of care. Whilst the nursing profession is expected to provide services to all humanity without discrimination, it is equally responsible to ensure safety for all clients on the other hand. *“...nurses providing spiritual care should guard against activities that are anti-life or not pro-life”*

A potential real challenge was the religion of Satanism. In this respect, awareness was summoned to ensure that the curriculum philosophical underpinning should be clear as to what the school stands for and what type of spiritual care is offered. They said that the curriculum should make it clear that: *“It should be made it clear as to what religion the curriculum caters for”*. Another issue was around issues of attitudes and different cultures as pointed out. Contradictions on these issues were identified at different levels. Traditional medicine versus western medicine preference was one aspect that was questioned and discussed. It was resolved by agreeing that the South African Human Rights Act demarcates the jurisdiction law to guard against anti-human behaviour such as violence and abuse whilst the SA citizens are allowed freedom of choice. They are free to choose how they want to be treated for medical problems and diseases which can be reflected in behaviour in attention seeking for health care. Participants agreed on the following: *“... Need to address student’s issues in clinical learning environment as promptly as they happen. “No need to understand contradiction between “professionalism” and “cultural” beliefs and contradiction between “professionalism” and “spirituality” as well as personal and professional”*. Atheists and agnostics were not viewed as a threat to nursing as they are regarded as humans who deserve to receive care like anybody else. It was acknowledged that atheists and agnostics have spiritual and emotional needs despite the fact that they believe in themselves as possessing all power.

3.4.1.3.2: Sub-Theme two: lack of role models

Lack of role models from the family background was assumed to be due to lack of family's involvement in moral and spiritual development of its members. They believed that lack of role models in the families where students come from was perceived as a contributory factor to students' misbehaviour. They concluded that: "*Students from the family backgrounds and or communities where moral values are not prioritised and practiced..., ...the off-springs from such families are viewed as more likely to not possess the moral principles*"; "... *The reason could be lack of sharing of challenges within the family structure*"

Besides the fact that in general humans are perceived and regarded as caring in nature, it was also pointed out that in other families or communities where caring is not modelled, a caring nature may not be developed in those students as a consequence. This was in line with what was mentioned by students saying that at times they [students] also bring their burden to the learning environment (both classroom and clinical) although students did not indicate having problems with lack of sound morals or possessing offensive behaviour that they bring along from their family backgrounds. But one educator's view was different to say that: "... *It is difficulty to change the student's untoward behaviour because the behaviour is linked with the student's personal beliefs at times cultural beliefs as well*"; "...*Families no longer share challenges...*"; "... *Student cross over to the profession of nursing without having what it takes...*"



The lack of role models from the nursing profession was a more worrying situation regarding ill practice from both clinical and education settings. Participants asked the question *what has changed?* This question was asked by the educators as an attempt to identify what could be the cause of the problem as perceived in the clinical practice. An issue of understaffed versus over-worked staff was raised. Surprisingly was the fact that despite the issue of understaffed and versus over-worked staff being mentioned several times, it was not delved in deeper with contrast to an increased work-load, task shifting and changing disease profile.

3.4.1.4 Integrated discussion on results from the nurse educators

Interviews with nurse educators revealed few issues about their perceptions of spiritual care. This was a significant response to the study inquiry as this was the purpose. Spiritual care was acknowledged as missing from the curriculum. Additionally, those who had made efforts to address spiritual matters found it challenging. Participants' perceptions that association of spirituality with God, deity or Supreme Being and significant others were discussed in Chapter three (3), therefore less attention is given to them in this section but only a reference to this

notion is made. Aspects that are discussed in this section include a need for a guiding theory and philosophy for teaching-learning of spiritual care, teaching- learning process and contents, challenges including myths about subject of spirituality as well as the role of the nurse educator in teaching spiritual care. Chapter four (4) discusses nurse educators' and clinical supervisors' perceptions on the definition of spirituality, spirituality as connectedness, spirituality as inherent in all humans, spirituality as a pre-dominating aspect in human beings as well as spirituality as an aspect of holistic nursing. Discussions on these elements will therefore be brief to avoid duplication and redundancy and to point to related aspects that are more significant to nurse educators.

Issues around definition and understandings of spirituality and spiritual care are discussed in depth in Chapter four (4) under the discussion of the findings from the nursing students. Therefore, in this section, the discussion is only directed to issues that point to complexity and differing views about spirituality and spiritual care. Stoll's (1989) broad definition of spirituality is conceived in this study as an acceptable definition and a relevant response to understanding spiritual care within the South African context. Stoll's (*ibid*) definition predominantly focuses on religion because it speaks to a person's religious-spirituality as foundational to spiritual care. This focus potentially presents a gap in the understanding of spirituality because to assume that a person's religious-spirituality is the originator for spiritual care excludes non-religious people.

Contrary to Stoll's (*ibid*) definition of spirituality, MacLaren's (2004) view supports the postmodernist approach to spirituality and warns about Stoll's view arguing that this approach may reduce the essence of spirituality and may stir possible spiritual turbulence or clash. However, authors including Kirkham, Pesut, Meyer, Hoff and Sawatzky (2004) counter caution against postmodernist view to spirituality. They attest that due to the postmodernist's view being detached from religion, it is exposed to a risk to decontextualise the meaning of faith and religion in certain situations or contexts. This risk may be true in the South African context where religion is perceived as underpinning spirituality. This was evidenced by the findings of a study conducted in South Africa to analyse the concept of spirituality which demonstrated spirituality to be heavy laden on religious beliefs and connotations (Mahlungulu & Uys, 2004).

Consequently, these two opposing opinions by MacLaren (2004) and Kirkham *et al.*, (2004) advice that teaching of spirituality should demarcate its applicability by describing the context it serves to ensure that it does not undermine other beliefs nor is it undermined. Another study

conducted in SA by Monareng (2012: 1) points a dilemma caused by the abstract and subjective nature of conceptualisation of spirituality in nursing care as resulting from differing worldviews with consequent different meanings and understandings. Nurses have an ongoing obligation to provide caring skills which means nurses must do something to resolve the confusion (Meiers & Brauer, 2008: 116).

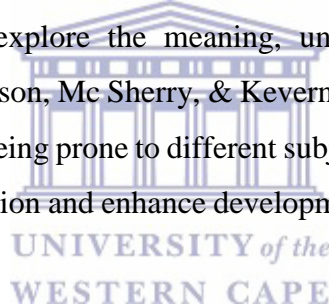
Challenges regarding inherent views in all humans can be misleading for some nurses based on the ambiguous, complex and vague nature of the very concept (van Leeuwen & Cusveller, 2004). Despite existing issues such as lack of universal definition which leaves spiritual care as an indefinable occupation, it should be acknowledged that it is nevertheless the most important component of care for all humans. Therefore, nurse educators should shift their thinking and view of spiritual care for what it real is and what it can do to a sick person. Spiritual care does not only enhance accomplishment of “holistic care” and “quality nursing care” but it is always religiously significant for the person to cope with illness and disease (Levin & Vanderpool, 1992).

Nurse educators need preparation through workshops and seminars on spiritual care teaching skills to bridge the educational gap (McSherry, 2006) in order to redress the current gap in the implementation of spiritual identified. McSherry, 2006) pointed out that preparation of nurses on diverse management and caring interventions including assisting patients and families on how to face loss, sickness, disability and death are the most certain events that humans embark on every day is of utmost importance. Integration of spiritual care in formal teaching-learning in the undergraduate nursing programme should be based on sound philosophy and theory. A theory-based curriculum should therefore represent unique values of the nursing school which are congruent with values of the profession of nursing. Grossvenor (2000: 30) in her paper on teaching spiritual care to nurses; suggests the use of professional guidelines to guide integration of spiritual care in formal teaching. For an example, the new definition of health by WHO (1998); UKCC, (2000).

American Association of Colleges Nursing (AACN), 1986) that acknowledges observance of customs, values and spiritual belief of the patient through the patient’s charter. This makes it clear that nurses should acknowledge their patient’s spiritual needs and aspirations. When teaching culture-based topics such as spirituality, Klopper’s (2009) constructivist learning model can be used as an ideal teaching strategy that promotes student’s attentive-listening-presence; a spiritual-cognitive skill necessary for execution of spiritual learning and

interventions. In this learning approach students will be motivated to engage in critical-analytical thinking when dealing with patients while their presence is meaningful to both them and patients.

The role of spirituality and spiritual care in health care has been acknowledged by many including Canadian Nursing Association (CNA) (2010); Carr, (2010); WHO (1998); and Pesut (2005). A study conducted by Rogers and Love (2007: 690) on nurse educator's perspectives on the role spirituality plays in the curriculum and pedagogy indicates a need for nurse educators to be alert about the education of spiritual care and to assume the necessary stance for teaching-learning of spiritual care in nursing. However, nurse educators have always regarded the affective domain as difficult to assess and as a result they pay less attention to this aspect of knowledge. Principles of spiritual care can be applied across all phases and settings for the seriously ill without clashes to culture, religion, tradition or spiritual frame of reference (Puchalski, *et al.*, 2009: 885). Nurse educators, practitioners and researchers are called to join efforts and commit to further explore the meaning, understanding and hence universal definition of spiritual care (Lewinson, Mc Sherry, & Kevern, 2015). The call is probably based on the conception of spirituality being prone to different subjective meanings. Joint efforts may achieve an agreed working definition and enhance development and advancement in providing spiritual care in nursing.



Conflicting issues such as religious or cultural discordance that may create an atmosphere of mistrust and become a barrier were reported (Daaleman, Usher, Williams, Rawlings & Hanson, 2008). A conflicting view that spiritual matters are perceived as private (Bradshaw, 1994) and personal would require new understanding that a nurse is neither trespassing into personal matters nor compelled to partake in certain unacceptable religious practices that are not ethically sound. The challenge to embrace different spiritualities in nursing without jeopardising the essence of nursing in order to preserve and promote life was argued by MacLaren (2004); who affirmed that nursing needs to find ways to reconcile the immense variety of approaches to spirituality.

Most definitions of spirituality support the notion that it is associated with an existential search for meaning and purpose on complex questions about life (Larson, Sawyer, & McCollough, 1998, also see Koenig, Larson & Larson, 2001; Thoresen, 1999). It presents challenges to people who do not ascribe to this existentialist's philosophy. Hill, Pargament, Hood, McCullough, Sawyers, Larson and Zinnbauer (2000) caution that although the existential

search appears to provide a fairly clear defining characteristic of spirituality, existentialism in and of itself is not equal to spirituality. Sawatzky (2002) proposes a criterion that will distinguish existential searching and ideology that is inherently spiritual in nature from that which is existential but not necessarily spiritual. Several researchers suggest that the criterion to distinguish spirituality from other potentially meaningful existential pursuits, ideologies or life-giving practices is its orientation towards the sacred (George, Larson, Koenig & McCullough, 2000; Hill, Pargament, Hood, McCullough, Swyers, Larson, & Zinnbauer, 2000; Larson, Sawyers, & McCullough, 1998).

Hill *et al.*, (2000: 64) state that "when the term 'spirituality' is invoked to describe ideologies or lifestyles that do not consider notions of the sacred in one way or another, they are not spiritualities at all, but are just strongly held ideologies or highly elaborated lifestyles". This sacred core of spirituality is conceptualised by a large panel of researchers associated with the National Institute of Healthcare Research (NIHR) as "a divine being or Ultimate Reality or Ultimate Truth as perceived by the individual" (Larson *et. al.*, 1998: 21). Similarly, Pargament (1999: 12) explains that the sacred encompasses concepts of God, the divine, and the transcendent, but it is not limited to notions of higher powers but to objects, attributes, or qualities that become sanctified by virtue of their association with or representation of the holiness. Sacred refers to those aspects of life that are either transcendent in nature or associated with a transcendent dimension. In addition, the sacred encompasses the transcendent and existential characteristics of spirituality discussed earlier. In consideration of the relational characteristic of spirituality, spirituality can then be defined as involving a relationship with the sacred. Similarly, Sussman, Nezami and Mishra (1997: 22) suggest that "spirituality involves transcendental processes that supersede ordinary existence, whereas religion involves subscription to a set of beliefs which are organized and institutionalized". This distinction recognizes the mutual concerns of people with backgrounds in transpersonal psychology, humanism, existentialism and formal religion that religious beliefs, expression and behaviours can be abused for forms of personal gain in ways that ignore the sacred (Sawatzky, 1999).

Understaffing and over-working were assumed to be some of the possible causes for lack of practice of spiritual care; however, these were never compared with changes in disease profile, prevalence and increased burden on caring professions. Shortage of nurses (Breier, Wildschut & Mgqolozana, 2009: 112) comes at the cost of caring a virtue at the heart of nursing. Time constraint implications as nurses are already juggling with limited time for caring-nursing interventions in contrast to technical or task-based nursing activities and procedures (Rogers,

& Love, 2007; Carr, 2010). The argument that essence of caring is underutilised in nursing practice and patients receive little attention indicates the lack of understanding of the essence of caring (van Leeuwen's, 2008: 12). This is regarded as a great mishap because health needs are different from personal and spiritual needs which may vary from fear, worry, need to talk, need to pray or religious and or belief rituals. Rogers and Love (2007) points to a client-centred approach to care which is non-directive care through which carers show a supportive attitude that models human value and acceptable communication as advocated. Potential possibility for conflict with different religions between the nurse and patient is a misconception that patients may be misdirected in their future life journey in the case of a dying patient (van Leeuwen, 2004).

3.4.1.5 Conclusion statements on results from nurse educators

- 1.** Spirituality refers to connectedness and it is an inherent virtue in human beings that expresses a caring value.
- 2.** Practice of spiritual care should be free from factors such as professional boundary and, lack of role models or any unacceptable practices that are contradictory to universal ethical principles and the Spirit of Ubuntu.
- 3.** Programme outcomes should integrate spiritual care throughout the curriculum and be based on a good nursing philosophy and theory that caters for differences in and between different individuals' cultures, religions and spiritualities. Outcomes should be socially acceptable to the universal law of "do no harm" "do good" humanitarian principle.

3.4.2 Results from in-depth interviews with the clinical supervisors

The table below presents comprehensive themes and sub-themes that emerged from individual interviews with the clinical supervisors.

Table 3.6 Comprehensive themes and sub-themes from clinical supervisors

Theme:	Sub-themes
3.4.2.1 Defining Spiritual care	3.4.2.1.1 Spirituality as a concept
	3.4.2.1.2 Spirituality as an inherent value in humanity dimension
3.4.2.2 Spiritual care in teaching and learning	3.4.2.2.1 Current status of teaching and learning of spiritual care
	3.4.2.2.2 Constraints in implementation of teaching & learning
	3.4.2.2.3 Awareness, willingness and desire for spiritual care
3.4.2.3 Benefits of spiritual care	3.4.2.3.1 Benefits to the patient
	3.4.2.3.2 Benefits to the nursing students
3.4.2.4 Need for spiritual care	3.4.2.4.1 Essentials of spiritual care
	3.4.2.4.2 Communication
	3.4.2.4.3 Patients' felt needs

The conceptualisation of spirituality and spiritual care portrayed spirituality as associated with the belief in a higher being or God, own religious and church life experiences. Defining of spiritual care was close to how it is understood by nurse educators and their counter parts. Table 3.7 below presents the theme and sub-themes that define spiritual care according to clinical supervisors.

3.4.2.1 Theme one: defining spiritual care

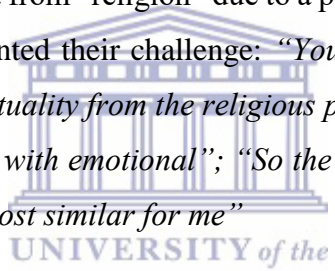
The first sub-theme addresses how connotation of religion and spirituality were confused. However, spiritual care was conceived and defined by clinical supervisors as relating to different aspects in a person's life which include religious beliefs among others aspects that were identified.

Table 3.7 Theme 1: Defining spiritual care

Theme:	Sub-themes
3.4.2.1 Defining Spiritual care	3.4.2.1.1 Spirituality as a concept
	3.4.2.1.2 Spirituality as an inherent value in humanity dimension

3.4.2.1.1 Sub-theme one: Spirituality as a concept

The supervisors’ understanding of spirituality was displayed by their explanation of what it means in general life. They typically made references based on individual understanding of spirituality after which such understanding could be transferred to health care involvements with spiritual care. Significantly, in line with other study participants namely the students and nurse educators, the clinical supervisors portrayed spirituality as an important source from which spiritual care is founded. However, they acknowledged difficulty in defining “spirituality” and differentiating it from “religion” due to a perceived thin line between the two concepts. This is how they presented their challenge: *“You know, I don’t think I can define spirituality”*; *“I mostly view spirituality from the religious point of view”*; *“...And when I say emotional I usually take spiritual with emotional”*; *“So the two for me is almost similar”*; *“I know it is not similar, but it’s almost similar for me”*



Evidently, the clinical supervisors were not only challenged with lack of judgement between the concepts religion and spirituality but they could not also distinguish between emotional and spiritual connotation of the concepts. Particularly their general perception portrayed spirituality as associated with belief in a higher being or God. Supervisors perceived challenges which related to their own religious and church life experiences that often presented a hindrance to implementation of spiritual care. This is what they said: *“...So we tend to differ when it comes to different religions”*; *“... and that is why it is difficulty to render spiritual care to our patients because we do not want to send them in the wrong way because it is the only time that we render spiritual care when they are dying”*; Another concern according to them was that: *“Religion is the way to the eternal life”*

The clinical supervisors’ conception of spirituality was related to different aspects in a person’s life including religious beliefs and personal characteristics. Religious beliefs referred to what a person does in relation to his or her religious affiliation primarily which may or may not include spiritual beliefs. This is what one clinical supervisor said it is basically about: *“It is my religion in the first place which places me on a different level because it teaches to be respectful*

and how to behave in certain circumstances and how to treat people [patients]”; “So you must be able to treat people positively, it does not matter from which religion they come or what background they come from” In this sense, spirituality was regarded as precursor of spiritual care. Personal characteristics on the other hand were regarded as contributory factors that can influence the provision of spiritual care. A person’s behaviour was expressed as having the ability to influence or be influenced by what he or she believes in. This was reported in this way: *“Your belief, what you believe in and your values and positive attitude influence your behaviour...”*; *“Respecting patients, treating people [patients] the same it does not matter [what is their background, religion or culture they’re from”*; *“...Respect [for people] is the one standing out for me”*. The concept of spirituality was perceived as relating to holistic nursing. The clinical supervisor attested that when she teaches spiritual care, she focuses on the holistic care and vice versa which includes physical, emotional and spiritual. This is what she said: *“When you talk about spiritual care for me you look at the patient whole being”*

3.4.2.1.2 Sub-theme 2: Spirituality as an inherent value in humanity dimension

Human beings were perceived as having different dimensions that need to be aligned with different dimensions of nursing care. The supervisor reported that all the dimensions of being human should be catered for when practicing nursing. An assumption that nurses often claim to provide holistic care without necessarily attending to the spiritual dimension of the patient was a point of contention. This is what was said: *“...when we [nurses] talk about a holistic approach we focus on the different illnesses that the patient has and not on the different dimensions of the patient itself [being]”*; *“... but we don’t render that care [spiritual care] routinely for the patient”*; *“The only time that we touch on spirituality is in near-death situations where patients are busy dying and where they basically ask for it”*. Spiritual care was regarded as part of caring process for humans because it is based on the value we put on a human being. *“You don’t value that person as a Moslem or the religion related to the person. You value that person as a human being...”* *“...because when you do the oath, you say regardless of race, of colour, of culture you will treat that [the] person as a human being...”*. The lack of provision of spiritual care was also blamed on difficulties posed by religious differences despite patients asking for it yet getting neglected most of the time. It was argued that nowadays patients who are terminally ill do not get that type of care because nurses do not have time to attend to them. Spirituality was viewed as being inherent by all humans. The inherent nature of spirituality was interpreted as beliefs and values which may or may not be religiously instilled into a person and it influences how one deals with things in life. The

supervisor claimed that her behaviour is influenced by her religion. Spirituality was viewed as relating to both religious beliefs, and personal characteristics. From a religious point of view, spirituality refers to what a person does directed by his or her religious beliefs. Personal characteristics on the other hand refer to observable behaviour which does not necessarily emanate from religious beliefs, for an example ‘respect’ for the patient. This is what another supervisor said spirituality is about: “...*your belief, what you believe in and your values*”; “*Respecting patients, treating people [patients] the same it does not matter [what is their background, religion or culture they’re from]*”; “*So you must be able to treat people positively, it does not matter from which religion they come or what background they come from*”.

Participants acknowledged that religion places them on a different level because it teaches them to be respectful and how to behave morally in certain circumstances including treating people [including patients] well. According to participants, respect for others was the most important and an outstanding attribute or characteristic of spirituality. Participants viewed spiritual care as part of the holistic care in nursing. Holistic care was described as providing care that attends to every need of the patient. The clinical supervisors presented that spiritual care focuses on caring for the whole-being of the patient, which caters for physical, emotional, and spiritual needs. Spiritual care was regarded as follows: “...*it is looking at physical, emotional and mental well-being... “It is about taking into consideration of all aspects of the human being which allows you [nurse] to look at the mind, the body and the spirit of someone [patient]”*”; “*It was very [strongly] emphasised that you check the spiritual aspect [of the patient] and make sure you look at [observe] the beliefs of the people*”; “*And when I say emotional I usually take spiritual with emotional*”

3.4.2.2 Theme two: spiritual care in teaching and learning

The second theme on teaching and learning of spiritual care is presented below in Table 3.8.

Table 3.8 Theme Two: Spiritual care in teaching and learning

Theme:	Sub-themes
3.4.2.2 Spiritual care in teaching and learning	3.4.2.2.1 Current status of teaching and learning of spiritual care
	3.4.2.2.2 Constraints in implementation of teaching and learning
	3.4.2.2.3 Awareness, willingness and desire for spiritual care

A narration on theme two and sub-themes is provided below to show how participants applied

their minds in account to the current status of teaching and learning of spiritual care at the time of data collection.

3.4.2.2.1 Sub-theme 1: Current status of teaching and learning of spiritual care

The participants [clinical supervisors] informed the researcher that teaching of spiritual care is not formalised because there is no structure for teaching spiritual care instead the clinical supervisors presented that they had not seen any formal implementation of spiritual care. This is how they expressed this: “...at the moment really, I would not lie from the clinical point of view I don’t see anything that has been done to address that [spiritual care]”. Despite the supervisors acknowledging the importance of spiritual care, few of them reported engagement in teaching of spiritual care or addressing of spiritual matters in the clinical settings. Most supervisors expressed challenges with implementation in the clinical teaching and practice of spiritual care. This is how they coined their position: “I haven’t taught them to, instead I just also transfer what I was told by my lecturer about what is needed”; “I haven’t taught them [referring to students] to take care of that aspect of the patient [meaning spiritual care]”; “But I made them [students] aware that about spiritual needs, it’s a need which is there...” “However I can never teach my students that [spiritual care]

The supervisors reported that in the midwifery programme, spiritual care is learned intuitively in the clinical learning settings through debriefing sessions. The challenge is that debriefing sessions are neither formalised nor structured, leaving a gap in which is perceived as negatively affecting students’ integration of spiritual care theory into practice. Furthermore, it deprives students an opportunity to share their emotions related to touchy clinical experiences. This is what she mentioned as examples: “There’s always a sharing time where they [student midwives] have to express themselves and sometimes it is [about] terrible things, sometimes it is a loss of a child”; “Other times it’s a big fighting delivery”; “It may be a first birth of the mother and the terror of unseen baby”; “...It could be a worry on how [whether] the baby will come out right”; “But they [i.e. debriefing sessions] are is not schedule or structured”

Midwifery students are often emotionally challenged because they are young enough to be able to meet some of the midwifery practice expectations; for instance, handling of a young mother who is HIV positive who is anxious and afraid about the baby who may come out deformed. The clinical supervisors regarded such situations as spiritual interphase depicting a tenderness state of the patient; yet also challenging for midwifery students. This is what the clinical supervisor’s expression of a spiritually inclined situation was: “...so, spiritual interface

confronts or interface the patient [midwifery client] with a life-changing reality at the same time...”; “...they [midwifery clients] are very tender cases, the HIV positive moms [mothers] ... they are very tender cases in terms of spirituality”; “...to such a point when the mother is in true labour when she’s truly labouring, it’s like she is in an altered state of consciousness. She [the labouring woman] is so vulnerable and in fact, her labour will not come on until you have a situation what I would like to call the guard at the gate”

The supervisors also pointed to other emotionally challenging situations to students where a student may be challenged to meet patients’ spiritual needs, for an example when participating in Termination of Pregnancy (TOP) procedures. This is what the clinical supervisors said: “*A student does [may] not want to be part of it [TOP] and yet she is sort of forced [as] she is in this profession*”; “*...then there is human rights question, so now I am being [she gets] into it.*”; “*In other situations the doctors will start the termination of pregnancy in a ward with pre-medication and the student will largely be uninformed as to what is actually happening*”; “*...she [student] then becomes an unknown part and parcel of the ...*”; “*... but you know that she may have a deep Christian faith who [that] would never consent[ed] to be part of it and yet because it is ... she’s being persuaded without her being informed*”

Another example was conducting the delivery of a stillborn baby where no medical intervention can be done, where the student is not formerly prepared to handle this. The clinical supervisor put it this way: “*This is grief, [i.e. the delivery of dead fetus] and for the first time in your [student’s] life and career that there is no medicine to apply; no injection to give nothing to offer except yourself, the only thing that you have in your hand is your spirit*”; “*Whatever response... to give to the mother who wants to hold the dead baby; smells it; she wants to know that this was mine but a short life*”; “*However students are often not proficient to deal with this because they are not formally prepared*”

The essence of spiritual care in contrast to medical care was acknowledged and the existing need for spiritual care recognised. The supervisors pointed to a current situation where often times the nurses assumed that holistic care is rendered where actually it is not because they would be no focus paid to the spiritual needs of the patient. This is what one supervisor said: “*The only time that we touch on spirituality is in near-death situations where patients are busy dying and where they [patients] basically ask for it*”; “*... but we don’t render that care [meaning spiritual care] routinely for the patient*”; “*...when we [nurses] talk about a holistic approach we focus on the different illnesses that the patient has and not on the different*

dimensions of being human or patient itself". The clinical supervisors reported that in the fourth year of BN programme, they teach students to engage spiritually with the patients during counselling sessions. They reported that they use a broad approach where they do not ask the patients specific questions. The objective is to give the patient space to open-up so that they can pick up the patient's beliefs with-out feeling pressurised. The clinical supervisors believed that in this way: *"It's easy to get to the actual cause of the issue without even interrogating that patient and ask[ing] many questions"*; *"I think [it] would be the kind of a problem is when you ask specific questions ..."*; *"...But if one [the nurse] just give a platform and let that person just talk, then it's easier to find out what the need might be"*. Broad communication with the patient would allow the nurse to determine if there are any other ways for the patient to cope. These would include religious needs for an example or the patient may need support from relatives, spiritual leaders, priests, imams or counsellors to deal with certain situations. A nurse may do the following: *"...Assist the patient with a prayer or you pray with them"*; *"If you're not of the same religion, you can also say a prayer for your patient"*; *"If you and your patient's religion are not the same it does not prevent yourself from praying with the patient"* *"...For meditation, it's [the need is] usually from the patient themselves. It is very rare that I come across those who needs to do it, [it] is very rare"*

The first year level clinical supervisors revealed that when they feel too close to a patient in the clinical teaching setting, they would go to the toilet to shed tears then compose them-selves and go back to the ward when they are ready or able to deal with the situation. Despite evidence of some implementation of spiritual care in the BN programme, it was noted that provision of spiritual care by students largely depends on the student's ability to feel what the patient is going through. According to the supervisor's perception, students' feelings or compassion of the situation was the main pre-determining condition for spiritual care. This is how they reported this: *"...At that point [in time] the student would sympathize with the patient as she feels what the patient is going through"*; *"...spiritual care occurs when you feel what the patient is going through"*; *"... You must feel with the patient in order to care for them properly"*. Whilst the supervisor acknowledged the value of providing spiritual care, they also pointed out to students' differences where some students appear unaffected by their first experience of a patient's death in contrast to those who are grossly affected. This is what they said: *"...for some they [students] do not go through the emotional experience for the patient"*; *"Some students they will just tell me no, I'm like that I never cry"*; *"... they asked me to wrap the body, I did it. I'm okay"*

Nevertheless, the question of how to teach students how to feel in a particular way at a specific moment when dealing with bereaved relatives remains a challenge for the supervisors. This is how they expressed this: “... *dealing with loss is completely something different, but how do I tell my students how to feel?*”. The supervisor revealed that whilst some students would appear untouched about a patient’s death, others would call the supervisor and report that they cannot handle their first patient death and the supervisor would come to assist the student. In contrast, other students were viewed as overreacting in contrast to those who appeared untouched by a patient’s death. The discussion may be well distorted to emotional care rather than spiritual care.

In the third year of the Bachelor of Nursing programme, structured patient counselling is taught especially in HIV driven modules. The subject was reported as close to emotional counselling subject. They reported that all of the HIV oriented modules are staunchly perched on counselling. One participant said: “*The only time that we actually impart that [spiritual care] to them [students] or passing to them [students] is when we try and teach them some structured for counselling*”; “*...And we pass this idea to look at things like spirituality, to look at things like sympathy as different from the empathy...*”; “*... I mean to the point where what we use to call the therapeutic use of self*”; “*...To reach to your physical body, to hold her hand, to have nothing else, except yourself to deal with the situation*”

Clinical supervisors presented about instances where a need for spiritual care would be observed in clinical settings where an inexperienced midwifery student connects with the labouring women to an extent that the midwifery student actually gets hurt when she or he witnesses impersonal interventions by the experienced staff. The clinical supervisor expressed the following: “*...the inexperienced midwife upholds the caring values when they interact with the client or patient and does not support purely tasked-based or procedure-based interventions*” According to the supervisors, the student’s state of being ‘less experienced’ in high technology monitoring in the labour ward and other specialised procedures offers the inexperienced student to remain at the level where she or he can only attend to the patient’s felt or expressed personal needs other than midwifery and or medical health needs. This is what the participants said: “*...the midwifery student at this stage she can only attend to less complex needs of the labouring woman and connects at that level*”; “*Midwifery students become hurt, spiritually because the more we are interfering there it then becomes a war between medicine and the mother*”. The midwifery student’s compassion and the labouring woman’s humanity

provides a common ground through which they connect. This was viewed as the reason why the midwifery students are naturally spirited and sensitive towards the pregnant mother.

3.4.2.2.2 Sub-theme two: Constraints in implementation of teaching and learning

In midwifery practice, spiritual care was broadly viewed as the care that may involve the entire family. However, a concern for lack of attention on the baby's father was an example depicting lack of humanitarian approach as pointed out. Clinical supervisors revealed the fact that the fathers are regarded as not having an active role in the birthing process yet this does not mean that they are not part of the process. One participant said nurses may not know how much the presence of the baby's father means to both a labouring and mourning mother. This issue was referring to the fathers who are often locked out of labour wards, pacing up and down in the hospital passages. This is how the clinical supervisors fleshed out their views: "...*But he [baby's father] is being withheld, his spirituality is barred at the door*"; "*All what the fathers can hear is the screaming inside the labour ward*"; "*When the man comes to the scene [labour ward] ...and they're thinking is that my one that is screaming*". "*Is that my child that is being born?*" "*What is happening there?*" ...*and yet you [the nurse] know when the man [baby's father] is invited in there is an interchange that happens between partners that is truly lovely*". They argued that when the baby's father is involved or allowed in the labour ward, the tension changes completely because of the support and hope and the feeling of security because of the man's presence. "*So straight away you find this young woman she becomes another person, my support, is here.*"

Different notions were expressed to depict a situation where spiritual care was either completely ignored and not addressed or a situation where the clinical supervisor's spirituality was transferred to the students by intent or role modelling. These were scenarios provided: "*The only time that we actually impart that [spiritual care] to them [students] or passing to them [students] is when we try and teach them some structure for counselling*"; "...*And we pass this idea to look at things like spirituality, to look at things like sympathy as different from the empathy...*"; "... *I mean to the point where what we use to call the therapeutic use of self*"; "...*To reach out to your physical body, to hold her hand ..., you have nothing else, except yourself to deal with the situation*" Participants argued that despite the fact that they often witness a lot of emotions for both patients and students; less attention is given to address spiritually based needs in the clinical setting. Additionally, they argued that although technical-nursing skills can be provided for the patient, if the patient is not well cared for from the internal

intimate issues, the skill-based nursing interventions will not work. This discussion was brought up because participants believed that the third year level programme is highly skill-based except for specific interventions including counselling that human touch as the focus for delivered care. This is what the participants said: *“I don’t think really at the moment it [spiritual care] is being addressed because everything else is extremely skills based”; “I don’t think that it [spiritual care] has been addressed sufficiently and taken care of..., and it shows that there’s a lot that we take for granted”*

Despite the fact that almost all clinical supervisors attested that they do not teach spiritual care in clinical learning interactions with the students, they indicated an interest in the formal teaching of the spiritual subject. Their view that the essence of spiritual care is wrapped in the effective communication was regarded fundamental to spiritual care. This is how this view was expressed: *“...Basically by talking to a patient, mostly by communication...”; “...facial expressions..., the physical behaviour observing the way people [patients] are behaving...”; “...By observing the patient and looking at them; how are they expressing themselves verbally and non-verbally, that is my communication”*

Lack of spirituality was also reported in relation to how it can compromise patient’s benefits and jeopardise benefits for student’s personal and professional development. Regarding students one participant said: *“They [students] make you to look at their values, emotions and wonder what it is that is in them”; “...I would say that that [spiritual care] we neglect[ed] most of the time”; “It is one of those things you come and then you just assume it is there and you just go ahead”; “...when you [clinical supervisors] look back you wonder why things are not happening”*.

The majority of clinical supervisors acknowledged that they do not actually teach about patient’s spiritual matters but make students aware of the patient’s possible spiritual needs. They informed the researcher that spiritual care is viewed as a sensitive matter although they can see that the patients are in need of spiritual care. The other reason for not teaching spiritual care is the concern that spiritual care can intricate with cultural beliefs or matters which may come into play concurrently. Another concern was the question on whether or not the students can render spiritual care, and if they can, to what extent. This view was related to the excerpts below: *“...with men [male patients] in hospital... and it happens that the student nurse who’s a girl she starts to persuade and to talk about the spirituality and all that. It happens that this man, yes, in as much as he is in need of spiritual care, but at the same time according to his*

belief no women can teach him or talk to him about their spirituality”; “... also because religions differ that is my main thing”. Yet another concern was about the scope or extent to which spiritual care can be provided. This was a question on where would nurses draw the line with the subject of spirituality. This was expressed in these words: “... and how are we going to know that this is where we draw the line” “...or this is where we can go up to so far”; “...This is how far we can go”

Although spiritual care was acknowledged as a need in nursing practice, most supervisors expressed challenges with implementation in the clinical learning settings. They informed the researcher that while they themselves were students, they learned that nurses are expected to provide holistic care which includes care of spiritual needs of the patient. However, as nursing students, they were not expected to literally provide spiritual care to patients. The reason for not teaching it is that as nursing students, they were taught that spiritual care was outside the nurses’ territory and a business far removed from them. They said as nursing students they were taught that: “As [a] student you can’t talk to patients about that [spiritual matters]”; “Spiritual care was not their territory as student, it was a business that was far from them” In retrospect, they also regard same for their students and hence they do not teach spiritual care. This is what they said: “We were informed that to provide for spiritual need of the patient...”; “... but the spiritual aspects [of care] were done by the ministers and the pastors, we were informed that it is not a given platform for nurse”

3.4.2.2.3 Sub-theme three: Awareness, willingness and desire for spiritual care

The clinical supervisors expressed deep desire and willingness to engage with the subject of spiritual care and they were open to any possible means that would assist them in the implementation of spiritual care: They said: “May be we [clinical supervisors] should get such a thing [guidelines] that say no you can’t neglect that [spiritual care] it is very important. Their heightened willingness led them to realise that the practicing of spiritual care should start with their interaction with students. They recalled instances where a student would give appreciation if a supervisor had come through in the student’s aid. This is what they said: “You [supervisor] will realise [that] when the student says thanks a lot, you have done a great job by being there for me and you listened to me”. “You were there when I needed a shoulder to cry on. The supervisors believed that if they can care for students, in turn the students will care for patients. They expressed a need to be taught about spiritual care and how to instil meaning of spiritual values to their students. Participants believed that spiritual values may be one of the things that

might really improve the student's moral and professional growth especially in the nursing profession. This argument was based on the understanding that spiritual care deals with the inner part or inner person of which patients are often confronted with decisions or experiences of dealing with inner issues. This is what they said: *"It starts with an attitude of acceptable behaviour [of the supervisor]"; "We really need to be aware of such things because we often attend to the outside appearance and do not look at the inside as to why the student is not displaying acceptable emotions, appropriate caring values"; "So that when students talk to a patient at some point they would have to talk in a way that is supportive, motivating, encouraging or being there for the patient because they understand..."*

Clinical supervisors argued that when students understand that they work with patients who are not only human but also emotional beings, wherein if neglected can arouse discomfort and feelings of abuse. They also indicated that students must to talk to a patient because that can really make a difference to a particular patient. They believed that: *"Our [supervisor`s] positive interaction with students will transfer the caring skill to students"; "...student will be able to diagnose spiritual need(s) or ill-health from the patient if students are taught how to take note of the person's attitude that suggests spiritual ill-health"; "...no spontaneity or not happiness in comparison to spiritual healthy people — who are transparent, happy, at peace and easy going".* The need for teaching of spiritual care was realised not only as a possibility but also as of great necessity. Teaching strategies to guide students on how to diagnose spiritual needs were suggested. These include facial expression, reading the patient's eyes among other clinical signals that can indicate the patient's emotional being. This is what a supervisor will teach students: *"...So as a nurse you're not only looking at the physical wellbeing of the person. You look at the emotional appearance..."; "... but you can also sense the spiritual appearance of a person".* They made reference to a saying that your eyes are the windows to your soul; they indicated that students can learn how to evaluate patients' eyes. These are some of the clues the supervisors provided: *"...So you can immediately see in somebody's eyes what kind of person they are"; "... People can smile but their eyes are not smiling"* Therefore according to the supervisor, students would have to be trained on how to assess patients' spiritual needs on admission and continually. They would be taught to make the following observations: *"Assess the patient as he comes in, look [ing] at his emotional appearance. Is he sad? Is he depressed? Is he happy? Is he frustrated? Is he angry?"; "Then you [student] also bring in the aspect of spiritual but if the student is not on par with spiritual she may not / cannot see that in a patient".* The teaching techniques could also include the use of demonstrations of a

negative student's behaviour or attitude as illustrations to fellow students. Spiritual guidance can also be used as a teaching strategy. A student must be able to interpret his or her observations. For spiritual health, the students can look for clues as taught which may include emotions and gestures of kindness, friendliness, care, support, helpfulness, compassion, loving attitude and harmonious living for positive attitude. This is what they said: *"It's about heart attitude if it is good because you also can't see it but the attitude and the way you speak with people, your attitude, the gestures because that is part of your appearance"*

In contrast to positive signs of good spiritual health, students can also look out for negative signs which may include the following; a hateful attitude, negative behaviour, unaccommodative, not flexible, unapproachable, negative attitude suggesting spiritual discomfort. The clinical supervisor suggested that group facilitation for teaching spiritual care subject was ideal. This teaching method was preferred as ideal because it would provide students with an opportunity to learn from each other. Furthermore, it was assumed that group facilitation would also promote student's engagement through meaningful interactive and interaction and debriefing and reflective sessions. An example of this was provided as reflected below: *"Teachers can use their own personal experiences and ask the students if they have any similar experiences"; "Have you experienced in this way? Do you know ... if anybody else [in class] got the same experience, comes and [will] share it with the class"; "...So we can learn from each other experience"; "... and also some case studies..."; "...Maybe you [educators] can develop cases"*

A comment that the current model of teaching is not only prescriptive but does not provide a platform for spiritual care was highlighted. This current situation leads to a teaching practice where the clinical supervisor's spirituality or conscience is passed on to the nursing students through role modelling or as expressed by the supervisor. In prospect for teaching-learning process, case studies were strongly advocated for. In spite of all the challenges pointed out that students may encounter in the clinical placement, it was still viewed as a preferred learning environment for spiritual care than simulation. The reasons presented for this were: *"...It [teaching spirituality] is difficult by simulation, I mean within the skills laboratory" "When teaching spiritual care you really have to deal with an [the] actual patient to see what patients are going through..."* Although simulation was recommended as a method for teaching nursing subject in general, its potential hindrances of losing emotional feelings from the student's side were acknowledged. Therefore, it was not fully supported as ideal due to the potential lack of effectiveness. This is what was expressed: *"...students can learn a lot but the emotional, aspect*

is lost”. “Clinical learning in the hospital clinical settings to learnt procedures on real patients and stuff where students can feel with the patient is different from learning from the skills lab”. The participants concluded that theoretical components of spiritual care can be taught in class but clinical implementation cannot be done in a simulated laboratory. Despite the use of Simulated Patients Encounters (SPEs) it was argued that the SPEs cannot precisely mimic a real patient, so it would possibly be difficult to teach spirituality.

3.4.2.3 Theme three: benefits of spiritual care

Table 3.9 below presents theme three and related sub-themes on benefits of spiritual care as reported by the clinical supervisors.

Table 3.9 Theme Three: Benefits of spiritual care

Theme:	Sub-themes
3.4.2.3 Benefits of spiritual care	3.4.2.3.1 Benefits to the patient
	3.4.2.3.2 Benefits to the nursing students

The sub-themes below address benefits of spiritual care to patients and nursing students.

3.4.2.3.1 Sub-theme 1: Benefits to the patient

The ultimate aim of spiritual care was conceived as a means to instil peace on patients; a feeling of being at peace with the self-awareness of what is happening around and the ability to cope. Supervisors acknowledged that where spiritual care is provided patients are perceived to improve quicker from their illnesses. “...If they [patients] have peace then they [patients] will get better quicker”; “To ensure spiritual health, emotional well-being and patient’s well-being”; “It also makes me aware of all those things I can do for a patient”; “Once you [a nurse] start to inform them or remind them that there is God who have [has] an interest in you and wouldn’t plan for you to suffer they become very much motivated lightning up from [a] state of being depressed”.

Supervisors argued that when the spiritual needs of the patient are taken care of, the patient gets balance and is able to bounce back to normal life and come to order. “It is that gap that you [as a nurse] are feeling in there, the patient gets that motivation and encouragement to hope for something. Spiritual care in nursing was regarded as important in the sense that it assists the patient to get their life balanced. It was also acknowledged that spiritual care is

important when a nurse is caring for a person who is in need of prayer, support or seeking peace that the nurse should be able to meet. *“If they [patients] have peace then they [patients] will get better quicker”*.

3.4.2.3.2 Sub-theme two: Benefits to nursing students

Another benefit of spiritual care is how nurses feel after assisting a patient with something. *“...it makes you feel better and knowing that you are helping somebody else, and you are aware of that patient; maybe that patient says that she feels much better after you have done something. “Make me feel better when the patient feels better because of a positive response from the patient”* Clinical supervisors agreed that spiritual care in nursing entails that the nurse has self-awareness about how she or he feels and how she or he wants to behave in a certain context or circumstance or situation within nursing intervention. This is what participants said: *“Spiritual care is when as the nurse feels what the patient is going through”*; *“...When the patient feels better it makes me [the nurse] feels better because of a positive response from the patient”*

Such self-awareness is therefore viewed as important because it prepares the nurse to engage with the patient on spiritual matters. Self-awareness was also related to a notion where nurses reflect on how they also would want to be treated if they were a patient. In this way, the nurse can empathize with the patient. This was expressed as: *“...When the nurse puts herself in the shoes of the patient she can easily provide spiritual care, and she can internalize a view as how she would want to be treated when she is sick”*. The rationale for this kind of reflection was that if a nurse is at a different level with the patient and does not empathise with the patient, the nurse may not treat the patient properly. The nurse’s sympathy for the patient was regarded as fundamental in the provision of spiritual care. Self-reflection was further associated with the benefits where the nurse would feel better after treating a patient. A feeling that comes from knowing that as nurse has assisted the patient with something was a reward in a sense. This is what they said: *“...it makes you feel better and knowing that you are helping somebody else, and you are aware of that patient; “...maybe that patient says that she feels much better after you have done something...”*

Issues around recruitment and selection criteria for prospective students to access the nursing UG programme were identified as common sources of students’ worries and stress. These were identified as needing control in order to reduce students’ anxiety and frustration when in the programme. The clinical supervisors pointed out that they do not believe that the nursing

programme should be taken as a second option. To become a nurse, one needs to be that person from the get go. One participant said: *“If student tried for MBChB and failed or tried for BSc and couldn’t get in or tried for whatever and now oh, well, I’ll just be a nurse. That’s unacceptable”*. *“Selection criteria and yes, it is going to actually break some [heads] but you have to do that to bake a cake”*; *“So if the selection criteria are not only the science component to it will ...”*

Carrying of subjects should not be allowed and should not be tolerated. The fact of the matter is that the selection criteria for nursing and midwifery must take a different shape. This is what the clinical supervisor said: *“...It is really not... it is not everybody’s cup of tea”*; *“It is pointless to wait until the student is in second year and then tries for throughput and pushes something that is not going to fit”*; *“They [students] will be a triangle in a square or something”*

3.4.2.4 Theme four: need for spiritual care

The following theme and sub-themes present the most findings of the study as these respond squarely on the phenomenon of inquiry.



Table 3.10 Theme four: Need for spiritual care

Theme	Sub-themes
3.4.2.4 Need for spiritual care	3.4.2.4.1 Essentials of spiritual care
	3.4.2.4.2 Communication
	3.4.2.4.3 Patients’ felt needs

The narration on this theme of a need for spiritual care is provided below to show how the participants’ discussion and arguments were levelled against and around their perceptions regarding a need for spiritual care in nursing education.

3.4.2.4.1 Sub-theme one: Essentials of spiritual care

Spiritual care was perceived as a giving and receiving encounter. This meant that spiritual care can only be provided where both parties (nurse and patient) are willing to engage. If a patient is willing and open to spiritual care, the nurse may engage with the patient in different ways including but not limited to: praying for or with the patient, providing therapeutic touch, listening to the patient, advocating for the patient including taking a stand against ethical issues,

calling spiritual leaders and a family member, an Imam or a Pastor or anyone according to the patient's request, as well as attending to any request from the patient. The nurse may also give health education on spiritual issue(s) without judging or taking decisions on behalf of the patient as these might be against the patient's current choices. This will also avoid potential regrets by the patient should a decision made by a nurse on behalf of their patient not work.

"The nurse may first share her views about the situation without judging"; "The patient must [would have to] still take a final decision in case it was a social problem so that the patient will [should] own the consequences of the decision taken"; "If it is [about] a health matter she [patient] will [might] be guaranteed of the nurse's support for related medical and nursing interventions but final decision is the patient's responsibility"

The role of the nurse in provision of spiritual care is to encourage the patient and help the patient come out of their unpleasant state. Spiritual care was regarded as a vital component especially in psychiatric nursing when a mental patient is encouraged and gets strength to face the outside world and deal with the situation. Participants said: *"If the inner men get[s] a boost or courage and then the patient would able to deal with the situation"; "...they [patients] are pulled out of that corner"*. Despite the clinical supervisors' portrait of differing views regarding what spiritual needs entail, they depicted similarities to confirm that spiritual needs are a reality in nursing. *"Hospitalised patients who are under crisis, stress or sick are in need for spiritual care"; "I learned as a student that spiritual care is important and I must treat patients holistically but"* The clinical supervisors reported that spiritual care is needed for hospitalised patients who are under crisis, stress or sick. They stated that as students, they learned that they must treat patients holistically. However, regarding spiritual needs of the patient,s they were informed that only ministers and pastors were legible to execute spiritual care because it was not an appropriate platform for nurses. This is what was expressed: *"I have notice that people [patients] are longing and looking for something that will lift their hope that will give them courage that will take them higher from where they are"; "Once you [a nurse] start to inform them or remind them that there is God who have an interest in you and wouldn't plan for you to suffer they become very much motivate lightning up from state of being depressed"*

All supervisors acknowledged that the need for spiritual care in nursing is a reality and it is necessary.

3.4.2.4.2 Sub-theme two: Communication

The clinical supervisors highlighted the importance of good communication between them and students. They believed that if they would demonstrate a caring nature to students through good communication, they would transfer the same caring nature to students especially if they are listened to when they report their learning challenges and problems. Listening was depicted as necessary for any human being. This is how it was pointed out: “...sometimes we run around looking for someone to listen to us”. “Here we are, we are teaching students and they go through such emotional things but when they need someone to talk to, to listen to them, to say what they’re going through they cannot find it. If we can really attend to such things I think it will help them”. Readiness to listen to what students say and describing the reasons why they chose nursing allows one to find out where they come from. But if those things are not attended to and just covered up, it would not help because of the intense emotional pain felt.

Therefore, caring for students’ personal needs by supervisors was viewed as a means not only to help them understand how students feel about the programme, but also most importantly instil caring skills which improve their learning experience and understanding of patients and their needs. This is how this view was expressed: “...because if we [clinical supervisors] don’t really listen to them [students] what they are experiencing, how they feel, ...and then we [clinical supervisors] don’t resolve whatever issues that they are experiencing then how are they going to understand another person?”; “How are they going to take time to listen to the sick person that is lying there? ...Because sometimes you come across a patient that would say, all I need is for you to listen to me”; “When I talk by listening to a person it means a lot to that person. By listening it allows the person to open up [i.e. to vent]. Allows the person to cry with you and it means a lot”

The clinical supervisors were asked how spiritual care can be taught. Midwifery clinical supervisors advised that in addition to counselling skills that students are currently taught, it would be best to teach spiritual care conventionally. The clinical supervisors for Fundamentals of Nursing Science (FNS), which is a first year nursing subject, pointed to the need to use interpersonal skills (IPS) learning sessions beyond one semester in the first year but throughout the four years. He believed that IPS can strengthen students’ spirituality because they can discuss their experiences with the lecturer or supervisor. He related his view to the fact that: “We start it [IPS] now at first year level. So you [students] should grow with it throughout

your career of nursing”; “Not to be viewed or seen as something that is for a term and then you are done with it.

Congruent to what nursing student participants had said that in clinical placements they experienced deaths and when they discussed their experiences with educators they felt spiritually cared for, the clinical supervisor said that students need to be cared for in order for them to care for patients. The clinical supervisor believed that caring should start with educators caring for students. Once a student feels cared for, she will always think of the patient in the same way. Because if they do not care about the students how are the students going to care for the patient? The clinical supervisor said: *“Let’s start caring here, care for students; ...because for those moments you are taking care of the student’s spirituality”* ; *“If your [students] spiritual needs are not attended to you’ll [student] break down because you are a human at the end of the day”*; *“You’re [clinical supervisor] taking care of because it doesn’t mean that if you’re in a nursing profession you are an iron you should [cannot] not break-down”*; *“No, spiritually, you need to be attended to, taken care of and be strengthened”*; *“...because they [students] are here and we are the first people that they should come to and if we neglect them then we really would miss a lot. It would be difficult for them [students] to deal with patients because really in nursing you [one] need[s] know your [one’s] really values, how your [one’s] attitude should be..., you know. You should be understood and be an acceptable individual”*

Clinical supervisors proposed better communication with students as a goal to work towards. Learning of communication skills should be extended to all year levels. This would require clinical supervisors to find out more about any issue presented by the student. They may need to call the student to find out if any improvement has been observed and refer the student if needs be. That shows that it is listening that complements caring at the same time. *“Because if I just listened, okay, it will be ok for now, it is over. If the student sees you [clinical supervisor] tomorrow and you have totally, completely forgotten that I [student] was crying tears in your office...”*; *“But if I listen with care every time I [clinical supervisor] will keep on checking on you [student], how are you doing? Are you getting any assistance there? Does this help you? Every time when you need to talk I’m there for you this is a type of listening that I’m referring to in this case”*

Listening is really one response that complements caring. Clinical supervisors indicated that awareness is the key and this may benefit the practicing nurses as well. If students understand

the importance of talking and listening to a patient, they can spend those ten minutes next to the person because at some point the nurses are not doing anything important. So if the sister sees the student standing there with the patient, they would find out why instead of scolding the student. This is how they said this: *“If they [nurses] know the power of listening; the power of being there...” “When the patient asks something you are there and then you listen and you show that you are not in a hurry”; “... and also let them [nurses] aware that you [the nurse] are as nurses they are neglecting their spiritual care. Because whatever [physical care] that is done might not really do anything for the patient if the inner person that you’re dealing with is neglected and you’re focusing on medicine”*

The point here was that nurses should not only focus on everything else and ignore talking to the patient to find out how they feel. How did they sleep? What do they think can be done today? Listening and respecting them and their values by respecting what they say. Nurses should not think that patients should not be listened to. A patient is a human save for that current state of being a “patient”; but they are still a human being at the end of the day. Whatever the patient tells the nurse, he or she must be effectively listened to and not just listened to for the sake of listening.

They reported their concerns about the attitude displayed by students and supported the need to address issues around a need for spiritual care because the nurses deal with such patients’ needs on a daily basis. The need to treat others humanly and behave as a human being was pointed out as core necessity in nursing care interventions. Such an argument was related to the participant’s expectation that a nurse should have good caring skills, and knowledge because if the nurse’s attitude is not positive it poses challenges. The participant’s assumptions that students are taught how to behave and or moral behaviour from their homes underestimated the reality that students come from different backgrounds. This is how this view was expressed: *“It was my first time that I’m really doing this module on communication skills; it taught me a lot..., that’s why I’m saying that you have to understand that you are dealing with people [students]”; “... How little things can really cause a lot of trouble or can make a big issue. Little things that we underestimate ...those things are powerful as I said, listening, caring that we take it for granted. “...and then often times our students say, our lecturers, they don’t care about us. Once a student says it’s over. You need to know that you’ve lost them.... where are they going to get the drive to carry on? So as facilitators really we need to be aware of such things”*

The clinical supervisor argued that caring should start with them caring for the students. This was viewed as potentially transferable to patients in the sense that they would in return holistically care for patients.

3.4.2.4.3 Sub-themes three: Patients' felt needs

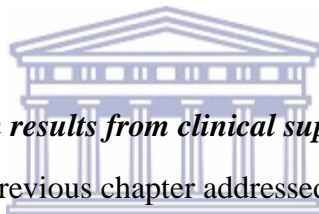
Supervisors acknowledged the need for spiritual care in nursing as critical and they pointed out to various reasons why a patient would need to be cared for spiritually. This includes spiritual needs when a sick person is feeling down, lonely and hopeless asking themselves questions such as “why me” through which they lose hope. These negative feelings were described as requiring spiritual intervention from the nurses. This is how they projected this view: “...required when a sick person is feeling down, lonely and hopeless”; “Required to.... when [a patient] is asking himself questions like why me”; “Required when a sick person lose[s] hope to everything and is fearful”

They urged that nurses need to pay attention in finding ways to engage patients on spiritual matters. In their view, spiritual care is more about handling certain situations including provision of spiritual health education and complete holistic health for the patient. Spiritual health, emotional well-being and patient's well-being were purposive patient outcomes to indicate that the patient is improving from the illness. Spiritual care was acknowledged as an important nursing intervention in psychiatric nursing particularly as it focuses on psychological and social issues from which most chances for spiritual needs emanate. They said: “When patient's spiritual needs are taken care of the patient becomes grounded and gets back to original state he or she was before becoming ill” This positive effect of spiritual care was awarded to the understanding that when caring for the spirit, the person's beliefs and intimate issues get addressed. As a consequence, to that view, the nurses' responsibility to provide spiritual care to patients was perceived as critical. They affirmed that nurses should pay attention to spiritual needs of patients and find ways to engage with patients' spiritual issues or matters. “...It's more about handling certain situations”; “... Also [it is needed] for spiritual health education of the patient” “... [Providing] complete holistic health for the patient”

The clinical supervisors shared how psychiatric nursing relates to spiritual care and they indicated its need in nursing care interventions. They argued that different psychiatric diagnoses and different reasons for psychiatric illnesses usually provide grounds for spiritual care. These reasons were provided as to why spiritual care is important in psychiatric nursing: “...for some patients it's disappointments and self-pity for others”; “They are depressed for

different reasons”; “They are worried of what other people are saying about them”; “Spiritual care becomes necessary because if everything else has lapsed [meaning has been lost] and only their spirituality inside them as an internal thing...”

The connection between spiritual needs and spiritual care was argued on the basis that spirituality is about a person’s inner man; meaning his secrets and intimate life. Supervisors also pointed out that nurses need to understand why psychiatric patients are admitted in the hospital as a means to direct spiritual care interventions. For instance: “...*They [patients] have self-pity*”; “*They are worried of what other people are saying about them, so they are feeling that pity for themselves*”. It was indicated that knowledge on why a psychiatric patient is admitted was the basis for caring for the patient. An issue where a patient has perceptions that other people have a particular view about him or her was pointed out as one of the challenges that psychiatric illness presents. This is how they put this: “... *it [the perception] brings to the patient ill-feelings and self-pity which they become stuck in if there is no one or anything to pull them out*”



3.4.2.5 Integrated discussion on results from clinical supervisors

The integrated discussion of the previous chapter addressed some of the issues that also apply to results from the clinical supervisors. It is acknowledged that those issues that were already addressed will therefore not be dealt with again in this discussion. Where applicable, reference will be made to previous result’s discussions. For an example, referencing challenges about the definition of spiritual care to portray seriousness and challenges on the matter. Issues that are not addressed here as they were addressed in the previous chapter include the following: (i) spirituality as a caring value, (ii) inherent nature of spiritual care (iii) conflicting issues including professional boundaries. The following are included in this discussion: (i) the caring aspect of nursing, (ii) spiritual care as an aspect of holistic nursing, (iii) spiritual care as a precursor for spiritual care, (iv) characteristics of a spiritual person including “good role models” and “willingness to engage in a patient’s spiritual matters and challenges” as well as “implementation of spirituality” will also be addressed. To some degree, the difference between religion and spiritual care will be addressed as this was one of the outstanding concerns from study participants.

Watson (2001) views caring as highly intertwined with nursing. However, caring in essence requires deeper connection with the self and with the patient. Caring as an aspect of holistic nursing should provide for patients’ spiritual needs, beliefs and emotional well-being as

primary areas in nursing (Tjale, 2007). This means that caring attitude should be at the core of meaningful nursing interaction and intervention. Caring holistically relates to nurturing of the “whole person” that is body, mind and spirit. Kotze’s (1998) anthropological model is holistic. Caring for the “entire being” which embraces the “wholesomeness” of humanity is recognised in Kotze’s (1998) model in which bio-psycho-spiritual dimensions of the human are addressed. Kotze (*ibid*) attests to the view that caring for the whole has health related benefits. Andrews and Boyle (2012) concur with this view of holistic approach to care stating that harmony in the body members leads to health whilst disharmony will result in ill-health or illness. Spiritual care approach supports holistic care which completes the notion of caring for “the whole”.

Spiritual awareness about own spirituality by the nurse promotes attention to patients’ spiritual needs. Monareng (2012: 4) in her study on analysing the concept of “spiritual nursing care” discovered attributes of “caring presence” and “harmonious connectedness” among others which are indicators of spiritual care. Daaleman, Usher, Williams and Hanson’s (2008) study participants attest to experiences of co-creation as they journey with the patient, which supports the attributes from Monareng’s (2012) study. Caring spiritually can mean advocating on behalf of someone (Meiers & Brauer, 2008: 110) which is the nurse’s moral responsibility as argued by Post, Puchalski, and Larson (2000). In one hand, if nurses are not well prepared in this type of holistic care, nursing can not materialise (Narayananamy, 1993). On the other hand, Burkhart (1989) argues that when patients face significant physical needs, their mind and spirit may be ill as well. However, many authors acknowledge that nurses should not be compelled to provide spiritual care as this may cause discomfort. However, there is also evidence that nurses are in every way ready and willing to learn how to provide spiritual care (Lewinson, McSherry & Kevern, 2015). Baldachinno (2008b), McSherry and Jamieson (2011) also point to a widely received need by nurses to provide spiritual care which goes beyond conception of spiritual care as belief and faith in God. This view is of primary importance to note as it expands on the study participants’ views that associate spirituality with God, Supreme powers and a higher being, primarily as such close views would discredit the intention and aim of this study which was to develop a theory that will cater for all spiritual species.

Timmins and Neil (2013) argue that the challenge in the education of spiritual care is caused by lack of direction from nurse educators. Thus, clarification of the concept of spirituality is vital in spiritual education to enable nursing students to see how spiritual care plays a part within holistic care. Dyson, Cobb and Forman (1997) warns against the restricted view on spirituality that it may down play the effects of spirituality on individualised care by

overlooking not only relationships and interactions but also other related attributes including hope, meaning and belief as experienced by patients. The concept accompaniment points to a similar notion of the role played by importance of contextual relationship (Kotze, 1998). The spiritual care model such as bio-psycho-socio-spiritual model, inter-professional spiritual care model can be used (Kotze, 1998). Education of spiritual care can be arranged in a manner that makes learning possible and effective for the student.

Authors including Lewinson (2015) point to the need for nurses to connect to the patients or clients which should be a focus area when teaching spiritual care. A model for development of therapeutic relationships that are truly patient-centred is of paramount importance. These models can be used to train students on how to provide spiritual care (Puchalski, 2009: 890). Education of spiritual care should clarify differences between emotional needs, psychological needs and spiritual needs as these are often confused and synonymous, which may lead to misdiagnosis. The learning process should begin with spiritual history taking and assessment which can then be followed by planning and implementation of the plan which is evaluated similar to mother nursing interventions.

Spiritual history and assessment are crucial aspects of spiritual care provision and they should be done without intimidation. A broad set of questions can be posed that point to spiritual concerns (Puchalski, 2009: 893). History taking tools such as Faith Beliefs. Importance Community Address in care (FICA), Spiritual belief system, personal spirituality, ritual restrictions Implication and Terminal events (SPIRIT) and Hoped organised religion personal spirituality (HOPE) (Puchalski, 2009: 893) should be included as part of spiritual content. Many authors point to various spiritual subject contents such as communication (Baldachinno, 2015), caring and meaning of suffering (McSherry, Kash & Ross, 2004), development of morality (Goldberg, 1998), and differences between spirituality and religion (McSherry, Kash & Ross, 2004; Markham, 1998;).

Challenges in implementing spiritual care in education and practice are numerous. Research findings present these issues to alert nurse educators and practitioners should they be willing to embark on spiritual education and practice. A qualitative study to investigate the extent to which spiritual care is addressed in nursing education of nursing students revealed that nurse educators did not define spiritual dimension in their programme yet they did not have difficulty in integrating it into current programmes because it entails basic nursing which they teach but do not define as spiritual (Olson, Paul, Douglas, Clark, Simmington & Goddard, 2003). This

notion is supported by Lemmer (2002) who conducted a study to investigate how spiritual care is taught. It was discovered that nurse educators did not have any issues because they viewed spiritual care as part of nursing. Lemmer concludes that nurse educators have a critical role to play in teaching nurses to understand their role in spiritual care which is supported by Nandi and Rhooda (2011) that spiritual care is similar to basic nursing care but valuable to the patient.

Awareness of the patient's spiritual needs will increase nursing students' knowledge and confidence in providing spiritual care. The need for spiritual care is affirmed by many authors including Baldachinno (2010); Taylor, Mamier, Bahjri, Anton (2008); Mitchell and Hall (2007); Lewinson *et al.* (2015: 318) who discovered that spiritual dimension in nursing is an established concept and that nurse educators are willing to teach it. However, the authors agree that on-going preparation of nurses in providing spiritual care is needed to ensure long term value and effectiveness.

Personal spirituality is a basic quality which underpins every nurse-patient relationship. It is a key in achieving spiritual competence. This notion is supported by Meyer (2003) who attests that the strongest predictor of perceived capacity to provide spiritual care results from own spirituality. In contrast to perceived capacity for spiritual care, formal education on spiritual care can cultivate competence and increase confidence in students by providing spiritual care (Baldachinno, 2008a). The notion that spiritual care is not taught but caught was evidenced in van Leeuwen's (2008) study findings which revealed students' reflections to show that their spiritual awareness increased and confidence developed from clinical practice. Nurses should possess personal characteristics such as good interpersonal skills, and communication. Professionalism, as basic aspects of care, should be provided to teach students how to speak in an interactive manner during their interventions with patients. At later stages it can be honed to counselling and therapeutic skills. Rogers's client-centred to care is a non-directive approach where carers have a supportive attitude that models human values and acceptable communication as advocated (Rogers & Love, 2007). This coincides with the findings of this study where clinical supervisor participants emphasised that the special personal quality is of great importance if teaching and learning of spiritual care is to materialise. Similarly, the nursing students in their focus group discussion had argued the same factor that personal attitude, interpersonal skills and how communication is conducted between them and nurses in the wards would protect them from humiliation, discouragement and offensive feelings they get which make the clinical settings as a toxic and dehumanising environment.

Basic caring values refer to sharing in human experience and through nursing interventions where empathy, and sympathy are directed at helping “the other” based on the understanding of the situation (Hessel, 2009: 276). This view is supported by van Leeuwen’s (2008) argument that spiritual care is underutilised in nursing practice and patients receive little attention. Nurse-patient relationships can promote spiritual care. Where the nurse is close to the patient, they can assist them through understanding of their fears, worries or simply a need to talk, need to pray or perform religious and or belief rituals (van Leeuwen, 2008: 12).

Spiritual care entails spending time with the patient, giving support and reassuring which allows that patient to find meaning, purpose and hope whilst in an adverse situation. Other interventions that constitute spiritual care include listening to patients, allowing the patient to talk and express fears and worries, anxieties and troubles, as well as providing respect, privacy and dignity by attending to religious and cultural needs or beliefs. Clarke (2015) views these interventions as fundamental in nursing and should be easy to address. Spirituality is an integral part of every person which makes it a basic virtue that all humans have (Meyer, 2008; van Leeuwen & Cussveller, 2004). The qualities of a spiritual person include willingness to talk with the other, assist, listen or extend one’s self to the other, being present, holding hands, offering water or tissues, allowing time for silence as this gives the other person time to collect themselves and apply their mind and soul to the matter they are dealing with.

Issues around implementation of spiritual care are multidimensional; they extend from person perception to institutional and policy related constraints. A view that spirituality is viewed as personal and a private matter has prohibited implementation of spiritual care. Some of the challenges in implementation of spiritual care emanate from the use of the scientific model of care. The introduction of scientific era in the twentieth century resulted to nursing moving away from a caring stance which was rooted in spiritual philosophy of care. Introduction of technical-based care, which has advanced to high-technology care (Breier, Wildschut & Mgqolozana, 2009: 16) also has an influence in the loss of the caring values.

However, Bradshaw (1994) calls for a re-orientation of nursing back to its roots as a calling. Ross (2006) responds to this notion saying that spiritual care matters should be attended by the nurses. Therefore, any barriers to discussion of spiritual and or religious matters and avoidance of religious discussions must be confronted. Wright (1998) alerts to sensitivity when approaching patient’s spiritual matter especially when the patient feels vulnerable, nurses should avoid intrusiveness. Ross, van Leeuwen, Baldachinno, Giske, McSherry,

Narayanasamy and Schep-Akkerman (2014) point to a lack of policy in health care to guide the practice and education of spiritual care which exacerbates the issue. McEwen (2005) and Lemmer (2002) also alert to the need for sensitivity to patient's religious background and related conversation to avoid discomfort. Other authors advise that the nurse should be guided by spiritual cues especially in diverse settings (Bhurkharth & Hogan, 2008; Narayanasamy, Clissett, Parumal, Thompson, Annasamy, & Edge, 2004).

Taylor, Highfield, and Amenta (1999) argues that when the individual is comfortable with proving spirituality, there are no ill-feelings because spiritual care is not equal to religion. Task intensive nursing approach may cause neglecting spiritual care (Carr, 2010; Ross, 1997). A study conducted by Du Plessis, Koen and Bester's (2013) affirmed spiritual care as a basic non completed intervention especially where it occurs spontaneously. Du Plessis *et al.* (2013) findings of the study conducted with final year psychiatric nursing students showed that spiritual care occurred indirectly as part of their caring through respect, active listening, sympathy which were at play during home visits. Coincidentally, the family and psychiatric nursing students who participated in the study shared Christian values as they all belonged to the Christian faith. This notion of simple actions such as presence constitute spiritual care and are perceived as spiritual interventions, as acknowledged by Clark (2014) Wallace *et al.* (2008); Jackson (2004); Sawatsky and Pesut (2005). This affirms Hall's (2005: 1) view that nursing is dynamic and evolving and as consequent to that, its theoretical and practical knowledge must also evolve.

Awareness and willingness to participate in spiritual matters is influenced by understanding of own spirituality. Nurses should be willing to partake in patient's diverse needs irrespective of the cause for the need. Awareness about own spirituality and willingness to engage in spiritual matters is a basic positive attribute on which spiritual care flows. This means that where nurses are aware of and comfortable with their own spirituality, they can provide spiritual care without difficulty. They connect easily with each other and with patients which expedites healing and recovery. Awareness about patient's spiritual needs can shape the nurse's attitude about self-sacrifice, solemnity, kindness, love, openness, readiness to help, diligent observation, intervention and use of own body language as part of communication. Some of the required characteristics of the nurses are to keep respect, be humble; be trustworthy and willing to provide emotional support to patients. The need for spiritual care should be perceived as important for patients' well-being and being healthy as these exist in a continuum as a dynamic

nature of human beings. Hence provision of spiritual care should be aimed at restoring hope and meaning to the patient (Mackinlay & Trevitt, 2007).

Literature is increasingly pointing to various benefits of spiritual health in health and healing (Tanyi, 2002). The benefits of spiritual care as a vital indicator of health status, is one broad encompassing benefit in health and healing such as finding hope, meaning and purpose in times of crisis. Spiritual health is a fundamental measure to a sick person as it provides strength to face adversity, increasing coping mechanisms (Polzer & Miles, 2007; Logan, Hackbusch-Pinto & De Grasse, 2006; Keeley, 2004; Ferrel, Smith, Juarez & Malancon, 2003; Marshall, Olse, Mandloco, Dyches, Allred & Samson, 2003).

Puchalski, Prabhakar, Jiao, Berns, B. & Davis (2010) study findings revealed that people who are spiritual tend to live longer. Puchalski (2001) argues that the elevation of IL6 plays a role in improved mortality. She associated reduced IL6 levels with increased levels of disease. A study that investigated 1700 participants found IL6 to be half elevated participants who attended church. Another study on pain questionnaire, found that people who pray did not only cope with illness but prayer was most commonly used as a non-drug method to control pain. Spirituality increases coping levels or strength when faced with an adverse situation. People turn to spiritual values to help them cope with or understand their condition (Puchalski, 2001: 353). Spiritual commitment enhances recovery from illness. The power of hope appears to be a factor where one worries less and focuses on positive thinking.

3.4.2.6 Conclusion statements on results from clinical supervisors

1. Teaching and learning of spiritual care should be facilitated in a manner that prepares students on how to instil peace in patients by reversing the de-humanising approaches to care; through effective communication and relationships that promote spiritual guidance, debriefing, intuition, self-awareness, emotional health and well-being of patients.
2. A need for spiritual care is embodied in willingness, commitment, and agreement in gesture or vocalized to engage in spiritual matters where communication is regarded as talking therapy associated with the patient's feelings of enhanced self-fulfilment, self-satisfaction and self-awareness as well as being in control.
3. Spirituality is an inherent virtue in all human beings and is a precursor for spiritual care.

3.5 CHAPTER SUMMARY

The chapter provided the findings from the nurse educators and clinical supervisors. It also provided how the challenges were managed. Further narrations on how each theme and sub-themes were constituted by participants were discussed. An integrated discussion was provided at the end of the findings' presentation. Lastly, the chapter presented integrated literature review in discussion of the findings and chapter summary.



CHAPTER 4: RESULTS FROM FOCUS GROUP DISCUSSION: NURSING STUDENTS

4.1 INTRODUCTION

This chapter presents the findings from the focus group discussion followed by literature integrated discussion. The chapter will highlight the following: materialisation of data collection process with regards to the sample and sampling technique, data analysis methods and rigour. A table of the comprehensive themes from participants will be provided after-which respective themes are also provided in tables with sub-themes and respective quotations. Conclusive statements that were from empirical data using deductive logic are presented. Finally, a chapter summary is provided. Below is a presentation of the process of data collection from the student participants.

4.2 MATERIALISATION OF DATA COLLECTION

In this section, the actualisation of data collection process is presented. On the set dates and times for data collection, the researcher met with individual groups of students according an agreed schedule. Nursing students were only participated in data collection if they met the requirement for inclusion criteria which was presented in Chapter 2.

4.2.1 Data collection using focus group technique

After students were invited and accepted for participation they were enrolled in the participant's list which was used to arrange appointments with students for data collection sessions. Students were given a few days to a week to indicate their willingness to participate in the study. The researcher continually updated the participants list as students affirmed or tendered apologies to be absent from focus group discussion.

4.2.1.1 Administration of Focus Groups

A total of nine focus groups comprising seven to ten individuals in each grouping of nursing students were conducted. Five focus groups from the year levels one (1) and two (2) and four focus groups from the year levels three (3) and four (4). The nursing students from different groups in the programme but of the same year level of study were allowed to partake in any of the focus groups scheduled for that particular year level of the undergraduate nursing programme. Therefore, there were no restrictions in placing students according to their

respective class groupings of their year levels for discussion purposes because they were regarded as “a class of 2012”.

Homogenous focus groups within their respective year levels were formed. The aim was not only to promote group cohesion and effective discussion decreasing conflict and unnecessary disagreements pertaining to shared information during discussions, but also to collect large amount of information within a shorter time. This nature of grouping participants was driven by the fact that it would be easier for students to dialogue based on their similar experiences about the phenomena under study. Relevant information about the use of focus groups in this study was provided in Chapter two (2). It was not always possible to contain all ten members in all the groups. The number of members per focus group varied between seven as the lowest and ten; seven being the lowest and ten the highest.

Teaching venues and the school boardroom were used as alternate venues which were convenient to participants because they were interviewed during lunch break. Students signed a confidentiality binding form after an information briefing session according to the university procedure for research ethics requirements. An interview guide was used with probing questions, prompts and cues to facilitate and control the data collection process.

- **Setting the scene for data collection from nursing students**

The researcher greeted and welcomed all student participants who then were given the opportunity to sign informed consent forms after brief information was given by the researcher (Kvale, 1996). The researcher made an announcement about their rights as study participants and gave information regarding the interview process. In-depth interviews were stirred by posing the question *what is your understanding of spiritual care in nursing?* The question was open to allow participants freedom to speak from their perspective. Prompts and cues were used in cases where the participants were not very forthcoming. Data generated or gathered (Lincoln & Guba, 1985) was used to develop a practice theory.

The researcher read out to the participants the information sheet of which every participant had a copy. The purpose of the data collection session was clarified once more. The intention was to recap and remind participants about their rights as detailed in Chapter one (1) section 1.11. Once the researcher had finished the administration, which was done with each focus group as a way to check and reconcile the participants in attendance and the booking schedule the focused interview discussion commenced. When all focus group members had been identified,

they signed individual informed written consent and focus group binding forms. Participants counter-signed for each other respectively. Examples of the consent and focus group binding forms are provided as appendix 4 and 5 respectively. When the administrative management of the group was completed, the researcher alerted participants that she was going to turn-on the recorder and pose the interview question.

4.2.1.2 Challenges with Focus Group Interviews

Challenges that were experienced included unforeseen circumstances from the students' side. Another challenge was students who came after forty (40) minutes of commencement of the discussion who were not allowed to partake in the discussion. Prohibiting late students from participation was used as a measure to protect both the prospective participants and the members of the focus group that was in progress; not only from possible distraction but also emotional discomfort that could result from lack of understanding or misunderstanding to follow of point of discussion already discussed, referred and even concluded during earlier discussions. Other reasons related to two potential participants who did not turn up altogether. They had tendered their apology for absence in order to attend to a bursary application session and attending to a sick child respectively, as these were urgent matters.

The discussion proceedings of the latter focus group which had the shortest discussion time is not included in the analysis. The rationale for not including data from this focus group is based on two factors; firstly, that discussion time was insufficient and secondly, the focus of the content of their discussion was based purely on religion and church experiences. Consequent to the researcher's attempt to rescue the discussion by briefing, explaining and re-orienting the group; the group experienced a hard start to resume the discussion. The researcher's discretion was not to pursue or push the group for further discussion as it had become very clear that the group had difficulty in making a mental shift from its initial mind set. The participants were informed about available services for counselling or emotional support should there be a need. Availability of counselling and support services for emotionally discomfort was announced to all nursing students; however, this particular group might have experienced the need. This was provided as a measure to prevent or address any potential harm to the participants. None of the focus group members approached the researcher during or after the group discussion.

4.2.1.3 Conducting Focus Group Discussions

Focus group discussions with nursing students were conducted during the orientation programme at the beginning of the first semester in 2012. The timing for data collection worked well for students and it was of great advantage to the researcher because students did not feel rushed; as they often do when they are asked to participate in any activity that does not yield marks or credits to their learning. Most focus group discussion sessions lasted about 45 minutes on average; the longest was 2 hours and shortest 30 minutes. The latter which is the shortest discussion is addressed above in section 4.2.1.2 under challenges with focus group interviews.

The researcher provided a brief introduction to contextualise the participants to the data collection session. The participants were then allowed to respond, answer or share their views on the matter under discussion. To maintain order and smooth sequencing of discussions, the researcher requested participants to introduce themselves as number 1 up to 10 or to the last participant in the group. Whoever spoke first was number one and the next would be number two and so forth. Assigning numbers was an automated process which took place in all focus groups. This was important for the researcher in case a need arose to follow a line of thought of a particular participant but more importantly it was also necessary in case of disagreements among the group. The voice of each member in focus group discussion was conceived to represent universal opinions, thoughts and experiences. Oneness of the focus group discussion was important to each member in the focus group as this represented a universal voice of group members. After focus group discussions were completed, the researcher thanked respective groups and switched off the tape recorder.

- **Facilitation of focused group discussion**

Focus groups (FGs) discussions were facilitated by the researcher who also moderated discussion process to ensure that all participants shared accordingly. The researcher also managed the group and its process ensuring time keeping was kept and used effectively, also giving an opportunity to participants who could not jump into conversation as the discussion progressed. The researcher also made follow up questions on issues that were not well addressed during the discussion making participants aware to further explore the point of discussion, conclude or change to another topic. The researcher's role was multifaceted including interviewing function, moderator and group administrator. As a result, students were engaged in discussions without being preoccupied with other academic or class related

activities such as a need to complete assignments, presentations and studying for a test. Each focus group discussion was held as planned.

- **Support to nursing students as participants**

The participants' physical and emotional safety was ensured by encouraging them to report any untoward feelings and or emotional disturbance during the interview and at least two to four hours after the interview in case of latent effects. However, should any untoward reaction be experienced, the participants would have been referred to the University Campus Counseling Unit if the researcher's intervention was not effective in addressing the matter. A contingency plan was for an alternative person to conduct interviews with those participants who would not feel at ease or comfortable to be interviewed by the researcher (who was also a colleague to them) was prearranged ((Burns & Grove, 2011).). A neutral academic researcher who had prior exposure to spiritual care subject matter was on stand-by to conduct the interviews if needed. However, all participants were comfortable to be interviewed by the researcher.

- **Probing**

When the question had been posed to student participants, the researcher probed further in case where the participants had run dry and or lost track of thoughts. Participants were allowed to talk freely to share their understanding regarding the phenomena under study. Field notes were taken by the researcher and interviews were audio-recorded.

- **Moderating the interviews**

Moderation was done by the researcher by asking clarifying questions during the interview process. The researcher followed guidelines including repeating a question to the participants. Congruency of what is said and non-verbal expression would be necessary to validate what the participants meant. Interviews were moderated by the researcher where a participant had not made him or herself clear in what was being shared. Probing and cues were also used where indicated.

- **Field notes**

The researcher made hand-written notes during the interview. The purpose for this was manifold including keeping active listening; making follow up comments as well as supplementary information as key points or overview of the discussion should there be a need to ask probing and clarifying questions from the participants.

4.3 DATA ANALYSIS

The Atlas Ti7 computer programme was used in phase one (1) steps one to three to manage raw data into emerged themes. Data analysis was further analysed and synthesised using Tesch's (1992) reasoning strategy. Qualitative principles that were applied were discussed in depth in chapter two (2). Rigour was maintained by ensuring that quotes, memos and families that were developed from empirical data using the AtlasTi7 programme were reduced in accordance with the processes as outlined by the programme instructions. Inductive-deductive reasoning was applied. Tesch's (1992) coding method was used to arrange categories, patterns and themes. Trustworthiness elements including credibility, confirmability, dependability and transferability were applied ((Burns & Grove, 2011). These are discussed in depth in chapter one (1) section 1.10.1 and chapter (two) 2 section 2.7.

4.4 RESULTS FROM THE FOCUS GROUP INTERVIEWS WITH NURSING STUDENTS

Notably, participants represented spirituality and spiritual care as possessing a mutual and inextricable relationship. Such a relationship was indicated through compulsive need by all participants to describe and explain spirituality in general context before they could relate and apply it in a specific health caring context in which giving and or receiving of spiritual care was perceived as dependable on the individual's spirituality. This relationship between spirituality and spiritual care was portrayed as constant and proportional. Comprehensive themes are presented in a table below after which a general discussion is presented on the data collection process as it was experienced by the researcher. Themes emerged from focus group discussions with the nursing students are presented in the section below.

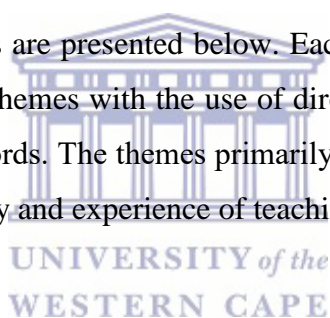
A table below presents comprehensive themes that emerged from focus group discussions with students. These themes are later presented in their respective table followed by sub-themes and thick descriptions to support the themes.

Table 4.1 Comprehensive themes from focus group interviews: Nursing students

Theme	Sub-themes
4.4.1 Defining spiritual care	4.4.1.1 Spirituality as connectedness
	4.4.1.2 Spirituality relates to being connected to inner self through a belief
	4.4.1.3 Spirituality implies connectedness to own emotions

	4.4.1.4 Spiritual care and connectedness to own personal motivation and energy
4.4.2 Relational connectedness / inter-connectedness	4.4.2.1 Spirituality as foundation for spiritual care
	4.4.2.2 Implementing caring values
	4.4.2.3 Connecting to someone at social level
4.4.3 Teaching-Learning of spiritual care	4.4.3.1 Personal experiences about learning of spiritual care
	4.4.3.2 Perceived challenges in implementing spiritual care in nursing
	4.4.3.3 Perceived conflicting nursing perspectives
	4.4.3.4 Student's recruitment-selection gap
	4.4.3.5 Lack of continuous integration of teaching in spiritual care

The three themes and sub-themes are presented below. Each theme will be briefly discussed and further discussed under sub-themes with the use of direct quotations to support emerged themes with participants' own words. The themes primarily provide insight on connectedness as the core construct of spirituality and experience of teaching and learning of spiritual care at the school of nursing.



4.4.1 Theme 1: defining spiritual care

Most students reflected on their own lives in order to recall on general knowledge about the concept of spirituality which was a point of departure in almost all discussions. It was obvious that participants could hardly embark on the concept of spiritual care that was under discussion without them having to first talk and unpack their understanding of spirituality in general. Participants presented spirituality as a vital component and requirement or source from which “spiritual care” or “a caring nature” comes from. Such an urge for the students to want to first give their personal experience was pointed out by authors including Baldachinno (1999: 557) and Pesut (2005) who proclaim that spirituality begins with a person. Accordingly, unpacking spiritual care as an aspect of nursing practice after how it was experienced is supported by these authors. After the students had shared experiences from ‘their own life’ they related to encounters of scenarios they had observed in the clinical practice. Evidently, students were then able to share how “spirituality” translates to “spiritual care” in a nursing context.

Table 4.2 below presents the first theme on how participants defined spiritual care.

Table 4.2 theme one: defining spiritual care

Theme	Sub-themes
4.4.1 Defining spiritual care	4.4.1.1 Spirituality as connectedness
	4.4.1.2 Spirituality relates to being connected to inner self through a belief
	4.4.1.3 Spirituality implies connectedness to own emotions
	4.4.1.4 Spiritual care and connectedness to own personal motivation and energy

The definition of spiritual care was coined around the term ‘connectedness’. Participants viewed connectedness in varied forms including vertical connection through which humans can connect with God or super powers; horizontal connection where individuals connect with each other. Horizontal connections were viewed as human to human which can be physical and spiritual.

4.4.1.1 Sub-Theme One: Spirituality as Connectedness

Spirituality was conceived as relating to being connected to a god or higher power or deity, self or anything that is significant to the individual. Students viewed connectedness as an overarching characteristic and meaning of spirituality. Spirituality was further viewed as means through which a human being connects to a Superior Power or a Supreme Being. This is how they expressed this view: *“Spirituality is connecting to God”*; *“It’s [spiritually] something that you believe in and connected to”*. Participants emphasized that a person cannot be physically connected to God. This portrays spirituality as human beliefs and interactions of the seen and unseen through which humans connect to “the self” or to “own spirit or person’s spirit. *“...And when I talk about belief in that sense it is when I talk about my belief which turn to faith because faith is the like belief [believing] in something seen and unseen”*

In an effort to explain how a person can connect to God, students indicated a need for every person to ask himself or herself questions of existence. These questions of existence were used as a springboard for discussion in their focus groups. The participants regarded the questions as truth seeking. Below are examples of the questions they posed: *“What is the spirit?”*; *“How do we [humans] connect to the spirit?”*; *“How can spiritualism be explained?”*; *“How do we [nurses] regard humans”*; *“How can nurses convince a patient that he is not bewitched for an example?”* The human spirit was presented as having no age, not measurable and being

embedded in “being human” rather than “human being”. *“The human spirit is a life driving force...”; “Human spirit is valuable to all humans; it is an aspect of ‘being human’”*

Students explained that spiritual beliefs come from the spirit part of being human. Students believe that the spirit part of humans can be accessed through faith. They presented faith as a state of believing in something seen and not seen. Student participants associated spirituality with faith and believing where the human spirit is a vital component in connecting to or with someone. This is what a first year participants said: *“It [spirituality] is relationship with the Superior Power. The Superior Power is the Creator; we call Him many names other call him Buddha etc.” “...If I refer to my spirituality, I speak about my faith...”*

Spirituality was also described as an inborn virtue through which all humans relate to God, Higher Power or Supreme Power. Students informed the researcher that a person’s spirit is the only means to connect with God. They said: *“Spirituality is present in all humans”; “They [humans] connect to God through their spirit”*; *“it is an inborn virtue in all humans”*. However, students acknowledged that spirituality is not only a way to relate to God but is the virtue that can influence and dominate everything else in a person’s life. They presented spirituality as the power inside a person and through which a person can connect with or to God or Super Powers. This is how students viewed spirituality: *“It [spirituality] is in all humans, it connects humans to a Higher Being through belief”*; *“Spirituality and belief system are closely linked...”*; *“Spirituality is a force of life in the [a] person...”*

Despite spirituality being described as an inborn virtue in all humans, it was acknowledged that it is a very broad term which people understand differently. In essence, students viewed spirituality as an evolving virtue for ‘belief’ and ‘believing’. A belief in Buddha, Muslim, Christian or what a person believes in, did not seem to be an issue. Of note is that student participants did not demarcate believing in God, higher being, or deity as only forms of believing. But they acknowledged belief in one’s self too as part of belief. For an example a case of an atheists and agnostics who believe in themselves was presented. Belief was the key that pointed to a particular kind of ‘belief(s) in something’. This is how this view was supported by the participants: *“Atheist and Agnostics believe in themselves as superior / higher power because a person has power from within his or her own self, through how [which] a person uses one’s brain or whatever”*; *“Beliefs in nature, sea, water etc. i.e. spiritual beliefs, [it] is what you believe in..., and it might be something that I believe in is unseen”*; *“...Because whatever a person does is influenced by his beliefs”*.

4.4.1.2 Sub-Theme Two: Spirituality relates to being connected to inner-self through a belief

Spirituality was described as relating to a person's state of belief and believing in something significant. Connectedness to inner-self either through personal values or beliefs were examples provided. Participants did not believe that spiritual beliefs always have to do with God. Conversely, they believe that it is also about being connected to self; that is to whom a person really is. This belief was based on their understanding that spirituality emanates from the human spirit of which all humans are born with. Students further reiterated that spirituality relates to being connected to values or some sort of beliefs not necessarily religious beliefs but more of moral beliefs and sound knowledge about and between right or wrong and emotional drives. "...Its [spirituality] being connected to your values or sort of beliefs not necessarily religious beliefs"; "...but more of moral beliefs, knowledge between right or wrong and emotional drives. Participants argued that whether a person is an atheist or not, they have a spirit. Irrespective of a person's belief, every human has a spirit. With such understanding of what spirituality means, a third year student mentioned that most people confuse human spirituality with the biblical version of spirituality where patients may ask for a prayer or to read a scripture for them. She emphasised that: "...Spirituality is about whom a person really is and his or her beliefs, it is a personal collaboration"

4.4.1.3 Sub-Theme Three: spirituality implies connectedness to own emotions

Connectedness to inner-self through emotions including inner peace is determined by stability of one's personal values and beliefs. The final student nurses reported that they believe in karma. They related how their belief in karma can affect their interaction with patients in clinical practice. They stated that when they go to the ward and they are not in a good space or good mood, they notice that it affects the care that they give to patients. They also believe that spirituality can be demonstrated and shared in different ways. They affirmed their view as presented in the following excerpts below: "Spirituality is in you as a human being [meaning that it is in every human being]"; "Spirituality can be shown through spiritually caring for someone or caring..."; "I can believe in nothing and still be a spiritual person, so it's more about my inner peace, my inner spirit". A third year student from a different focus group attested to this connotation of connecting to own emotions that a person must ask him or herself questions like *who am I? Where am I heading to? And why am I here?* These are existence questions that were used to indicate that spiritual care can only be recognised when a person is aware of such critical questions about life.

4.4.1.4 Sub-Theme Four: Spiritual care and connectedness to own personal motivation and energy

First year students made a reference to the nurse in charge in the ward that they recognised as spiritually motivating. They viewed the clinical environment as inspiring because the registered nurse showed interest in their learning needs and or challenges. Students regarded that nurse as a role model who demonstrated spiritual influence in clinical nursing practice. A first year student said: *“When I was working in the ward at JFJooste Hospital a sister who would speak to the patient in a manner that she was trying to see where the fears of the patient were and what the patient’s feelings were”*; *“The sister or charge nurse was driven by something inside of her”*; *“You could see when she [the sister in charge] is [was] talking to patients that she is [was] not just talking for the sake of talking but she is really interested in them”*. According to the first year nursing students, the professional nurse was not just being there to sign their timesheets but really cared for both students and patients alike. This is what was related: *“The sister would always ask questions teach even give us [students] homework to research things. She was interested in students learning”*; *“Spirituality is something that radiates from you”*. Fourth year nursing students also related similar experiences where patients called a student “Sunshine”. Although they are not sure why the patients called the student “Sunshine”, the student in question personally associated it with his spiritual life which allowed him to interact with people in a very kind way, showing acceptance and impartiality. He said: *I’m not sure if I’m very spiritual but I have some’*; *“...I drive that’s within...; it’s something that drives me to living”*

Another student from first year level said that on different occasions the patients asked him questions that either associated to or labelled him with their [i.e. patient’s] religions respectively. The student was asked question like: *“...My dear are always smiling, are you a Christian? The patient qualified the reason for asking the above question by saying that the way you do your work denoted something to a patient. On another occasion, another question was asked to the same student: “...Are you a Muslim? Because you are so loving and caring....”* These questions from the patients indicate that patients or people are willing to associate themselves with caring, positive and well-behaved individuals.

Theme two, that is presented below, provides continuation of the nursing students’ thoughts and it builds on the first theme. The nursing students’ constructs of spirituality influenced how they utilised their definition of spirituality from its general use to spiritual care in nursing.

4.4.2 Theme 2: relational connectedness or inter-connectedness

Relational connectedness was understood as connection that requires relationship. Table 4.2 below presents this second theme and subthemes, followed by thick descriptions for each sub-theme.

Table 4.3 Theme two: relational connectedness

Theme	Sub-themes
4.4.2 Relational connectedness/inter-connectedness	4.4.2.1 Spirituality as foundation for spiritual care
	4.4.2.2 Implementing caring values
	4.4.2.3 Connecting to someone at social level

The above theme's relational connectedness is constituted from three sub-themes that are narrated below. They are spirituality as foundational for spiritual care, implementing caring values and connecting to someone at social level. Quotations and para-phrasing will be used to provide clarity on the discussed issues.

4.4.2.1 Sub-Theme One: Spirituality as foundation for spiritual care

The participants acknowledged that spirituality can provide a foundation for spiritual care in nursing. A similar argument was laid by the other participants who claimed that spirituality was a precursor for spiritual care. Nursing students considered a state of being relationally connected or inter-connected. This connection was viewed as a vital condition for spiritual care through which the nurse connects to the external world. Faith, belief and culture were the most ways mentioned that activate such connection between individuals. The student participant who claimed to be a Christian believer attested that before he joined the nursing profession, he believed in laying of hands to heal a person from any condition including medical conditions or related suffering. This is what he said to show how the external world can interfere or clutter a person's belief or beliefs: *"If I was not in the profession we... [Referring to nursing], I'll just lay hands to patients because some [i.e. Patients] have demons, I believe that all these things [referring to mental illnesses] are just demons"; "...But then, now when you are inside the profession you can't deal with these people [patients] as though they have demons so you turn to succumb and say okay now its illness you understand"; "So it clashes with your [student nurses] beliefs"*.

Students further reported that they believe in the karma and acknowledged that spirituality and

spiritual care are close to the practice of nursing. Notwithstanding the students' inability to describe karma and or explain the differences between religion and spirituality with precision, they however agreed that spirituality can influence provision of spiritual care. This is what one student said: *"I believe in the karma thing"; "if I am [i.e. as student is] not in a good mood it affects the care that I give to patients"; "If I am [i.e. as student is] not peaceful patients can see it; "Spirituality or human spirit is a vital aspect in a person which if he or she is in good balance with the body and mind indicates [culminates] to a good state of health"*.

Students were aware of the importance of keeping a good and balanced relationship between the inside and outside environments. In view of what spiritual care entails, students acknowledged that nurses have a role to play in terms of the patient's spiritual and religious needs when providing care. They said as a nursing student: *"You have to know what the spiritual needs of the patient are as well..."; "...for example if I am working with Muslim people [patient]it is very important for them that at 13h00 they pray, I let them go to pray at 13h00 during the day"*. Clearly, belief and believing was not only associated with belief in God, supreme powers and deities but it was also seen as a deep engagement with societal traditions or culture. Examples of cultural engagement mentioned included the following: *"...Cultural beliefs and practice protect a person from the evil for an example cutting of [the] lips [vulva majora] by a certain ethnic group of people in South Africa"*. Another example of traditional beliefs was a belief in traditional medicine. Students argued that in South Africa patients are permitted to bring their traditional medicine to hospital. This is what they said: *"It is now allowed in the hospital to bring in your own traditional medicine for the doctor to check if it does not have an effect whether negative and positive on the western medicine. Patients bring their traditional medicine to hospital because they [patients] believe in that bottle"; "Even though you [the nurse] know that it [the traditional medicine] is not helping but [it] is the western medicine that is making the patient better"*.

Furthermore, students indicated that spiritual care is wrapped in a complex related belief system where personal, religious, spiritual and cultural beliefs primarily interface. Despite the students acknowledging that a person's spirituality can influence or be influenced when providing (giving) spiritual care or where spiritual care is provided (received), they also indicated limitations where a nurse's own religion is distant from that of the patient's. This is what they said: *"...It may pose difficulty in facilitating the religion of another person [the patient] because it fights or collides with your [nurses] own religion"* In such instances where religions are not the same, the students reported that they would not feel well [i.e. *comfortable*]

to facilitate the religion of the patient or other person. They said: “...If it [the religion] was not the same with theirs it will be difficult...”; “Spiritual care should be offered accord to one’s belief or religion”; “Spiritual care should be rendered based on the patient’s religion”

Students defined spiritual care as purposeful interaction between the nurse and a patient or with a patient. The emphasis was put on the nurse’s intention to know what and why she does what she is doing for or to the patient. Spiritual care was also viewed as a means to keep the balance between the body, mind and spirit. In this view, students argued that spirituality is not only related to spiritual care but to a person’s state of health as well. They believe that: “...a person can only be healthy if the body; mind and spirit are in a balance”; “...The nurse interacts with a patient or patients to ensure that a person’s state of health is well”. By making a reference to a person's state of health, students meant that when the three human components are equally taken care of, the person will experience positive health and well-being. Students argued that the balance between body, mind and spirit must be maintained at all times so that the human [biological/life] processes can happen to the [person’s] whole body. They associated this with the provision of holistic nursing to meet patient’s wholesome needs. Holistic nursing would include: “...Doing [providing] what the patient wants or believes in like prayer and other religious requirements”; “...It doesn’t matter what he [patient] believes. It could be Buddha or anything; but it is a belief that must be addressed”

Students shared their life experiences where their own spiritual and cultural requirements or even religious prescriptions needed them to comply, for an example, a religious practice or an expectation that they must not have a child or children before marriage. This view in a way demonstrated how students understood the importance of keeping up with the patient’s religious and or spiritual requirements. They provided examples of actions that may be required of or expected from them by patients in meeting the patient’s religious and cultural requirements. They included the following examples: “...A Placenta for Muslim patients after delivery is [should] not [be] kept with others in the fridge, but [it] must be labelled and kept aside for the family to collect”; “...A need to call [summon] for a religious leader for the patient if she [patient] is requesting for that because it [prayer] works for certain people.

This understanding of the students proves that they value the spiritual aspect of human beings and regard it as a very important irrespective of what the person’s belief is. A statement from the students that nurse’s assumption of spiritual care is a minor thing was pointed out as an important observation that participants had made to demonstrate some understanding of how spiritual care is related to being human.

4.4.2.2 Sub-Theme Two: Implementing caring values

Basic human values and professional-ethical principles were regarded as a foundation for caring values. Basic human values for caring were perceived as attributes that every human has which is critical in embracing spiritual care. On the other hand, professional-ethical principles were apparent as significant to producing a conducive environment for practice of nursing and its espoused ethos. Treating everybody equally for an example was acknowledged by the students as a real challenge and they admitted that unless a nurse is guided by these ethical requirements, it would not be easy to treat all patients equally. This is what the first year nurses said to support this view: *“I think it’s human nature that you want to treat a certain person in a different kind of manner, so when I learnt about autonomy and justice I thought that okay, everyone is equal, I’m going to try to treat everyone equally, just care, care to all”*.

Participants agreed that ethical principles of nursing have a positive impact in positioning the nurse at a point where she or he can better offer services to the patient. In a way, ethical principles influence and guide nurses to disposition their conscience and drive or influence their spiritual involvement. This view was affirmed by acknowledging that nursing practice is grounded in ethical principles of nursing including autonomy, beneficence, justice and all the other ethical concepts.

Participants viewed individualised holistic care through nurse-patient relationships and provision of emotional support as the most basic and best way to achieve spiritual care. Individualised care was regarded as the most ideal means to promote spiritual care in nursing because patients’ needs are addressed at an individualised level and in accordance with patients’ expectations. Examples of individualized holistic care included the following expectation: *“... Ensuring each patient’s comfort...”*; *“...that the nurse interacts with the patient on a continuous basis”*; *“Finding out how the patient feels and what more can she [a nurse] do for the patient in order to make the patient feel at ease*. The students agreed that love is fundamental [significant] when caring for a patient whether an Islamic, Jewish or Christian.

They made a reference to what they had observed that by loving and talking to a patient, a nurse can care spiritually. When a nurse shows the patient what they [the nurse] believe in without imposing it on the patient, it can also promote spiritual care. In line with this view, the student nurses gave an example of what they meant: *“Give them the medication they [patients] want [need] ... but also talk to them, and show them that you care”*. *“Not just talking the normal things that are about nursing but talking about the person himself”*

Students also mentioned that it is important to show empathy and sympathy to patients. They explained that empathy enables the nurses to show true understanding of what the patient is going through. To validate their point, they made a reference to a registered nurse sister whom they regarded as role model for spiritual care; a nurse who often provided emotional support to patients. This is what one participant said to support his opinion: *“She would speak in a manner that brings hope to the patient; ...a manner that will be able to help a sick patient or that person that was down”*.

In an effort to show how they view spiritual care, they related it to practical experiences where a critically ill patient had problems with oxygen saturation (O₂ sats). The patient requested that her pastor be called in during the experience. The pastor prayed for the patient over the phone, whilst the pastor prayed the O₂ sats came up and continued to improve to normal. At the same time, the student witnessed that the patient felt better probably due to hope that was instilled through the prayer. This observation led the student to the understanding that: *“Spiritual care is like when you talk to your patient or communicating with the patient encouraging the patient that it’s going to be fine...”*; *“It is like you try to motivate that patient on a spiritual level; you’re going to make this through...”*

The final year students informed the researcher that through the years in the training programme, they had not understood sympathy, until in their final year when they started to understand what empathy is about; true feelings about what the patient is going through. In efforts to explain what they meant they said: *“When a doctor diagnoses a patient with a terminal condition and prescribes tender loving care (TLC) that was a prescription for spiritual care”*; *“TLC care is intended to cater for the person spirituality”* An order for TLC was interpreted as an opportunity for the nurse to offer spiritual care. However, students had observed while they were in the clinical placement that when nurses provided what the patient believed [wanted] in, it worked for the patient.

4.4.2.3 Sub-Theme Three: Connecting to someone at social level

The student nurse participants acknowledged that a patient, as a social being, needs another person other than the nurse that must be there for him or her [i.e. the patient] during the time of illness and suffering. That somebody who is not a nurse would connect with the patient at a different level. That somebody usually would be a close person that is available to spend time with the patient or to come in any time when the patient is in need of them. The student participants informed that the aim of having this other person was not only to keep company

with the patient but also to keep the patient at peace. One participant said “...*It will ensure that the patient is at peace and the patient is comfortable and the patient is feeling motivated and cared for*”.

Furthermore, the student argued that the benefit of making the patient at peace is many fold including the following although not limited to these: “...*the patient becomes involved in own health as well the treatment*”. “*When the patient is motivated the patient would want to be involved in his or her care; thus it does not make the patient feel excluded or the patient feels that she or he is just an object*”.

The students made distinctive reasons as to why it is important to involve the patient in own care. They related to a patient who was not cooperative with the medical and nursing staff; the patient did not want to take his medication. One student, who took a close look at why the patient was behaving that way, attested that the reason was that the patient was not involved in his management. This is what they said: “*The patient did not even know what medication he was taking, nobody had ever bothered to explain the medication to the patient*”; “*Also there was this lack of connecting, connection, they were [referring to the staff] not touching to the patient’s needs, so the patient didn’t even understand why she should keep taking medication*”.

The student attested that if the patient is not part of the provided care or does not even know what medication he or she is receiving, they will not be motivated to partake in their health. Additionally, lack of involvement will cause disconnection or lack of connection with the nursing staff.

4.4.3 Theme 3: Teaching-learning of spiritual care

Students’ attempt to define spirituality influenced their understanding of how it should be taught and practiced in nursing. The theme below presents students’ experiences on teaching and learning of spiritual care in the nursing programme as offered at the nursing institution where the study was conducted.

Table 4.4 Theme Three: Teaching-learning of spiritual care

Theme 3	Sub-themes
4.4.3 Teaching-learning of spiritual care	4.4.3.1 Personal experiences about learning of spiritual care
	4.4.3.2 Perceived challenges in implementing spiritual care in nursing
	4.4.3.3 Perceived conflicting nursing perspectives

	4.4.3.4 Students' recruitment-selection gap
	4.4.3.5 Lack of continuous integration of teaching in spiritual care

The first sub-theme from the theme teaching and learning of spiritual care is directed at showing how students experienced learning of spiritual care subject.

4.4.3.1 Sub-Theme One: Personal experiences about learning of spiritual care

The students acknowledged that they learned about spiritual care as part of holistic care in their first year. They, however, felt that the subject matter is dealt with very shallowly which in their view only served as an introduction. They reported on two interdisciplinary modules namely Introduction to Philosophy of Care (IPoC) and Primary Health Care (PHC) which according to students, the subject matter relates close to spiritual care. These modules address issues and factors that are causes of inequality in health care provision and ethical dilemmas which either denies patients from receiving health care or access to health care. Otherwise students stated that most of the nursing modules hardly addressed the subject of spiritual care in detail with an exception of the Fundamentals of Nursing, a first year module. This is what the second year students said: *“Spiritual care was done here and there it was not continuous”; “Spiritual care was mainly addressed in the first year when we [students] did the subject of stages of death and dying and bereavement in the family”*

Students testified that they were not taught how to care for the patients let alone spiritual care. They informed that instead they were taught and guided on how to get competence of nursing skills. Students verbalised their concern regarding this motion as they wondered why it is so because the profession that they are studying towards is a caring profession. They expressed this opinion saying that: *“But they [the nurse educators] don't [did not] teach you [us/students] how to care yet our profession is a caring profession”; “They only teach us nursing skill”.*

Students also felt that they were not properly informed about the importance and relevance of certain modules they were studying. They informed the researcher that at the time of their study, they did not know why they had to do PHC subject in the first place let alone its importance in nursing as this was not well explained to them. This is what they said: *“...I did not know that PHC is the big thing in nursing”; “I have just learned that PHC is the big thing in nursing; otherwise I never even knew why I had to do it. It was not explained well”*

Students acknowledged such modules as only sensitizing them on moral and spiritual matters and hence students expressed the need to be taught about spiritual care. The students agreed that there is a need for them to learn about spiritual care because they often see patients being in need of such care every time when they are in the clinical placements. But it is not easy for them to embark on the spiritual subject in the clinical placements due to lack of confidence and other varied reasons. Occasionally, students would try to meet the religious needs of the patients as they attested to a situation where a patient needed to attend to his religious requirements. A student assisted by allowing the patient to go for prayer. This act was regarded as spiritual intervention in a way and they acknowledge it as part of providing spiritual care for the patient. The student said: *"...I allowed the patient to go for the prayer; fortunately, the prayer time did not clash with the nursing routines because they pray at 1 o'clock [i.e. 13h00]"*.

Regarding teaching and learning of spiritual care in class, students made most of their references to the subject of death and dying. They also indicated that the subject of spiritual care is mainly addressed in the first year programme even though it is not done in depth. *"Although we learned the subject of spiritual care in the first semester but we did not do it in depth, for an example, I did not know what would happen if I do not allow the Muslim patient to go for prayer"; "They [educators] tried to teach us caring for the patient how to provide holistic care to a patient but then it just stops, it stops there and you never hear about it until you finish"* Students acknowledged that the spiritual subject was not dealt with in depth because they learned mainly about how to observe a patient's religious requirement or practice but they were not informed in most cases what would be the consequences be when such requirements were not met or if the nurse refused to partake in whichever way. They expressed their uncertainty in the following statement: *"...but we did not do religious care in depth for an example I did not know what would happen to the patient if I give pork to a Muslim patient or if I do not allow the Muslim patient to go for prayer"*

Students admitted that they experienced patients being in need of spiritual care in the clinical learning. However, they pointed out that clinical learning was much different from theoretical learning in a way that what they had learned in class about death and dying was experienced differently in work integrated learning than how they had conceived it theoretically. They related such a difference to be based on the fact that work integrated learning involves emotions; and thus the experience was completely different from the mental picture on the subject of death and dying. This comment from the student was in a way pointing to an existing gap between the realities of theoretical classroom learning and clinical practical learning where

the experience of a patient's death was in essence different from the book based subject matter as learned in class. In this view, the experience of actual death of the patient brought the subject of death and dying to a different dimension in their understanding. This is what final student said: *"When I experienced my first [patient's] death..., you see all the signs that you learn in class patient becomes bluish grey, grasp for air but ... I was just shocked..."; "...I did not know what was happening until the nurse said get a sheet to wrap the body" "I did not know what to do I was just shocked" It really felt like I had lost my family member. After that death I was so surprised that I had become so close to the patient".* In essence, this is how the student expressed this experience: *"I realized that I did not know much about what I was supposed to do there [meaning in the death scene]"; "I was not fine for some time but I did not know who to turn to in the hospital and on campus"*

In response to death related issues, the students expressed the need for support in cases where such incidences occur. They would want an emotional support system to be available in relation to this particular student's experience of shock of death of a patient that she was observing. While the same death was not a big deal to the other nursing staff who were there at the death scene, the student realised that there was a need for support on their part as students. This is what the student said: *"The nurses just continued to work as normal..."; "One nurse pulled me aside and said it does feel like you lost your family member..."* In line with the student's experience, the nursing student proposed that the school of nursing should provide them with support because it really gets too difficult to handle. They said such issues fall on them as heavy demands from the clinical practice while the university demands are equally pressing on them. All this makes them [the students] to feel like dropping out of the programme because it feels too much to bear. They expressed the need for support in any form including: *"...support from the supervisor who may spend just thirty minutes session in one week with the students in a group when they [students] are sitting with their clinical supervisors they can bring up issues and scenarios [questions] like what would you do in a situation like this and that"*.

In response to the question of how students would want spiritual care subjects to be taught, they were not sure what method they would prefer. However, they were convinced that they would welcome the subject of spiritual care. They said that they need to know it because it is important. This is what they said: *"...I mean the importance of spiritual care for patient..., taking care of the patient"; "... patients are in need of spiritual care, it's not about me and my problems..."; "...I don't like talking or whatever [about] their [patients'] problems no, no, but they are in need of it and it's not like that..."*.

Students also did not only iterate that death and dying subject was merely touched or shallowly addressed in class but further, they made a reference to the need for short courses or short programmes for the hospital staff too who, according to the students, are aloof to patients' spiritual matters. Students diverted from the focus on their needs as experienced and pointed to nursing staff's issues regarding provision of spiritual care in nursing practice. At this point, students expressed that they felt the nursing clinical staff is usually on their [student's] way when they [students] are trying to get close to the patients. Therefore, students' assumption was that the nursing clinical staff also needed to be educated on the spiritual care subject. *"We [nurses] need to make sure that the nursing staff [also] understands that spiritual care is part of the healing process or of health of the patient. It's not just physical, it's not just emotional, and [but] it's also spiritual included"*

As the same question on how they would want to learn or to be taught spiritual care was brought back to students in search of their opinions for solutions; they gave a range of possible teaching processes including cases and scenarios. Students also said that accompaniment by the supervisors could be done on weekly intervals for the supervisors to see how students are doing on spiritual care matters in clinical practice. Furthermore, students said that the supervisors' intervention must be directed at assisting them [the students] with what they are doing at the time of arrival. This is what they said: *"The supervisor can ask the student how she [the student] is doing. Is she having any problems? What are things she is happy or not about?"*; *"The supervisor can assist the student there and there with the problem and that will help the student not to go through the problem with wrong conclusions"* Students perceived the Simulation Laboratory (SimLab) as not suitable for both teaching and assessing spiritual care competence. When the students were asked why they considered simulation as not ideal, they said there are no real feelings involved in the simulated sessions although they had acknowledged that it helped them in the acquiring of communication skills.

4.4.3.2 Sub-Theme Two: Perceived challenges in implementing spiritual care in nursing

Students presented challenges from clinical scenarios that were conceived as crippling learning and contradicting what was learned at school. The most challenge was theory-practice gap which students presented in various forms including lack of role models in the clinical practice to assist them in practicing what was taught. Lack of role models was one of the main issues mostly spoken about by all student participants in relation to their experiences in the clinical placements in particular. They said: *"...role modelled practice by qualified nurses is*

demotivating. *“What I’ve seen in many senior nurses it’s almost like they lost passion for everything... they have been doing this like over the years” ... that 1st start time and it becomes a job” “The attitude of the nurses and the staff, the people that are supposed to be giving that care, is so demoralised they don’t..., they’re just there because they have to be there”.*

Contrary to inspiring experiences reported by students, there were situations where the nursing staff did not show interest in students’ learning needs. Students gave an example where they enquired about something to enrich their learning but they could not receive positive response or an expected outcome. Other experiences were situations where the nurses would wrongly perform a nursing procedure and when the students ask about it the nurse would shut them down. This is what they said: *“... they [nurses] say don’t do what I [i.e. the practicing nurse] do, do what you are taught at school”*

Students pointed out to such an environment as not conducive to practicing nursing and demotivating to their learning. They concluded that with time, qualified nurses become desensitised to patient needs and such behaviour is demotivating to them who are just embarking on the profession. This is how they perceived the nurses’ behaviour: *“...Disillusion registered nurses that are coming [to the profession] they are just making the process worse...”*

Although examples of ideal role models were acknowledged, there was however a strong message about lack of good role models in general from both health and education institutions. Their interaction with nursing staff in particular was perceived as demotivating. This is what they said: *“...spiritual care in our profession, ...the nursing profession, it’s slowly fading away bit by bit, because the old staff as I could say they don’t see spiritual care as important”.* Students indicated that they come into the profession and they’re all excited with a high sense of spiritual enlightenment and wanting to help. However, there are things that happen and break them down. Eventually they [students] cannot keep up with their spiritual commitment to care but feel like doing things in an inappropriate way, as it is done in the clinical practice. They depicted a need to be helped in this matter. This is what they said: *“So we need to be strengthened here [i.e. within our learning institution]”*

Noticeably, students did not speak about the lack of NE role models as they did with clinical learning context. Although it was not clear as to why there is such an inconsistency; an assumption is that students’ theoretical learning is probably less challenging than work integrated learning in the clinical settings. Students probably have less need for role models for theoretical learning than they do for clinical learning as depicted in their perceptible voice

regarding their experiences in the clinical settings. Students' observation that the nursing staff do not bother about spiritual care for patients was based on their view regarding the staff that do not provide spiritual care. The fact that it is the same staff who does not consider talking with patients, is important. Therefore, their assumption was that the nursing staff do not support spiritual care. This is what one student said: "...*They regard talking to patient as waste of time, so according to them it is not working [meaning it's not a nursing activity]*"; "...*the clinical placements environment is toxic...*"; "*and you're going into a toxic environment and the cycle just goes on and getting worse*" Students expressed this view owing to the behaviour demonstrated by practicing nurses in the clinical placements. In fact, students expressed their discontent about the lack of role models in clinical placement.

4.4.3.3 Sub-Theme Three: Perceived conflicting nursing perspectives

The students argued strongly about their challenge that despite them being willing to give supportive and spiritual care to patients, there are lot of hindrances experienced in clinical placements. Students referred to professional boundaries as the main hindrance. They reported that they cannot demonstrate empathy and sympathy to the patient the way they deem fit because of the professionalism that requires them to keep caution not to get too close to and with patients. They expressed this view saying: "*It makes it difficult to truly comfort that patient they you feel at that particular moment*" "*We can give sympathy but we have to keep that professional side, so it's like hugging but also keeping that distance*".

Another challenge was that the sisters [registered nurse or charged nurse] often interfere when they see students talking with or to the patient. The students testified that the sisters in the wards call them when they see them talking with the patient and instruct them to do more work. This was not favoured by the students because they said it prevented them from practicing what they were taught in Interpersonal Skills (IPS) learning sessions about getting to know their patients. They expressed their feelings towards this as an unacceptable behaviour saying that: "*The sisters do not want to see you having some time with the patients, when they see you talking with the patients they will always call you*"; "*They just motivate you and you don't know what to do*". "*Sisters in the wards do not understand spiritual care*"

Yet another challenge that was discussed mainly by the final year students was conflicting values between "spiritual values" and "professional values". They said that teaching of Professional Practice (PP) informs that they can be friendly to the patient but not become friends or too close. However, students claim to understand that such an allowance is needed

for legal purposes. For an example, a female patient may report a male nurse for harassment. In reality, it does not seem natural. This is what they said: *“When you are comforting the patient it would be like you are hugging but keeping a distance at the same time. Students acknowledged that despite their willingness to do give sympathy and empathy to the patient when practicing nursing, they appeal to be taught how to balance “spiritual values” and “professional values”. In the same thought, another student said they [educators] are more focused on the professionalism of the profession. They are compelled to participate as duty calls. This is what the students said: “We need to find our balance”; “They [educators] don’t really worry about how we’re going to care for the patient in terms of..., like holistically, completely caring for that patient. We did like a few modules on caring but it is like scattered a little [bit]”; “... when it comes to empathy for instance, it was like in a professional manner how much can I show towards the patient, because it demanded that I must stay professional”*

Students verbalised that it was difficult for them to provide emotional support and or spiritual care to patients because there are different religions and their concern was the possibility of misdirecting the patient in his or her future life in the case of a dying patient. Students realised that they were actually not taught how to care for a suffering person but only to provide technical nursing. This is what students said in this respect: *“They [nurse educators] teach you [student] technical things to make you a professional but they don’t teach you about caring because our programme is BCur- Latin for Baccalaureus Curationis. It’s a degree in caring, but I don’t think they teach you how to care”*

The final year students brought insight into the challenge of integration of spiritual care and professionalism or being professional. They said that nursing care is an on-going process, so they wouldn’t think it as something that should be taught in 4th year but in all year levels. This is what the student said: *“...for me the being spiritual is beautiful things, showing compassion and I’ll always do most of those things, but being professional is for me like this rigid type of person. You must learn to communicate... my norms and values that...”* Students persistently made reference to an existing clash between spiritual care and professional caring principles. This is what they said: *“...like there is a clash between spiritual care and professional practice. They even tell you must keep a distance between you and the patients”*

4.4.3.4 Sub-Theme Four: Students’ recruitment-selection gap

A gap in selection of students was pointed out where some students enter nursing for other reasons other than genuine love for nursing. The gap was noted when comparing the candidates

that are selected for nursing training and their commitment in the clinical learning or practice which revealed lack of motivation for caring or lack of a caring personality. This was thought to be related to selection criteria which do not allow the selection of good candidates for nursing. Often selected individuals are not fit for the purpose and use in the profession of nursing and they are worn out or lose their passion and or love for nursing. However, students were not sure if such a loss of love and passion for nursing was due to work overload or other reasons. This is what the participants said: “...*Eighty per cent [most] of the nurses now have lost their taste of loving, of caring. It’s like now they just go there [workplace] for money*”; “*It is not because they [nurses] are people who do not want to make the difference*”; “*Some people [nurses] don’t know how to care for other people*”.

Based on the view that the caring aspect of nursing is missing, students thought that if they are taught how to give or practice spiritual care, it would be good because it would bring everybody including nurses and students to a caring mode which is currently not prioritised. Students informed that they want to be taught how to render spiritual care. This is what they said: “...*so it would be good to be taught that [spiritual care] ...*”; “...*Some people have it [caring], some people don’t. For example, some people came to do nursing as a calling. They said nursing was a calling for some, some people they came to do it because they fell in love with it*”; “*Everyone has got a different personality, so some of us... and some of the sisters they can’t even smile mam; they can’t even smile to a patient or even to other staff*”

Students thought that it might be challenging to teach an individual how to provide spiritual care because of different personalities. They stated that it is important that on entry to the programme, prospective students should at least possess some soft skills such as respect qualities. They indicated that recruitment of students should be directed at identifying individuals who are natural carers or those who possess soft skills. For those students who are already in the system, they should be encouraged to reflect on their passion for nursing and about their own religion in order to allow them grow in this aspect of caring.

4.4.3.5 Sub-Theme Five: Lack of continuous integration of teaching in spiritual care

Teaching of spiritual care was perceived as “pieces of information” related to loss and grieving and information about different religions. Students confirmed that they learned about death and dying and how to deal with the bereaving patient and family. “...*But it was just like an introduction, we did not do much*”; “... *We [students] were just introduced to different types of religions but nothing further than that*”. The final year students said they cannot really

pinpoint what they studied on the subject of spiritual care. They informed that the programme is more focused on professionalism. They reported that educators do not really worry about how they, as students, were going to care for that patient in terms of holistic and complete care. Students acknowledged that they did a few modules on a related subject matter yet it was scattered in the programme. This is what they said: “...and a little bit in the modules that we do like in general nursing science (GNS); also in the fundamentals of nursing (FNS) where we do [did] stages of dying [i.e. of a dying patient]”.

Students also stated that they had just discovered by the end of their third year that primary health care is important in nursing. They said that they were just introduced to PHC for one term and not even one semester. This is what another student had to say: “*I think that we were just introduced to primary health care (PHC). It doesn't really equip us with what we need to know about caring*”

Students acknowledged at least having touched on the subject of death and dying as the only period in time within the programme where the subject of spiritual care was obviously addressed. They affirmed that in their view, the practice of nursing has avoided the spiritual care part of comforting the patients.

They also informed that they did not get the training in dealing with patients' spiritual matters. They gave a scenario to support their view and to prove their point that there is a need to learn about providing spiritual care. This is what a second year student said regarding this matter: “*I did not learn how to care or how to comfort people. But in my spirit I know how to comfort a person. I would try to tell them to please not to cry*”. Another first year student expressed the following in relation to how they view the challenge of rendering spiritual care, he said: “*...how can I, how can I for example a 22-year-old male teach a 44-year-old woman that what she believes or what she thinks is wrong...*”; “*... because I know that if you have a broken spirit you need to be taught..., how am I going to take the patient from point A to point B and healing...*”

Although students acknowledged that they had learned about spirituality mostly in the first year of the programme, they maintained that educators did not explain to them in depth as to what exactly spirituality does to a patient. Students reported that they still need to learn more about the knowledge and skills on how to handle the spiritual needs. “*It should not be introduced only in the 1st year only, it should be part of the curriculum throughout the nursing career or your nurse schooling*”. Students also felt not cared for as they made reference to a number of

expectations to participating in procedures that are against their belief. *You come in the programme with that positivity wanting to contribute and make a change but there are things that are happening that we're seeing every day that are making us break away from what we are supposed to do to have that change.* Examples of these procedures are termination of pregnancy (TOP), euthanasia and administration of blood transfusion. They said these things affect them because there are against norms and values that they had been brought up with. *"I've been brought up with..., you know it kind of kind of being in clash with each other, so you have to find a way to adapt to those situations"; "You must forget about your-self at that point and give care that the patient requires"*

Students were asked who is a good nurse. They said that a good nurse is a nurse that goes an extra mile, goes beyond the nursing routine, making sure the patient is comfortable and their needs are addressed. *"...It is just to check am I doing this correctly"*. In general, students were content that providing holistic nursing care through incorporation of spiritual care is a good thing. However, they needed more guidance on how to apply spiritual care and professional care values without feelings of mutual exclusiveness.

Students were also concerned with their own personal challenges. They said: *"...Sometimes if you [students] come with your baggage like they say if you, had a bad day and come to the hospital, you're not going to treat your patients the same way that you would have wanted to treat them like on a good day because you're bringing your baggage from your personal life into your professional life"*. Students acknowledged that they too need to be cared for. They said *"knowing that someone cares for you makes you feel good about yourself and you feel that you belong. It boosts your self-esteem, it boosts your sense, your sense of character as well. Making a reference to this point the students said even if you are sick, just knowing that someone cares and that you are important in society.* It also coincides with the psychological and social aspects of human needs and it boosts everything in the person. You start off caring for your spiritual needs, it gets on to other aspects of health holistically. In this sense spiritual care was seen as important not only for the patients but for the students as well. One student said: *"I stay alone and I don't have relatives or whatever, but talking to my patients and when my patients say to me thank you, when they appreciate myself for services [rendered] it makes me feel good and I'm looking forward to go back there tomorrow to offer what I have"; "It gives me a sense of smile, the sense of appreciation that senses of knowing that I have been of help to another person, it's so rewarding for you don't need anything else but just the response"*

Student nurses expressed a need to be cared for spiritually. They did not only relate to the baggage they come with from their personal lives, but they also related to the need to meet nursing demands and expectations which were experienced. Especially when they had to deal with patients' values that supersede their personal values demanding them to comply with what is expected of them. They said: *"We just push our feelings aside and do the job that's supposed to be done. I think and that's why nurses become closed and they have breakdowns"; "... For example you don't believe in abortion, you don't like abortion, you value life that much and at that point in time there's nobody else who can do that and you have to think of the patient"*. Students reported that they struggled with dealing with their own personal values versus the patient's values and expectations. However, they often ignored and overrode theirs for the sake of the patient's health needs.

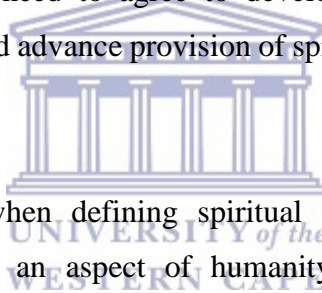
4.5 Integrated discussion of results from nursing students

The first theme from the participants was on how they defined spiritual care. The participants' definition of spiritual care was perceived as being connected to God or anything that is regarded as valuable by the person. This finding was in line with Leonard (2003) who argues that no discussion of spirituality would be complete without referring to the concept of a Higher Power or Creator which is commonly referred to as God. Different people refer to the person of God in different names including; Goddess, Higher Power, Divine Spirit, Ultimate Being, the Absolute, Lord, Inner Light, Life Source, Allah, Tao, Spirit, The Way, and Universal Love. In the current study, connectedness was strongly perceived as positive value for spirituality. Findings of the current study which associate spirituality and spiritual care with God, these were expressed by almost all student participants. Different focus groups agreed about an existing a link between a person's spirituality and God.

Authors including Hsiao *et al.*, (2010: 387); and Narayanasamy (1999b) attest to this connotation too, saying that spirituality relates to God and it often develops through mainstream religions. This view strongly represents how the concept of spiritual is conceived in a South African context in contrast to atheist's, agnostic's and heathen's spirituality which were not discussed in depth in the current study. Perhaps this was due to lack of clarity on the nature of other spiritualities that are not centred on God. Rassool (2000) acknowledges that the non-religious-based beliefs are not mutually justifiable and thus not easy to explain.

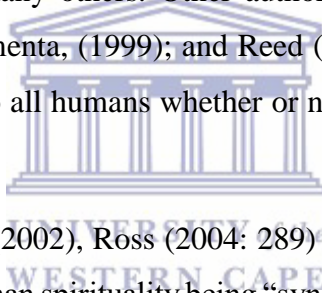
Defining spirituality is not easy as the terms spirituality and spiritual care are sometimes used interchangeably (McSherry, 2006; Wright, 2002). Also, the fact that secular connotation of

spirituality is different from the non-secular connotation. Spirituality entails meaning in life, meaning of life, love as a fundamental value, relatedness and transcendent state of being (Pesut & Sawatsky, 2005). However, according to another view it denotes a religious state of existence and belonging (Dover & Bacon, 2001). Spirituality is also associated with assisting the patient in difficult times such as end of life (Yardley, 2009; Bush & Bruni, 2008). Nonetheless, other authors associate the term spirituality with the quality of life (Büssing, Fischer, Haller, Heusser, Ostermann & Matthiessen, 2009). In relation to nursing care, the term is conceived as relating to holistic nursing care (CNA, 2010; Pesut, 2008; Phuchalski, 2006; Ross, 2006 & Tanyi, 2006). However, there are issues of concern about the need for a common acceptable definition of spiritual care (Puchalski *et al.*, 2009). A two-day Consensus Conference which was sponsored by Archstone Foundation of Long Beach in California, was held on the 17-18 February 2009 afforded the National leaders who congregated in Pasadena, California to discuss issues of spiritual care in nursing. The outcome of the conference was a pronouncement made by these leaders about a need to agree to develop consensus-driven definition of spirituality in order to improve and advance provision of spiritual care in nursing (Puchalski *et al.*, 2009: 886).



One of the critical elements when defining spiritual care is to establish meaning of connectedness to spirituality as an aspect of humanity (Puchalski *et al.*, 2009: 886). Connectedness is one of the ways through which spirituality is observed which can be expressed in varied ways. Spiritual-connectedness can be expressed in relation to a person's quality of life based on meaning and purpose (Chiu, Emblen, van Hofwegen, Sawatzky, & Meyerhoff, 2004; Delgado, 2005), personal beliefs, life experiences as well as a sense of wellbeing. Reeds's (1992) connotation of intra-personal, inter-personal and transpersonal enhances understanding of existentialist view of connectedness in which a person transcends to self during the experience (McBrien, 2006; Delgado, 2005). Connecting to self and others brings an appreciation of wholeness of the experience through a person, further connecting at different levels (Tanyi, 2002; Bush & Bruni, 2008; Carr, 2008; Hood & Olsen, 2007; McSherry, 2004; Cash & Ross, 2004; Mahlangu, 2004; Wright, 2002). Connectedness or disconnectedness in each of the three spiritual connection levels as reported by Reeds (1992) can indicate discomfort; religious discomfort to a lesser extent and or spiritual to a more serious extent.

Study participants also pointed to connectedness as a core value of spirituality. They acknowledged different forms of connectedness including connecting to self, to own emotions, own motivation and energy as indicators for a spiritual caring person. Baldachinno (1999: 557) reported indicators for spiritual care should embrace a need for meaning and purpose in life, harmonious interconnectedness, and acceptance of self and others as sources of hope. Van Leeuwen *et al.* (2009: 2862) refer to a similar notion through which nurses can provide intra and inter professional communication to the patient. Reed's view on different levels of spiritual connectedness support the findings of the current study in which participants' perceptions presented spirituality as an "inborn" or "inherent" virtue that is present in all humans. Spiritual awareness can be conceived as a means to observe the other but also to assess the self about spiritual growth. Tiew and Drury (2012: 162) attest that everyone has innate nature of spirituality therefore spiritual education should progress from spiritual awareness to spiritual assessment. Meaningful communication in nursing is based on these inherent virtues such as compassion, love, respect and many others. Other authors including Mahlangu and Uys (2004); Taylor, Highfield and Amenta, (1999); and Reed (1992) also refer to similar notions of spirituality as being intrinsic to all humans whether or not explicitly demonstrated through a belief system.

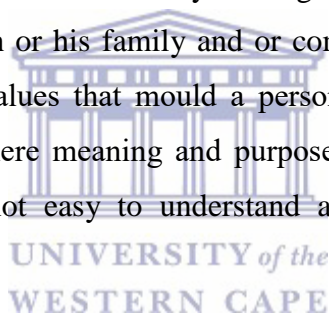


Other authors such as McSherry (2002), Ross (2004: 289) suggest that spirituality be viewed as "transcendent religion" rather than spirituality being "synonymous with religion" as an ideal. However, differing notions are assumed to be based on the extent to which an individual connects to a belief based programme as opposed to personalised meaning and purpose in life (Yardley, Walshem & Parr, 2009). Van Dover and Bacon (2001: 26) also point to spiritual care where the nurse may enhance connecting the patient with God by channelling the dialogue with the patient into dialogue with God through prayer. Therefore, an existing gap in understanding of spiritual care is a vital component for nursing as expressed by van Dover and Bacon (2001) who pointed to a series of studies that attempted to explore various terms including life, hope (Herth, 1993); spiritual needs (Highfield & Cason, 1983); spiritual well-being (Carson & Green, 1992) among others yet in vain. The gap is assumed to emanate from a deficiency of insight especially of the quantitative studies which do not explore the actual substance or essence of what spirituality is about.

The term spiritual care may be viewed as relating to holistic nursing where all the person's different dimensions are addressed (Narayanasamy, 2001). Nurses should be aware of the spiritual well-being and spiritual-distress continuum in order to provide holistic care. Authors

including Narayanasamy (1999), Tiew and Creedy (2012) as well as Tiew, Creedy, & Chan, (2013) agree that spirituality and spiritual care are vital components for holistic nursing. Furthermore, these authors attest that spiritual awareness and patient-nurse relationships founded on trust are a prerequisite for spiritual care in nursing. This argument concurs with the findings of the current study which indicated that relational connectedness is foundational to spiritual care. Additionally, the participants acknowledged relational connectedness as a caring value which connects people at different levels. Yet, the challenge is lack of understanding of the other's needs and failure to occupy other's positions as means to understand what they might be going through.

Spirituality and or spiritual needs are often wrapped in a complex phenomenon where personal, religious, spiritual and cultural beliefs interface presents a challenge and makes it difficult for nurses to facilitate spiritual care in their practice. A belief system can be considered as personal or socially acceptable codes that are influenced by binding-relationships between a person and the self, a person, another person or his family and or community. It shapes and upholds a person's spiritual and cultural values that mould a person's character. Other connotations including existentialist views where meaning and purpose in one's life is a guide (Unruh, Versnel, and Kerr, 2002) are not easy to understand as these are based on individual experiences and personal beliefs.



Mackinlay and Trevitt (2007); Baldachinno (2003); McSherry *et al.*, (2000) and McSherry (2006) argue that meaning and individual belief lie at the centre of being-human and are key points through which spiritual care interventions can be initiated and maintained. Spiritual connections do not only refer to inferred intra-connections and inter-connections but also refer to meaningful social connections. Spiritual connection allows the patient to connect to someone either a relative or close friend who may be available to spend time with the patient, especially during hospitalisation. The purpose of social connection is to keep company, motivate and encourage the patient whilst connecting with the patient at different levels other than nursing.

Connectedness and awareness about own spiritual state of being is conceived as a positive condition for spiritual growth and competence to occur. Whilst connecting to own emotions when caring for patients is indicated as vital, failure to connect may or may not relate to a person's prior spiritual state. This then disputes the findings of the current study in which the participants assumed that a person's spiritual state or lack of it before commencing the nursing programme were associated with lack of good spiritual behaviour in students. Participants'

suggestion for serious recruitment and selection procedures was a response to that. Tiew and Drury (2012) in their study with final year nursing students discovered that pre-existing conditions such as cultural perspectives were actually not a problem in their caring duties and nursing responsibilities. These authors alert about possible confusion and ambiguity regarding scarcity of preregistration spiritual education as a cause for concern. If an individual can connect to one's inner-self, they can experience spirituality. Connecting to one's self through emotions and inner peace was determined as a state of "being" through which nurses can access the spiritual level of care (Hoover, 2002). However, they indicated that a person's values and beliefs also play a major role in spiritual care nursing. This notion from the students is in line with Carpenter, Girvin, Kintner and Ruth-Sahd (2008) who argue that when providing spiritual care, nurses should be aware of their own spirituality. In fact, these authors attest that provision of spiritual care begins with one self (Baldachinno, 2008: 554; van Leeuwen et al., 2009: 859; Narayanasamy, 2001; Highfield & Amenta, 2000).

Burnard (1988) on the other hand affirms that this notion that nurses should clarify their own spiritual beliefs or lack of beliefs in order to help clients to engage spiritually is of primary importance. Bradshaw (1994) argues about mutual connection instincts between the nurse and patient and acknowledges the benefits that nurses receive when they provide spiritual care to patients. Bradshaw's argument is from a different perspective urging nurses to view the opportunity of providing spiritual care to patients as of equal benefit to them too. Nurses who truly make an effort to feel what the patient's experiences of illness, suffering and coping, contribute to promoting professional practice of nursing (van Leeuwen 2009: 862).

Caring takes various forms with the goal to assist the patient go through the process of ill-health and suffering and hence indispensable from nursing (Freshwater, 2005). Caring is often fuelled by spiritual, ethical or contractual dispositions. According to Morrison and Burnard (1997: 13) caring is the "loving" aspect of nursing. Nursing tasks, procedures and technically skilled nursing interventions should not be viewed as replacement for caring. Only a human-to-human interaction can truly provide a caring experience. Dearth in caring in health professions has been acknowledged not only as a dehumanising effect, but more importantly as failure to assist patients and clients to attain their lost state of health and this is ethically unacceptable. Nurses' ignorance or lack of awareness about potential detrimental consequence of their lack of knowledge to assist patients who are seeking health may account for this jeopardy. This is affirmed by the findings of a study conducted by Monareng (2009) that nurses in SA regard spiritual care as complex and undefined, posing difficulties in interacting with

patients in that regard. In that study, the nurses who were participants had difficulty in differentiating spiritual care from emotional, psychological or religious care (*ibid*).

Arguments about the lack of time were intensely contested reasons by the study participants' as a contributing factor for lack of spiritual care in nursing practice. Impracticality associated with business-driven health delivery (Helming, 2009), account for lack of time in the implementation of spiritual care in nursing practice. This lack emanates from lack of spiritual education and hence lack of spiritual awareness (Brush & Daly, 2000). Treolar (2000) argues that inadequate preparation of nurses in this dimension of care possess detrimental effect to patients. Despite the remarkable changes the nursing profession has undergone, it is still going through relevant changes to provide "human-centred nursing care". Embracing human-centred care would assist nurses caring for the 21 century society to achieve satisfaction of meeting the nursing client's personalised needs.

Professional boundary was reported by the participants who explained it as caused by coexisting principles of "spiritual values" and "professional values" which are conflicting. Narayanasamy and Owens (2001) argue differently; that nurses in practice are often confused about the nature of spiritual care to offer, which poses a challenge because their understanding of spirituality has a direct influence on how they will deliver spiritual care. Bath (1992) expands on this view and explained that nurses who defined spiritual care narrowly perceived themselves as engaging in it less frequently and vice versa. Similar conflicting situations were pointed by Highfield (2000) who argues about existing barriers from professional principles which promotes inability to deal with patients' felt needs including pain from loss of loved ones, unfamiliar imminent fear, death, suffering and or disruption of meaningful religious routines and practices. Carr (2008) reiterates the issue of disruptive patient care by pointing to certain realities that hinder implementation of spiritual health in nursing which include intense task-based focus of nursing, among others.

Despite some appearance of positive professional practice attributes including nurse-patient relationship, communication skills and assessment skills, it is acknowledged that to some extent professionalism may hinder implementation of spiritual care (Highfield, 2000). The challenge is that caring attributes still need to be facilitated by the nurse which often requires application of moral and ethical standards. However, some of these attributes have guided the practicing of nursing over past decades.

In contrast to professional boundary, personal emotional sensitivity or lack thereof may cause challenges in teaching-learning and clinical practice of spiritual care as reported by nursing students. This is based on the participants' experience arguing that "a feeling" of what the patient is going through is the main pre-determining condition for spiritual care. McSherry (2006); Chan *et al.*, (2006); Grosvenor (2000) argue that whether spiritual needs originate from cultural beliefs or religious beliefs (Narayanasamy, 2006; Chan *et al.*, 2006, Arnold & Boggs 2011: 85) it needs to be addressed for the sake of the patient. Professional boundary, amongst other things, was pointed as a measure to protect both the patient "who is at a vulnerability position" and the nurse "who is at the position of power" where tolerance of diversity is a prerequisite for ethical nursing. Although the participants from the current study spoke about recruitment selection- gap as an issue, this is not fully supported by literature. Therefore, it was not conceived as a serious threat to teaching-learning of spiritual care.

Teaching of spiritual care should therefore be directed at assisting students to grow their knowledge and skills in a manner that it is easy to integrate caring values to nursing interventions (Lee Hesieh, Kuo, & Tsai, 2004: 504). Practical learning sessions should allow students to experience connecting to self and others, find meaning, purpose and being aware of what they are going through whilst clarification of confusion be assisted by senior staff or clinical teachers (Hover *et al.*, 2004). In the past decades, various tools for teaching and assessment tools and scales for spiritual competence have been developed (Pesut, 2005; van Leeuwen and Cusveller, 2004; Narayanasamy, 2001). Assessment scales such as Spiritual Indicator Tool (Carpenito, 1999), amongst others, can be used to detect the level and extent of the spiritual disturbance in a person's belief system. Some tools are designed to measure the extent of spiritual disturbances in terms of religious beliefs, meaning and purpose including cognitive-related stress which may require crisis interventions.

4.6 CONCLUSION STATEMENTS FROM FOCUS GROUP DISCUSSIONS WITH NURSING STUDENTS

1. Spirituality refers to connectedness to the invisible higher power and inner-self through a belief system.
2. Spirituality is viewed as an in-born virtue and connectedness to the inner-self through emotions driven by personal motivation and energy.
3. Spirituality provides a foundation for spiritual care and it is connected to a complex belief system that integrates personal, religious, spiritual and cultural beliefs.

4. Connecting with the patient at a social level is embedded in spiritual value of caring which is demonstrated through relational and inter-connectedness.
5. Teaching-learning of spiritual care should be integrated throughout the curriculum and in clinical situations with the aim to limit perceived conflicting nursing perspectives.
6. Teaching-learning of spiritual care should provide spiritual care competence to students and instill the confidence to embark on spiritual matters through integration of caring skills. In a manner that eases and enhances connecting self with others as a means to redress theory-practice gap; through appreciation of own beliefs and values thus counteracting the lack of role models and a non-conducive environment.

4.7 CHAPTER SUMMARY

The discussion in this chapter was focused at demonstrating how the terms spirituality and spiritual care were perceived by the nursing students. The concept of spiritual care was further related to various terms or concepts to denote different uses. Such uses mostly application covered the meaning of spirituality and how it is linked to God, spirituality as connectedness in which varied connections were explored by participants. Vertical and horizontal connections were depicted through a relationship with God and others respectively. Spirituality was also related to holistic nursing which was contrasted with conflicting ideas or perspectives that hinder its implementation.

Participants concluded that the defining spiritual care remains a challenge as it is often dependent on what spirituality means which may differ from individual to individual. The conclusive statements that were drawn from the discussions on spirituality and spiritual care depicted connectedness as the most feature of spirituality; which is demonstrable in the following conceptualisation or connotations (i) belief and belief system (ii) spirituality (iii) relationships (iv) human values (v) caring values which are viewed as components of holistic care.

CHAPTER 5: DOCUMENT REVIEW: ACADEMIC RECORDS

5.1 INTRODUCTION

This chapter presents the findings from document review procedure which was conducted in response to the study objective three (3). The review was primarily conducted to identify the existence or non-existence of the elements of spiritual care from the academic learning contents. A detailed exposition of the process of document review as a data collection method was described in Chapter two (2). In this chapter, a synopsis of how the process of documents' review materialised and the findings are presented. Interpretation of the findings and an integrated discussion are also provided to enhance understanding of the outcome of the document review.

5.2 MATERIALISATION OF THE PROCESS OF DOCUMENT REVIEW

The document sampling framework, criteria for document selection and brief description of the selected documents were presented in Chapter two (2). A total of seventy-three (73) documents were reviewed which included one (1) curriculum, eighteen (18) module guides and fifty-four (54) assessments. Table 5.1 below presents the modules of the undergraduate nursing programme as depicted in the university calendar.

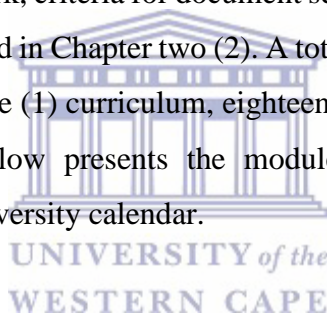


Table 5.1 The Undergraduate Nursing Curriculum as per University Academic Calendar

	Year 1	Numeric Code	Alpha Code	Credits	Reviewed
1.	Fundamentals of Nursing 111	873014	NUR111	15	X
2.	Fundamentals of Nursing 112	873015	NUR112	15	X
3.	Introduction to Philosophy of care 114	873011	IPC214	5	X
4.	Primary Health Care115	873012	HDP115	5	X
5.	Clinical Nursing (Lab) 111	821012	CUR111	15	X
6.	Human Biology 118	301118	HUB118	15	
7.	Human Biology 128	301128	HUB128	15	
8.	Physics for CHS	336018	PHY118	15	
9.	Chemistry 128 (CHS)	311128	CHM128	15	
	Year 2				
10.	General Nursing Science 211	822211	NRS211	20	X
11.	General Nursing Science 212	822212	NRS212	20	X
12.	Intro to Mental Health 214	821025	CUR214	10	X

13.	Brain and Behaviour 112	861015	PSY112	7.5	
14.	Introduction to Psychology 111	861013	PSY111	7.5	
15.	Human Biology 218	302218	HUB218	20	
16.	Human Biology 228	302228	HUB228	20	
17.	Pharmacology 204	871204	PHA204	20	
	Year 3				
18.	Unit Management 334/336	821034	CUR334	15	X
		821336	CUR 336	15	
19.	Midwifery 331/326	821048	CUR331	30	X
		821326	CUR326	30	
20.	Midwifery 332/327	821049	CUR332	15	X
		821327	CUR327		
21.	Community Health Nursing 324/311	821324	CUR324	30	X
		821032	CUR311	30	
22.	Community Health Nursing 325/312	821325	CUR325	15	X
		821033	CUR312	15	
23.	Child Health 324/313	821324	NRS324	15	X
		821313	NRS313	15	
	Year 4				
24.	Psychiatric Nursing 411	821411	NRS411	30	X
25.	Psychiatric Nursing 412	821412	NRS412	30	X
26.	Research Methods 421	821421	NRS421	20	
27.	Professional Practice 423	821423	NRS423	20	X
28.	Gender-Based Violence 401	821047	NRS401	20	X

X= reviewed modules

5.2.1 Materialisation of the curriculum

Structurally, the curriculum was bound in brown hard cover comprising of six (6) chapters that were dispersed over 227 pages. It was conceived as an official document because it contains the signatures of the Head of School and the representative member of the South African Nursing Council (SANC). The signatures were significant in validating the authenticity of the programme. A total of seven programme outcomes (POs) were identified which translate to exit level outcomes (ELOs) for each year level. Therefore, the ELOs are programme outcomes that have been modified to depict similar nursing subject matter and topics but at different complexity levels and approaches. Other outcomes identified from the curriculum were also

reviewed; they include: (i) Specific Outcomes Associated with Degree (SOAD); (ii) Developmental Outcomes (DOs); and (iii) Clinical Learning Outcomes (CLOs).

5.2.2 Materialisation of the module guides

A total of eighteen (18) module guides were reviewed. Five (5) modules from the first year included two (2) theory modules, one (1) clinical nursing module for Fundamentals of Nursing Science (FNS) and two (2) interdisciplinary modules from the Faculty of Community of Health Sciences Teaching and Learning Unit (ITLU) namely Introduction to Philosophy of Care (IPoC) and Primary Health Care (PHC) were reviewed. Three (3) modules from the second year level included: General Nursing Science (GNS) 1 and 2; and 1 Introduction to Mental Health modules (IMH). Six (6) modules from the third year level included two (2) Community Health Nursing Science (CHN); two (2) Midwifery (MID) modules, one (1) Child Health and one (1) Unit Management (UM). Four (4) modules from the fourth year included two (2) Psychiatric Nursing Science (PSY) modules, one (1) Professional Practice (PP) and one (1) Gender-Based Violence (GBV) module.

Nursing modules that were not reviewed are CUR327, CUR326, CUR311, CUR312, NRS336 and NRS324 as indicated in Table 5.1. These modules were excluded because they were a duplication of those selected in the same discipline.

5.2.3 Materialisation of the assessments documents

The formative assessment included tests, assignments, group projects and clinical skills instructions. Module credits weighting varied between five (5) and thirty (30) credits. A minimum of two (2) formative assessments and one (1) final assessment were a standard for each module. Summative assessments included all final examinations that were conducted at the end of a semester or year. Out of ninety-six (96) assessments that were targeted, only fifty-four (54) were reviewed as shown in Chapter 2.

5.3 PRESENTATION OF THE FINDINGS

The findings from data source are presented using tables. Each table represents a type of the document that was reviewed. There was both lack of matching spiritual elements and matching spiritual elements with the criteria items of the checklist. Sections 5.3.1 to 5.3.3 present both spiritual elements that matched and those that did not match. Each section was followed by a brief narration to account for unmatched criteria items which indicates the absence of the particular spiritual criteria item. Section 5.4.1 provides a comprehensive discussion of the

spiritual elements that came across all data sources. Literature was used not only to support the outcomes of the review but also to explain the possible contextual meaning and implications of the current status in teaching-learning of spiritual care in the undergraduate nursing programme at the school of nursing where the study was conducted. Lastly, an integrated discussion and chapter summary will be provided.

5.3.1 Elements from the curriculum

Data extraction from the curriculum was conducted across all the outcomes as these were covered in different year levels. These outcomes were sequentially reviewed according to how they were presented in the curriculum.

The first set of outcomes is *programme outcomes (POs)* which were regarded as the main outcomes because they are competency-based outcomes for nursing knowledge, skills and values for the entire programme. The curriculum outcomes were presented with *associated assessment criteria (AAC)* and *associated assessment (AA)*.

The second set of outcomes is *developmental outcomes (DOs)*. The DOs outcomes relates to development of critical learning skills in nursing students. They address the cross-field outcomes including transferable skills such as problem solving, critical thinking and clinical judgment. In addition, the DOs were aimed at shaping personal development of the students to become professionally responsible and sensitive practitioners.

The third set of outcomes is *specific outcomes associated with the degree (SOAD)*. These outcomes were associated with assessment criteria for nursing practice by nursing students in the undergraduate nursing programme in general, psychiatric and community areas and Midwifery areas of care. The SOAD outcomes were aimed at shaping the professional behaviour in students. They were depicted in different levels in different year levels of the programme where they address different issues such as communication, professional and ethical behaviour. These outcomes were addressed mainly under Ethos of nursing subject in the earlier years 1 and 2 and as Professional Practice (PP) subjects in senior years.

The fourth set of outcomes is *Clinical learning outcome (CLOs)*. Clinical learning outcomes (CLOs) are purely clinical-based. They relate to clinical learning and practice of the nursing students. They were directed at ensuring that clinical components were integrated in the learning contents for each module. Clinical assessment is integrated in the sense that students

are evaluated on their ability to integrate knowledge gained from nursing theory and Human Biology lessons in the execution of nursing activities.

Data extraction revealed that elements of spiritual care were spread across the year levels and nursing disciplines. However, there were also elements that were pitched at a high spiritual complexity level regarding required knowledge, skills or behaviour for a particular nursing competence within a particular year level.

Out of twenty-five (25) criteria items from the checklist, four (4) did not match with any spiritual elements. These include: item 14: awareness of personal transcendence; item 16: meditation, item 17: principle of radial experience of truth, and item 25: purpose in life. The rationale for the lack match of these criteria items is assumed to be based on the fact that the curriculum did not intentionally or clearly address the spiritual care topic; as it was depicted in all programme outcomes. These four items also did not match with identified elements of spirituality because they relate to deeper non-tangible meanings which are cognitive-spirituality, emotional-spirituality and connectedness-spirituality (Scott, 2007) Despite some elements that were identified such as communication, their application and use were not directed on spiritual care but on general and professional interventions.

Document review depicted that certain elements of spiritual care and spirituality were mostly found in the first and last years of the undergraduate nursing programme. In the undergraduate nursing programme year level two (2) in particular, the spiritual care elements were scarcely found as the year level content focuses mainly on the pathophysiology. Whilst in the year level three (3), scarcity of identified elements was based on the fact that both nursing disciplines in the third year are rigidly focused on skills relating to midwifery and community health nursing science respectively.

Table 5.2 below presents the elements that were identified and extracted from the curriculum. Highlighted sections in the tables indicate areas where no element was found to match with respective criteria, which is also indicated by a dash sign.

Table 5.2 Elements of spirituality from the curriculum

Theory Categories & Sub-categories: Burkhart & Hogan, 2008	Item No	Criteria items of spirituality	Extracted spiritual elements
Category 1: Cue from the patient	1.	Personal communication (<i>may include traditional beliefs & practices</i>)	Inter-personal skills; Interrelation; Strategies to solve culturally diverse issues and needs.
	2.	Need for rituals	Tolerance of diversity, demonstrate awareness and interest in own culture and other cultures, awareness about the role of culture in disease causation, facilitate solutions that cater for a culturally diverse society
Category 2: Decision to engage / not to engage	3.	Respect for individuality	Ethics of care; advocacy role; facilitate solutions that cater a culturally diverse society; show empathy and understanding of other problems and contexts.
	4.	Assessment of spiritual concern	Strategies to solve issues that emanates from a culturally diverse society, facilitate solutions that cater a culturally diverse society; interpersonal skills with focus on communication, caring, compassion and empathy; attentiveness, responsibility and duty.
	5.	Relationship with self and others	Inter-personal skills; awareness about the role of culture, interest in own culture and other cultures, coherently and effectively communicate; interrelation with individual, families and communities; professional and advocacy role
	6.	Focused attention (Reciprocity)	Strategies to solve issues that emanates from culturally diverse society, attentiveness, responsibility and duty.
	7.	Allow patient to talk and ask questions	Inter-personal skills, coherently and effectively communicate, Interrelation, Interpersonal skills with focus to communication, caring, compassion and empathy.

	8.	Active listening	Inter-personal skills, Coherently and effectively communicate, Interrelation, Interpersonal skills with focus on communication, caring.
Category 3: Spiritual Intervention	9.	Harmonious connectedness and providing space	Tolerance of diversity; culturally sensitive alternative strategies to address health issues of a culturally diverse society; show empathy and understanding of other problems and contexts; Interpersonal skills with focus on communication, caring, compassion and empathy.
	10	Responding to spiritual needs (present, still and silence)	Coherently and effectively communicate; awareness about the role of culture in disease causation; professional role as role model; facilitate solutions that cater a culturally diverse society, attentiveness, responsibility and duty.
Category 4: Immediate Emotional Response	11	Kindness to self and others	Inter-personal skills; interest in own culture and other cultures; responsible to others; advocacy role; facilitate solutions that cater a culturally diverse needs; understanding of other problems and contexts.
	12	Positive effect in a person's health	Interrelation; ethic of care; advocacy role.
	13	Learning about self through relationships	Inter-personal skills, Interrelation, Awareness about the role of culture in disease causation,
Category 5: Searching for meaning	14	Awareness of personal transcendence	-
	15	Personal meaning and experience of truth and experience of truth	Demonstrate awareness and interest in own culture and other cultures.

	16	Meditation (e.g. <i>self-awareness, self-healing</i>)	-
	17	Principle of radical experience of truth	-
Category 6: Formation of spiritual memory	18	Setting of life values	Tolerance of diversity; awareness about the role of culture in disease causation
	19	Valuing a person\ others	Awareness about ethics in health care; Inter-personal skills; Advocacy role.
	20	Being secure in one's life	Demonstrate awareness and interest in own culture and other cultures.
	21	Increase self-understanding and reduced self-criticism	Interrelation, Awareness about the role of culture in disease causation
Category 7: Nurse spiritual well-being	22	Critical view of spirituality through holistic focus:	Strategies to solve issues that emanate from culturally diverse society, advocacy role; awareness of culture in diseases causation; tolerance of diversity; facilitate solutions that cater a culturally diverse society;
	23	Creativeness	Strategies to solve issues that emanate from culturally diverse society,
	24	Pre-requisite of spirituality in the nurse	Attentiveness, responsibility and duty.
	25	Purpose in life	-

5.3.2 Elements from modules guides

Data extraction from the modules guides was systematically conducted starting from year one to year four of the undergraduate nursing programme. The findings from review of the module guides will be presented in the sequence from year one to four as a measure to enhance structural coherence and ease to read. Furthermore, findings from each year level will be presented in a separate table. Below Table 5.3 shows how modules were arranged across year level per discipline. Furthermore, it shows how each module provided distinct data.

Table 5.3 Modules reviewed per discipline

	MODULE DISCIPLINE PER BN YEAR LEVELS	CRITERIA FOR SELECTION	NUMBER OF MODULES SELECTED	NUMBER OF SELECTED MODULES PER YEAR LEVEL	RATIONALE FOR POTENTIAL SPIRITUAL ELEMENTS PER MODULE
BN Year Level 1 (Fundamentals of Nursing Science and Art)					
1	Fundamentals of General Nursing code FNS 111 (15 credits)	Semester 1 Nursing Module	1	5	The module addresses basic nursing care as students are introduced into nursing as offered in the programme including teaching methods
2	Fundamentals of General nursing code FNS112 (15 credits)	Semester 2 Nursing Module	1		
3	<i>Interdisciplinary Module:</i> Health Development and Primary Health Care Nursing code HDP115 (5 credits)	Semester 1/ Term 2 Inter-disciplinary Module	1		Module focuses on primary health care which is an aspect of nursing that is responding to a particular mode of nursing in line with SA Health Care Delivery System.
4	<i>Interdisciplinary Module:</i> Introduction to Philosophy of Care Nursing code IPC114 (5 credits)	Semester 2 / Term 3 Inter-disciplinary Module	1		Module focuses on ethical and moral issues on professional practice in nursing.
5	Clinical Nursing (Lab) code CUR111 (15 credits)	Year module	1		The module was reviewed in anticipation of possible application of spiritual care as part of nursing intervention.
BN Year Level 2 (General Nursing Science and Art)					
6	General Nursing Science 211 code NRS211 (20 credits)	Semester 1 Nursing module	1	3	Both modules were selected due to the different subject matter

	MODULE DISCIPLINE PER BN YEAR LEVELS	CRITERIA FOR SELECTION	NUMBER OF MODULES SELECTED	NUMBER. OF SELECTED MODULES PER YEAR LEVEL	RATIONALE FOR POTENTIAL SPIRITUAL ELEMENTS PER MODULE
7	General nursing science 212 code NRS212 (20 credits)	Semester 2 Nursing module	1		they contain. They address general nursing based on medical and surgical health problems. Integration of the clinical component could provide most opportunity for application of theory.
8	Introduction to mental Health NRS214 (7.5 Credits)	Semester 1	1		The module provides introductory care to mental health which is a special discipline in nursing.
BN Year Level 3: (Community Health Nursing – clash groups)					
9	Nursing Practice in Community Health settings codes CUR311 / CUR324 (30 credits)	Semester 2 Community health nursing skills modules	1	6	The module provided primary care & clinical skills which are special aspects of nursing.
10	Child Health 312 codes NUR312 / CUR325 (15 credits)	Semester 2 child-based	1		The module provides special aspects of nursing specific to child health
11	Child Health 313 codes NRS313 / NRS324 (15 credits)	Semester 2 child-based	1		The module provides clinical skills for managing child health illnesses
BN Year Level 3: (MIDWIFERY – clash groups)					
12	Normal Midwifery CUR331 / CUR 326 (30 credits)	Semester 2	1		The module CUR331 addresses normal labour and the CUR332 obstetric emergencies.
13	Obstetric emergencies CUR332 / CUR327 (15 credits)	Semester 2	1		
14	Unit Management CUR334 CUR336 (15 credits)	Semester 2	1		The module addresses wards administration. It was reviewed to see what preparatory measures are provided to meet spiritual needs of patients.
BN Year Level 4: (PSYCH)					
15	Psychiatry Nursing code NRS411 (30 credits)	Semester 1 module	1	4	The module addresses therapeutic management of mental illness which is an aspect of nursing.

	MODULE DISCIPLINE PER BN YEAR LEVELS	CRITERIA FOR SELECTION	NUMBER OF MODULES SELECTED	NUMBER OF SELECTED MODULES PER YEAR LEVEL	RATIONALE FOR POTENTIAL SPIRITUAL ELEMENTS PER MODULE
16	Psychiatry Nursing code NRS412 (30 credits)	Semester 1 module	1		The module addresses rehabilitation and management of psychiatric patients
17	Professional Practice code NRS423 (20 credits)	Semester	1		The module addresses Professional Practice role.
18	Gender-based Violence code NRS401 (20 credits)	Semester	1		The module addresses Gender-based violence as a public issue
	Total of modules reviewed			18	Each module had specific nursing focus as a reason for inclusion.

5.3.2.1 Elements from MGI

Out of the 25 checklist criteria items, seventeen (17) matched with spiritual elements from the module guide. But eight (8) criteria items did not match with spiritual elements from the MGI. The unmatched criteria items include: item 14: awareness of personal transcendence, item 16: mediation, item 17: principle of radical experience of truth; item 20 being secure in one's self; item 21: increased self-understanding and decrease self-criticism; item 22: critical view of spirituality through a holistic focus; 23: creativeness; and item 25: purpose in life. It is assumed that the eight (8) criteria items that did not match with spiritual elements are based on the following reasons:

- Learning content was derived from the curriculum which also did not match most of the checklist criteria items.
- The curriculum design did not explicitly address spiritual care phenomenon as this was shown from the curriculum and module outcomes.
- Identified elements of spirituality that narrated the deeper meaning and non-tangible experiences were not plainly addressed in the curriculum despite existence of certain elements which to some extent related to physical experience of spirituality rather than an abstract. Hence lack of matching of the deeper meanings and or non-tangible criteria items from the curriculum; presumably, this is due to spirituality and spiritual care not being addressed as a subject matter in the undergraduate nursing programme.

Despite the eight (8) criteria items which did not match with spiritual elements in MG1; it was acknowledged that the learning content about cues from the patients, decision to engage or not to engage with patients' spiritual matters and intervention, spiritual interventions and immediate emotional response were found in the MG1 nursing content.

Table 5.4 below table presents spiritual elements that were identified from MG1.



Table 5.4 Elements of spirituality from MG1

Theory Categories & Sub-categories: Burkhart & Hogan, 2008	Item No	Criteria items of spirituality	Extracted spiritual elements
Category 1: Cue from the patient	1.	Personal communication (<i>may include traditional beliefs & practices</i>)	Inter personal skills (IPS); Communication; patients' rights; patients as humans with fundamental rights to life; informed consent; human rights to life, Patients' right to refuse treatment
	2.	Need for rituals	Patients' rights
Category 2: Decision to engage / not to engage	3.	Respect for individuality	Terminal care, death and dying and caring for a bereaved family; Ethical decision making based on ethical values; Patients' rights; Willingness to reach out to the sick
	4.	Assessment of spiritual concern	Terminal care, death and dying and caring for a bereaved family; ownership of responsibility; ethical decision making based on ethical values; Willingness to reach out to the sick
	5.	Relationship with self and others	Patients' rights; Patients as humans with fundamental rights to life; Informed consent; human rights to life Patients' right to refuse treatment
	6.	Focused attention (Reciprocity)	Patients' rights; willingness to reach out to the sick; discusses various codes of ethics and how they would resolve ethical issues managing ethical dilemmas Patients as humans with fundamental rights to life; Informed consent; human rights to life, patient's right to refuse treatment; patient's Bill of Right Charter; ICN Code of Nurses; Patient Charter; Batho Pele
	7.	Allow patient to talk and ask questions	Inter-personal skills; patient's rights; communication; ethically-charged environment; socially-awareness practice; willingness to reach out to the sick

	8.	Active listening	Inter-personal skills; communication; socially-awareness practice
Category 3: Spiritual Intervention	9	Harmonious connectedness in providing care	Inter personal skills (IPS); communication; socially-awareness practice; Willingness to reach out to the sick;
	10	Responding to spiritual needs by being present, still and silent	Inter personal skills (IPS); communication; ownership of responsibility; ethical decision making based on ethical values; willingness to reach out to the sick
Category 4: Immediate Emotional Response	11	Kindness to self and others	Inter personal skills (IPS); communication; terminal care, death and dying and caring for a bereaved family; Social-awareness practice; Ethical decision making based on ethical values; willingness to reach out to the sick;
	12.	Positive effect in a person's health	Ethically-charged environment; ownership of responsibility; willingness to reach out to the sick; patients as humans with fundamental rights to life; Informed consent; human rights to life, patient's right to refuse treatment;
	13.	Learning about self through relationships	Inter-personal skills; communication; terminal care, death and dying, caring for a bereaved family; Socially-awareness practice
Category 5: Searching for meaning	14	Awareness of personal transcendence	-
	15	Personal meaning and experience of truth	Terminal care, death and dying, caring for a bereaved family; Patient's rights; Acknowledgment of patients as humans with fundamental rights to life; Informed consent; human rights to life patient's right to refuse treatment
	16	Meditation (e.g. <i>self-awareness, self-healing</i>)	-

	17	Principle of radical experience of truth	-
Category 6: Formation of spiritual memory	18	Setting of life values	Ethically-charged environment; patient's rights; ownership of responsibility; patients as humans with fundamental rights to life; Informed consent; human rights to life, patient's right to refuse treatment; ethical decision making based on ethical values;
	19	Valuing a person\ others	Terminal care, death and dying and caring for a bereaved family; ethically-charged environment; ethical decision making based on ethical values; Willingness to reach out to the sick;
	20	Being secure in one's life	-
	21	Increase self-understanding and reduced self-criticism	-
Category 7: Nurse spiritual well-being	22	Critical view of spirituality through holistic focus	-
	23	Creativeness	-
	24	Prerequisite of spirituality in the nurse	Ethically-charged environment; compassion, tenderness and impartial giving of self; Love or express love, sympathy, empathy, inspirational;
	25	Purpose in life	-

5.3.2.2 *Elements from MG2*

Out of the 25 checklist criteria items, sixteen (16) spiritual elements from the module guide could be matched with the criteria items; and no data from the MG2 could match the remaining nine (9) criteria items. The unmatched criteria items included: item 1: personal communication; item: 5 relationship with self and others; item 8: active listening; item 14: awareness of personal transcendence; item 15: personal meaning and experience of radical truth; item 16: mediation; item 22: critical view of spirituality through a holistic focus; item 23: creativeness; item 25: purpose in life.

The rationale for lack match of the nine (9) criteria items with spiritual elements from the MG2 can be awarded to the three rationales that were provided for MG1 above.

Table 5.5 below presents findings from MG2.



Table 5.5 Elements of spirituality from MG2

Theory Categories & Sub-categories: Burkhart & Hogan, 2008	Item No	Criteria items of spirituality	Extracted spiritual elements
Category 1: Cue from the patient	1.	Personal communication (<i>including traditional beliefs & practices</i>)	-
	2.	Need for rituals	Patient's rights; providing and maintaining holistic caring for patients
Category 2: Decision to engage / not to engage	3.	Respect for individuality	Patient's needs: e.g. psychological needs; cultural needs; emotional needs; social needs; and dignity effective communication both verbally and non-verbally; sound communication; rapport; effective communication skills; good listening skills; sympathy and empathy.
	4.	Assessment of spiritual concern	Identification of patient needs due to sudden change in person or and family processes; identification of ineffective family coping strategies e.g. signs of grieving, denial, depression.
	5.	Relationship with self and others	-
	6.	Focused attention (Reciprocity)	Identification of patient needs due to sudden change in person or and family processes; identification of ineffective family coping e.g. signs of grieving, denial, depression relating; person needs and cultural needs; providing and maintaining holistic caring for patients.
	7.	Allow patient to talk and ask questions	Identification of patient needs due to sudden change in person or and family processes; respect, empathy, effective communication both verbally and non-verbally; person needs and cultural needs therapeutic

			counselling skills, respect for others, empathy, effective communication both verbally and non-verbally; rapport; good listening skills; sympathy.
	8.	Active listening	-
	9.	Harmonious connectedness in providing care	Respect, empathy, effective communication both verbally and non-verbally; effective communication both verbally and non-verbally; interaction with patient; honest, courteous and respectful.
	10	Responding to spiritual needs	Providing counselling skills; empathy; sympathy
Category 4: Immediate Emotional Response	11	Kindness to self and others	Sensitivity to patient's needs e.g. need for privacy, respect, dignity
	12	Positive effect in a person's health	Accountability; trustworthiness; sensitivity to patient's needs for privacy
	13	Learning about self through relationships	Respect, empathy, effective communication both verbally and non-verbally;
Category 5: Searching for meaning	14	Awareness of personal transcendence	-
	15	Personal meaning and experience of truth	-
	16	Meditation (e.g. <i>self-awareness, self-healing</i>)	-
		Meaningful work	Identification of patient needs due to sudden change in person or and family processes; identification of ineffective family coping e.g. signs of grieving, denial, depression relating; providing and maintaining holistically caring for patients.

	17	Principle of radical experience of truth	Identification of ineffective family coping e.g. signs of grieving, denial, depression relating.
Category 6: Formation of spiritual memory	18	Setting of life values	Ethical behaviour, respect, dignity and rules of conduct
	19	Valuing a person\ others	Rules of conduct; accountability; patient's needs; sympathy, empathy, respect, and dignity.
	20	Being secure in one's life	-
	21	Increase self-understanding and reduced self-criticism	Identification of ineffective family coping e.g. signs of grieving, denial, depression relating.
Category 7: Nurse spiritual well-being	22	A critical view of spirituality through holistic focus	Identification of patient needs; cultural needs; rapport; effective communication skills; good listening skills; interpersonal skills (IPS) counselling skills.
	23	Creativeness	-
	24	Prerequisite of spirituality in the nurse	Identification of ineffective family coping e.g. signs of grieving, denial, depression relating; Sensitivity to patient's needs for privacy.
	25	Purpose in life	-

5.3.2.3 Elements from MG3

The extraction of data from MG3 modules commenced by reviewing Midwifery modules then followed by Community Health Nursing modules.

Out of the 25 checklist criteria items, seventeen (17) spiritual elements from the module guide matched with the criteria items. The unmatched criteria items data from the MG3 were eight (8) which included: item 4: assessment of spiritual concern; item 5: relationship with self and others; item 15: personal meaning; item 16: meditation; item 17: principle of radical experience of truth; item 18: setting values; item 20: Being secure in one's life; item 23: creativeness; item 25: purpose in life.

The same rationale for unmatched criteria items awarded to MG1 and MG2 are equally applicable for MG3.

Table 5.6 below presents the elements of spirituality extracted from MG3.



Table 5.6 Elements of spirituality from MG3

Theory Categories & Sub-categories: Burkhart & Hogan, 2008	Item No	Criteria items of spirituality	Extracted spiritual elements
Category 1: Cue from the patient	1.	Personal communication (<i>may include traditional beliefs & practices</i>)	Open communication; appropriate communication skills; counselling skills.
	2.	Need for rituals	Responsiveness to patient's need;
Category 2: Decision to engage / not to engage	3.	Respect for individuality	Cultural sensitivity, gender sensitivity, acceptance of diversity, respect for dignity, personal honesty; integrity, empathy, sympathy, caring, compassion, patience, and gentleness.
	4.	Assessment of spiritual concern	-
	5.	Relationship with self and others	-
	6.	Focused attention (Reciprocity)	Responsiveness to patient's need; holistic care
	7.	Allow patient to talk and ask questions	Open communication; appropriate communication skills counselling skills; listening skills
	8.	Active listening	Open communication; appropriate communication skills; counseling skills; emotional and psychological support, listening skills. Allaying patient anxiety.
Category 3: Spiritual Intervention	9.	Harmonious connectedness in providing care	Patient counselling; allaying patient anxiety.
	10.	Responding to spiritual needs by being present, still and silent	Cultural sensitivity, gender sensitivity, acceptance of diversity, respect for dignity, personal honesty; integrity, empathy, sympathy, caring,

			compassion, patience, and gentleness; emotional and psychological support; open communication.
		Truth telling, answering questions	Open communication; appropriate communication skills; emotional and psychological support; counselling skills.
Category 4: Immediate Emotional Response	11.	Kindness to others	Responsiveness to patient's need; integrity, empathy, sympathy, caring, compassion, patience, and gentleness; patient counselling; allaying patient anxiety.
	12.	Positive effect in a person's health	Responsiveness to patient's need; integrity, empathy, sympathy, caring, compassion, patience, and gentleness;
	13.	Learning about self through relationships	Patient counselling; allaying patient anxiety; counselling skills
Category 5: Searching for meaning	14.	Awareness of personal transcendence	Reflective practice; willingness to disclose and receptiveness to feedback
	15.	Personal meaning and experience of truth	Responsiveness to patient's need;
	16.	Meditation (e.g. <i>self-awareness, self-healing</i>)	-
	17.	Principle of radical experience of truth	-
Category 6: Formation of spiritual memory	18.	Setting of life values	-
	19.	Valuing a person\ others	Cultural sensitivity, gender sensitivity, acceptance of diversity, respect for dignity, personal honesty
	20.	Being secure in one's life	-

	21.	Increase self-understanding of spirituality and decreased self-criticism	-
Category 7: Nurse spiritual well-being	22.	Critical view of spirituality through a holistic focus	Responsiveness to patient's need;
	23.	Creativeness	-
	24.	Prerequisite of spirituality in the nurse	Responsiveness to patient's need; Integrity, empathy, sympathy, caring, compassion, patience, and gentleness;
	25	Purpose in life	-



5.3.2.4 Elements from MG4

Out of the 25 checklist criteria items, eighteen (18) spiritual elements from the module guide could be matched with the criteria items; and no data from the MG4 could match the remaining seven (7) criteria item. The unmatched criteria items are: item 6: focused attention (reciprocity); Item 12: positive effect in a person's health; item 15: personal meaning and experience of truth; item 18: setting of life values; item 23: creativeness; item 24: prerequisite of spirituality in a nurse and item 25: purpose in life.

The same rationale for unmatched criteria items awarded to MG1 and MG2, MG3 are equally applicable for MG4.

Table 5.7 below represents the elements that were extracted from MG4.



Table 5.7 Elements of spirituality from MG4

Theory Categories & Sub-categories: Burkhart & Hogan, 2008	Item No	Criteria items of spirituality	Extracted spiritual elements
Category 1: Cue from the patient	1.	Personal communication (<i>may include traditional beliefs & practices</i>)	Effective communication; Sharpened communication skills.
	2.	. Need for rituals	Affective skills to handle extreme emotional disturbance.
Category 2: Decision to engage / not to engage	3.	Respect for individuality	Transcultural nursing and sensitivity to diverse cultural group.
	4.	Assessment of spiritual concern	Discover patient's willingness to disclose and receptiveness to feedback
	5.	Involves relationship with self and others	Reflective writing - describe their feelings; transcultural nursing and diverse cultural group; affective skills towards extreme emotional disturbance.
	6.	Focused attention (Reciprocity)	-
	7.	Allow patient to talk and ask questions	One-on one therapeutic strategy; supportive interviews, trauma counselling sessions, or environmental manipulation to alleviate extreme emotions disturbance.
	8.	Active listening	Effective communication; sharpened communication skills; communication and interpersonal skills; group dynamics; communication channels, initiating timely communication, appropriate responses and listening.
Category 3: Spiritual Intervention	9.	Harmonious connectedness in providing care	Effective communication; sharpened communication skills; communication and interpersonal skills; group dynamics; communication channels, initiating

			timely communication, appropriate responses and listening; affective skills towards extreme emotional disturbance.
	10	Responding to spiritual needs	Transcultural nursing and diverse cultural group.
Category 4: Immediate Emotional Response	11	Kindness to self and others	Transcultural nursing and diverse cultural group; affective skills towards extreme emotional disturbance.
	12.	Positive effect in a person's health	-
	13.	Learning about self through relationships	Reflective writing - describe their feelings; reflective practice.
Category 5: Searching for meaning	14	Awareness of personal transcendence	Reflective practice; affective skills towards extreme emotional disturbance; discover patient's willingness to disclose and receptiveness to feedback
	15	Personal meaning	-
	16	Meditation (e.g. <i>self-awareness</i> , <i>self-healing</i>)	Reflective practice.
	17	Principle of radical experience of truth	Discover patient's willingness to disclose and receptiveness to feedback.
Category 6: Formation of spiritual memory	18	Setting of life values	-
	19	Valuing a person\ others	Transcultural nursing and sensitivity to diverse cultural group.
	20	Being secure in one's life	Reflective writing - describe their feelings.
	21	Increase self-understanding and reduced self-criticism	Reflective writing - describe their feelings.

Category 7: Nurse spiritual well-being	22	Critical view of spirituality through a holistic focus	Transcultural nursing and sensitivity to diverse cultural group; accountability; responsibility; and ethical-based practice
	23	Creativeness	-
	24	Prerequisite of spirituality in the nurse	-
	25	Purpose in life	-



5.3.3 Elements from the assessments

Data extraction from the assessment was systematically conducted starting from year one (1) to year four (4). However, the findings from all the year levels are presented concurrently because the process of data extraction was guided by identification of spiritual elements rather than the content which is contextualized by specific spiritual competencies or outcome-based interventions as indicators of spirituality. It is for this reason that the findings of the assessment from all the year levels are presented in one (1) table.

Out of the 25 checklist criteria items, eighteen (18) spiritual elements from the module guide could be matched with the criteria items; and no data from the assessment documents could match the remaining seven (7) criteria items. The unmatched criteria items are: item 11: kindness to self and others; item 12: positive effects in the person's health; item 16: meditation; item 17: principle of radical experience of truth; item 18: setting of life values; item 23: creativeness; item 25: purpose in life. The same rationale for unmatched criteria items awarded to MG1 and MG2, MG3 and MG4 are equally applicable assessment documents as these assessments were based on module outcomes and learning objectives.

Findings from review of assessment from all year levels are presented in Table 5.8 below.

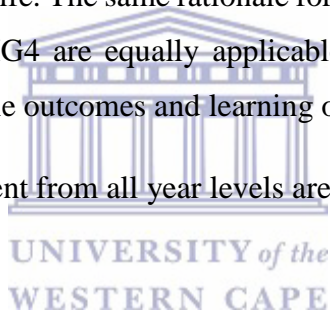


Table 5.8 Elements of spirituality from ASS

Theory Categories & Sub-categories: Burkhart & Hogan, 2008		Criteria items of spirituality	Extracted spiritual elements
Category 1: Cue from the patient	1.	Personal communication <i>(may include traditional beliefs & practices)</i>	The awareness of one's own limitations and the need to seek help where necessary; communication; listening and verbal skills; open communication with and responsiveness to patients, families and community at large; self-awareness; gaining understanding and insight of own behaviour; in interpersonal relationships.
	2.	Need for rituals	Learning about beliefs and their sources; intervention towards a patient who wants to talk about personal issues; transcultural nursing; appropriate interactions / sensitively when interacting with individuals of diverse cultural groups.
Category 2: Decision to engage / not to engage	3.	Respect for individuality	Learning and understanding of others beliefs and their sources.
	4.	Assessment of spiritual concern	Assessment of emotionally depressed patient with feelings of isolation and or missing home.
	5.	Involves relationship with self and others	The awareness of one's own limitations and the need to seek help where necessary; self-awareness; gaining understanding and insight of own behaviour; in interpersonal relationships.
	6.	Focused attention (Reciprocity)	Nursing students' intervention towards a patient who wants to talk about personal issues.
	7.	Allow patients to talk and ask questions	The awareness about the patient's limitations and need to seek help where necessary; displays good interpersonal, communication; listening and verbal skills; enhanced interaction with the client and caregiver; communicate at the level of the caregiver; allow the caregiver to ask

			questions, nursing students' intervention towards a patient who wants to talk about personal issues.
	8.	Active listening	Interpersonal skills; effective communication; listening and verbal skills; communicate at the level of the caregiver; allowing the caregiver to ask questions, displays good listening skills; listening to a patient who wants to talk about personal issues.
Category 3: Spiritual Intervention	9.	Harmonious connectedness in providing care	Interpersonal skills; communication; listening and verbal skills; open communication; with and responsiveness; shows empathy; gives appropriate responses; and listens actively group dynamics; nursing students' intervention towards a patient who wants to talk about personal issues; transcultural nursing; appropriate interactions / sensitively when interacting with individuals of diverse cultural groups.
	10	Responding to spiritual needs	Learning and understanding beliefs and their sources; creating an enabling environment that is therapeutic to meet the patient's needs and their right to privacy; confidentiality and preservation of dignity; nurse intervention for a person who is sad, anxious, and angry and disappointed, and those in need of the following peace, contentment or going through a grieving process.
Category 4: Immediate Emotional Response	11.	Kindness to self and others	-
	12.	Positive effect in a person's health	-
	13	Learning about self through relationships	The awareness of one's own limitation and the need to seek help where necessary; self-awareness; gaining understanding and insight of own behaviour; in interpersonal relationships.
Category 5: Searching for meaning	14.	Awareness of personal transcendence	Self-awareness; gaining understanding and insight of own behaviour; in interpersonal relationships.

	15	Personal meaning and experience of truth	Awareness of one's own limitation and the need to seek help where necessary; transcultural nursing; appropriate interactions / sensitively when interacting with individuals of diverse cultural groups.
	16	Meditation (e.g. <i>self-awareness, self-healing</i>)	-
	17	Principle of radical experience of truth	-
Category 6: Formation of spiritual memory	18	Setting of life values	-
	19.	Valuing a person\ others	Creating an enabling environment that is therapeutic and meets the patient's needs and the right to privacy; confidentiality and preservation of dignity; philosophy of rendering services according to the Batho Pele principles; Ethical-Legal Framework for practice; professional in behaviour.
	20.	Being secure in one's life	Positive attitudes; demonstrate professional accountability and responsibility; being a role mode" and a positive influence on the nurses; self-awareness; gaining understanding and insight of own behaviour; in interpersonal relationships.
	21.	Increase self-understanding and reduced self-criticism	The awareness of one's own limitation and the need to seek help where necessary; self-awareness; gaining understanding and insight of own behaviour; in interpersonal relationships.
Category 7: Nurse spiritual well-being	22.	Critical view of spirituality through a holistic focus	Learning about beliefs and their sources; intervention towards a patient who wants to talk about personal issues.
	23.	Creativeness	-

	24.	Prerequisite of spirituality in the nurse	Development of traits such as “integrity, empathy, caring, compassion, patience, gentleness, cultural and gender sensitivity, acceptance of diversity, respect for patient’s dignity, privacy and confidentiality, personal honesty; intervention for a person who is sad, anxious, and angry and disappointed, and those in need of the following: peace, contentment or going through a grieving process; positive attitudes; demonstrate professional accountability and responsibility; professional accountability; being a role model and a positive influence on the nurses; positive attitudes; demonstrate professional accountability and responsibility; being a role model and a positive influence on the nurses
	25.	Purpose in life	-



5.4 OVERVIEW OF THE RESULTS FROM THE DOCUMENTS

An overview of the findings from the programme is outlined in this section to depict the elements that were found per data source. The purpose of document review was not to find out how the spiritual elements were functional; neither did it intend to explore the extent of use or effectiveness of spiritual elements. However, it was aimed at identifying the existence of the spiritual elements by affirming their presence in the undergraduate nursing curriculum.

5.4.1 Comprehensive spiritual elements across data sources

Despite the use of Burkhart's and Hogan's (2008) experiential theory of spiritual care in nursing practice as a framework to guide extraction of the elements; the discussion will not literally be based on the seven (7) processes and sub-processes of the theory framework. Table 5.9 shows the frequency of appearance and scoring of data elements across the programme. The scoring of the spiritual elements ranged from one (1) to six (6) with 1 being less appeared meaning or less used in the programme; and 6 being the frequently and most appeared in the programme whilst zero (0) represents elements that were identified in any of the data sources. Where six (6) and five (5) meant high scoring, four (4) and three (3) moderate scoring and one (1) and two (2) low scoring. Table 5.9 provided how the scoring was used to show high, medium and low scores. The high scores of six (6) were awarded to spiritual elements such "as need for rituals", "respect for individuality", "allow patient to talk and ask questions", "harmonious connectedness", learning about self through relationships" and "valuing self and others" were accepted as most covered in the programme.

The second highest score of five (5) was awarded to the following element: "personal communication", "assessment of spiritual concern", "focused attention or reciprocity", "active listening", "kindness to self and others" and "increased understanding", "reduced self-criticism" and "prerequisite of spirituality in the nurse" as they appeared in the programme. The moderate score of four (4) was awarded to the following elements: "relationship with self and other", "positive effect in the parson's health", "personal meaning" and "experience of truth", "being secure in one's life" and critical view of spirituality through a holistic view". The moderate score of three (3) was assigned to an element such as "awareness of personal transcendence", "intuition of deeper meaning of illness and death" as well as "setting life values". The low score of two (2) and one (1) were awarded to the following elements: principle of radical experience of "truth" and "meditation", and "creativity" respectively. Spiritual elements that scored a moderate three (3) points and the low scores of two (2) and

below were situated in the categories “searching for meaning” and “nurse spiritual well-being” respectively. This finding is in line with Burkhardt and Hogan’s (2008: 932) theory which explains the progression of spiritual growth in a person. The authors distinguish the nurse’s spiritual well-being phase as a personal dimension through which a person grows the potential and capability to offer spiritual care to others based on own personal spiritual encounters, meaning and sense of purpose in life. The last score of zero (0) was awarded to one element “purpose in life” as it was not identified from any of the data sources. This can be assumed to be due to the fact that spiritual care was not formerly integrated in the programme; hence deep spiritual subject topics were neither significantly covered nor overtly taught. Convincingly, the spiritual elements relating to the deep spiritual experience such as transcendence, life purpose and radical experience of truth for instance primarily were not intentionally presented and taught.

Three (3) elements that exclusively did not match with spiritual elements from any data source include meditation (item: 16), creativeness (item: 23) and purpose in life (item: 25). These items are examples of deep spiritual phenomenon as described by the connotations of searching for meaning as appeared in the data extraction tool. This means that the curriculum did not provide for facilitation of deep spiritual interventions as depicted in the results. The programme outcomes and learning contents did not support the teaching of deep spirituality and spiritual care in the undergraduate nursing programme. This shows potential lack of understanding of the value and significance of spiritual care from the nurse educators’ perspectives.

Burkhardt and Hogan (2008) attest that searching for meaning and formation of spiritual memory do not only influence a person’s spiritual well-being but they are mutually entangled in the sense that transition from searching for meaning to formation of spiritual memory depend on reflection with self and others which then allows the person to transit to spiritual well-being. According to the finding of this review, “searching for meaning” in particular which relates to deeper meaning of spiritual well-being were absent in the curriculum. Therefore, existence of unmatched criteria items across all year levels indicated a lack of nursing contents that engages students in forming personalised relationships with patients; for an example setting of life values appears was the most unmatched. The lack of spiritual care that goes beyond religious requirement was observed as the levels at which patients’ spiritual needs were met.

5.4.2 Themes derived from identified spiritual elements

This section focused on overarching spiritual components emanated from diverse spiritual elements as depicted in the data extraction tool. These components were not intended for spiritual use but merely directed at teaching professionalism as it was shown in their contextual application. For instance, “communication” was taught to enhance interaction between the professional nurse in charge and the staff about new developments in nursing profession and management of patients primarily. These themes include: (i) communication, (ii) ethics, (iii) cultural diversity and (iv) caring-relationships. Each of these themes will be discussed below. No sub-themes are provided because the themes were formed from the elements and not complete units of speech or meanings.

▪ Communication

Communication appeared to be the most appeared and used elements as represented in various ways in the documents reviewed. This theme was made for the following elements that relate to “active listening”, “harmonious connectedness in providing care”, “responding to spiritual needs”, “allow patient to talk and ask questions”. Morrison and Burnand (1998) argue that despite nursing education having evolved, changed and transformed in many ways including theories, models, teaching strategies and delivery methodologies; yet caring and communication needs have not changed. Furthermore, these authors argue that caring and communication are non-replaceable nursing responsibilities. Hence nurses are required to become competent carers and communicators. Mellish, Oosthuizen and Paton (2011:3) concur with Morrison and Burnand (1997) that nursing is a caring human activity with a primary goal to reach out to the needs of human beings which requires the nurses to be skilful communicators when relating to patients. The need for good communication skills for nurses is also supported by Kourkouta and Papathanasiou (2014: 65) who argue that effective communication brings understanding of the patients and their expressed experiences which are of great importance to the nurse.

Despite the need for effective communication increasingly being acknowledged in nursing as a vital aspect in patient-centred care, it is still not well understood (Smith & Pressman, 2010). Challenges in creating effective, transparent and open communication in health care have been reported by many authors (Chapman, 2009). In the current study, the subject of communication was formally integrated in the curriculum from year one (1) to year four (4). Notably, it was used specifically to address aspects of the professional nursing practice which require clear and effective communication in contrast to its unique use in spiritual care or spirituality. The value

of communication especially when giving information to the patients is well accepted in nursing education and practice. However, Ryan (2000) admits to existing challenges in curricular variation with regards to content, depth and integration of communication subject in one hand and its teaching on the other.

Futhermore, Boshier and Smallkoski (2001: 61) argue about challenges on communication courses in nursing which do not promote effective communication. They point to existing concerns about speaking and listening skills in health-care settings through which assertive skills, therapeutic communication, information gathering and role of culture in health care can be developed in students in order to promote effective communication between students and patients. Other studies also reveal existing communication difficulties among nursing students (Lambrini & Papnasioau, 2014) which include inappropriate stress, intonation with client, low voice volume, nervousness, lack of understanding and assertiveness.

Therefore, in this study it is acknowledged that communication in nursing programmes can be integrated in various ways and depths. This supports Lambrini and Papnasioau (2014) who argue that nursing education should teach students two important aspects of communication which are “content” and “value”. The value of communication and interpersonal relations are components of wholeness and dialogue that can bring authentic and congruent practice through enhanced meaning and satisfaction (Morrison & Barnurd, 1998). Often than not, communication content is addressed while there is dearth in addressing its value which is equally vital in achieving positive patient’s spiritual health outcomes. Therefore, nurses must be equipped on how to communicate well because they deal with human related ethical issues or dilemmas among other things which often do not have straight answers (Steinberg & Angelopulo, 2015). Teaching communication with regard to spirituality and spiritual care is one of the effective methods that can be implemented to improve such communication (Lambrini & Papnasioau, 2014).

Understanding of communication in nursing is of vital importance especially when caring for a diverse society or population (Lou & de Leon, 2008). Diversity is one of the expanding roles of nursing as they come into contact with all cultures. This means that the nurse will at some stage be influenced by patient’s need to engage with belief, art, morals, law, customs, and any other cultural aspects and habits in order to satisfactorily care for the patient. This means that nursing profession should be clear not only on how challenges of defining and standardising

the concept of cultural diversity is addressed but more importantly it should determine how much diversity tolerance can the profession tolerate (Habayeb 1995: 224).

- **Ethics**

Ethically-based practice was associated with ethically sound nurse's response to the patient's needs. The spiritual elements that constituted this theme include the following but not limited to: "assess spiritual concern", "responding to spiritual needs, "relationship with self and others", as well as valuing self and others. Expanding role of ethics in nursing requires incorporation of specialised communication skills and knowledge in nursing programmes. Nursing ethics curriculum in undergraduate nursing programmes should provide foundational knowledge and skills to guide students in decision making in managing ethical dilemmas arising in professional practice (Peirce & Smith 2008: 270). But more importantly, to train nurses who are skilful communicators when engaging with patients who are often bound by stressful experience due to ill-health. Such communication skills will promote the nurse's understanding that the patient's dialogue usually departs from the point of stressing which is evidenced in their emotional and psychological imbalance (Lewinson, *et al.*, 1015: 808). Therefore, nurses should always ensure ethical communication with patients which promotes and maintains healthy nurse-patient relationships, as well as ethically-based nursing practice through effective, sensible and purposeful communication where both content and value of communication are considered.

- **Cultural diversity**

Some of the elements that constituted this theme include: "need for rituals", "respect for individuality" and "assessment of spiritual concern". Despite debates as to what are best ways to teach cultural sensitivity and acceptance of different cultures, nursing education should teach nursing students how to meet the common human needs associated with cultural diversity in nursing (Cannaerts, Gastmans, & de Casterle). Whilst Mellish, Oosthuizen and Paton (2011) argue cultural sensitivity is crucial in South Africa because of great diversity of the Rainbow Nation. Kikuchi (1996) suggests that transcultural ethics should be grounded in moderate realism whilst respecting the patient culture and beliefs on one side. Nurse educators should review moral injection and tenets of multicultural ethics in order to avoid cultural relativism (Zalta, 2016). Lack of clarity about the concept of spirituality and or spiritual care (Monareng, 2012; McEwan 2004; McSherry & Ross, 2002; Narayanasamy & Owen, 2001; and Sawatzky & Pesut, 2005) causes lack of implementation of spiritual care in nursing. Also, diverse cultures

may increase strain on the nurse's side owing to multicultural norms, biases and expectations caused in an attempt to meet inherent human needs (Kukichi, 1996). Literature points to confusion in ethics education created by lack of systematic approach (Cannaerts & Casterle, 2014). Spiritual care has potential to redress ethical and culturally-based human issues, which can be achieved by teaching nurses how to increase self "*understanding and reduce self-criticism*". Ethics education can benefit students as it increases awareness of own personal limitations and discovery of personal and professional values. This can benefit both nursing students and their patients.

- **Caring-relationships**

This theme was constituted from the elements including: "focused attention", "Involves relationship self and others", "valuing a person and others", "relationship with self and others", "critical view of spirituality through a holistic focus" among other spiritual criteria. Freshwater's (2005: 5) conception that nursing practice is concerned with "caring" and "relationships" primarily puts these two terms in an inextricably related relationship. Caring is about relationships and vice versa. A "caring relationship" is not only related to companionship but it is crucial for therapeutic and healing purposes (Morrison & Burnand 1998). Watson (2001) argues that despite caring and nursing being so intertwined; caring is often neglected due to nurse's feelings that they are pressed for time. Watson's (2001) theory of caring-presence are expressed through caritas factors that denote an interface between caring, nursing and ethic of care as basic essentials in nurse practice; yet the moral aspect of nursing as an activity that is often challenging to nurses (Gatsmans, 2006). According to Watson's (2001) argument about importance of caring presence, spiritual care becomes vitally needed in education of nursing students. Therefore, spiritual care within the nursing curriculum could cover topics on importance of the nurse being available, sitting with, holding hands and talking with the patient. Narayanasamy and Owens (2001) strongly support that inclusion of spiritual care education in nursing education would increase nurses' knowledge, understanding, and provision of spiritual care.

Anorl and Boggs (2011: 7) conceive a healthy nurse-patient-caring-relationship as the very basic therapeutic strategy that can provide basis for sound nursing interventions. The purpose of holistic nursing theories is to convey to the nurses the meaning of health experience whilst guiding them on how to effectively engage with patients (Anorl & Boggs, 2011: 89). Therefore, developmental changes that have occurred in the profession of nursing should not

be misinterpreted as substitute to caring. First and foremost, nursing is about caring and not curing (Morrison & Burnand 1998). Nursing content should “prioritise caring” and teach nurses to understand the difference between “nursing” and “caring”. Caring is not only a basic value for holistic nursing but a component of spiritual care. However, spiritual curricula in nursing education are underdeveloped and not integrated consistently. The role of moral development, responsibility and accountability in nursing students through learning mould their personal and professional growth. The nursing student’s personhood and spiritual maturity also get enhanced (Scott, 2007). Bukhardt’s (1989) definition of spirituality encompasses every humanity-based activity that are important to the person or individual. Notably, most definitions of nursing capitalise on the “value of human being” as the basis of practice of nursing (Bruce *et al.*, 2011: 6; Pera & van Tonder, 2014).

Many definitions of nursing depict and require nurses to undergo personal and professional growth. Such development should be measured through an individual’s extent to purpose of nursing, focus, values, knowledge, competence and skills attributed to a nurse (Bruce, Klopper & Mellish, 2011: 7). Students’ moral development leads to maturity which causes students not only to become more sensitive to the needs of individual patient family and community but also accountable and responsible practitioners (Bandman & Bandman, 1985: 51-53). The findings from reviewing the academic records revealed that the terms responsibility and accountability were significant constructs in an attempt to develop morally sound and ethically sensitive qualities in nursing students.

Table 5.9 presents scoring of the review findings from six data sources. The meaning of scores was explain in overview of the results from the documents in section 5.4.1. The purpose of this table was not only to show document sources from which spiritual elements were identified but also to illustrate the degree to which each spiritual element was represented in the academic records. For an example the criteria item one (1) shows the degree to which “*need for rituals*” was represented or covered across all data sources hence it was scored at 6 points. This means that “*need for rituals*” was extracted from all six data sources. Another example is criteria item twenty-three (23) which was scored at one (1) meaning that “*creativity*” as a spiritual element was identified from only one (1) data source excluding the other five data sources that were also used for review. Criteria item twenty-five “purpose in life” shows yet another picture where no data source was identified that contain this spiritual element hence it was scored at zero (0).

Table 5.9 FINDINGS FROM DOCUMENT REVIEW PRESENTED PER DATA SOURCE

Theory Categories & Sub-categories: Burkhart & Hogan, 2008		Spiritual Criteria items	Data sources where spiritual elements were extracted						
			Curriculum	MG1	MG2	MG3	MG4	Assessment	Tally Scores
Category 1: Cue from the patient	1	Personal communication	✓	✓	X	✓	✓	✓	5
	2	Need for rituals	✓	✓	✓	✓	✓	✓	6
Category 2: Decision to engage / not to engage	3	Respect for individuality	✓	✓	✓	✓	✓	✓	6
	4	Assessment of spiritual concern	✓	✓	✓	X	✓	✓	5
	5	Relationship with self and others	✓	✓	X	X	✓	✓	4
	6	Focused attention	✓	✓	✓	✓	X	✓	5
	7	Allow patient to talk and ask questions	✓	✓	✓	✓	✓	✓	6
	8	Active listening	✓	✓	X	✓	✓	✓	5
Category 3: Spiritual Intervention	9	Harmonious connectedness	✓	✓	✓	✓	✓	✓	6
	10	Responding to spiritual needs	✓	✓	✓	✓	✓	✓	6
Category 4: Immediate Emotional Response	11	Kindness to self and others	✓	✓	✓	✓	✓	X	5
	12	Positive effect in a person's health	✓	✓	✓	✓	X	X	4
	13	Learning about self through relationships	✓	✓	✓	✓	✓	✓	6
Category 5: Searching for meaning	14	Awareness of personal transcendence, intuition deeper meaning of illness & death	X	X	X	✓	✓	✓	3
	15	Personal meaning and experience of truth	✓	✓	X	✓	X	✓	4
	16	Meditation (e.g. <i>self-awareness, self-healing</i>)	X	X	X	X	✓	X	1
	17	Principle of radical experience of truth	X	X	✓	X	✓	X	2
Category 6: Formation of spiritual memory	18	Setting of life values	✓	✓	✓	X	X	X	3
	19	Valuing a person\ others	✓	✓	✓	✓	✓	✓	6
	20	Being secure in one's life	✓	X	✓	X	✓	✓	4

	21	Increase self-understanding & reduced self-criticism	✓	X	✓	✓	✓	✓	5
Category 7: Nurse spiritual well-being	22	Critical view of spirituality through a holistic focus	X	✓	✓	✓	✓	✓	4
	23	Creativeness	✓	X	X	X	X	X	1
	24	Prerequisite of spirituality in the nurse	✓	✓	✓	✓	X	✓	5
	25	Purpose in life	X	X	X	X	X	X	0

Colour code for scores: orange=6; green=5; blue =4; avocado=3; mink= 2, grey=1; dusky pink=0 and red= X (i.e. unmatched criteria per data source).



5.5 CHALLENGES IN INTERPRETING EXTRACTED DATA

Although the identification of the elements was to some extent backed by applying Burkhardt's and Hogan's (2008) theory of spirituality, these were just broad categories with no specific action or experiences. The progression of interpretation of findings from data was therefore, enhanced by Morse's view which denotes that complex human experiences can be categorised to achieve suggested meaning (Morse, 1995: 31).

Based on this suggestion, probability view was used to assign meaning to elements through application of an exemplar or prototype (Jabareen, 2009: 51; Melodie 2011a: 152). Therefore, where the spiritual elements were not definitive in their nature, the probability principle was applied. The findings were presented in respective tables according to data sources from which they came. Table 5.9 presents a comprehensive picture of the data extraction. The cross (x) indicates the absence of the spiritual elements per data source per criteria item. The tick (✓) indicates the presence of the spiritual elements per data source per criteria item.

Despite the checklist items being composed in a manner that aided uncovering of existing spiritual elements in the learning content, the fact that the checklist items were broad and did not focus on specific spiritual occurrence or event posed potential for non-stringent application of the element. Therefore, extraction of the spiritual elements was not only a challenge in terms of mere identification of spiritual elements; however, the most critical aspect was the identification of spiritual elements in view of their contextual meaning from which they were used. In some instances, the identified element did not match with universal meaning of spirituality yet, in contrast to spiritual focus that was sought. This challenge warranted that the documents and or elements be read repeatedly to get their contextual meaning. The purpose was to gain the closest understanding and meaning of the spiritual element which would ensure its appropriate interpretation thereof. This was necessary owing to the broad criteria items that were used when extracting data. Below is the researcher's description of some of the challenges that were experienced during data extraction.

- (i) Extracted elements that were assumed to have spiritual connotations such as "*communication*" were however used for professional "*communication*" which contains a different intention in the nursing curriculum in contrast to the use of communication in spiritual focus. The implication for the study findings is that despite communication being identified as spiritual element, its nature and or meaning when investigating deeper addressed a different intention and nursing outcome.

- (ii) Other elements such as “*ethical and morally based interventions*” did not in particular bear any spiritual meaning as such. However, such elements were found to represent academic and philosophical perspectives which are fundamental when developing student’s spiritual care competence. Despite these terms being selected, they raise empirical questioning as they do not fall directly under spiritual subject. Nevertheless, these concepts were extracted based on their relevance and role they play in development of spiritual awareness as well as moral behaviour. Interpretation of the findings may possibly suffer criticism based on different understandings and meanings of spirituality. Another predictable challenge relates to transferability of the findings from one context to the other because the data extraction tool was not literally used as a blueprint. However, it provided broad contextual statements signifying the likelihood of extracted elements to possess different meanings in different contexts which was viewed as posing challenges of transferability.
- (iii) The process of review did not permit accounts of misunderstandings or wrong conceptions of terms including myths, or complex spiritual connotations and experiences for different religious, cultural and professional beliefs. In view that these beliefs emanate from different set of norms, values, mores, traditions, behaviors and morals, it highlights a possible challenge with spiritual learning content. Nevertheless, movement towards implementation of spiritual care in nursing practice should not be motionless. Literature alerts about potential hindrance and delay in advancement of spiritual care in the nursing practice which is grounded on lack of understanding about the patient’s desperate need for spiritual care.

Document review revealed that certain elements did not hold an absolute spiritual meaning as they changed accordingly in different contexts. For an example, certain phenomena were interpreted differently depending on participants’ understanding and experience. Potential clashes inherent in complexity of spiritual elements as used by academic and philosophical meanings in contrast, pure spiritual-focus is unavoidable.

A protocol to review academic documents was used systematically to extract spiritual elements. The idea of extracting the elements of spiritual care rather than looking for whole units of the subject matter of spirituality and spiritual care was based on the premise that spiritual care as a learning area was not formally integrated in the curriculum at the time of the review of the undergraduate (UG) bachelor of nursing (BN) programme at a university nursing school in the Western Cape. Therefore, searching for spiritual elements rather than units or big chunks of spiritual subject matter was more real. Hence, searching for elements that closely relate to spiritual

care was unconditional. Further, the nature and type of selected spiritual elements was influenced by theoretical knowledge on the spiritual care content for nursing.

5.6 CONCLUSION STATEMENTS FROM DOCUMENTS REVIEW

1. Spiritual care relates to purposeful communication as an essential non-replaceable nursing responsibility and practice for nurses. Therefore, preparation of nursing students to become skilful communicators should accommodate varied spiritualities and the importance of communication that prepares the nursing students to speak clearly; listen actively as they grow personally and professionally in assertiveness and therapeutic communication with regard to patient's culture.

2. Spiritual care relates to purposeful communication as an essential non-replaceable nursing responsibility and practice for nurses.

3. The starting point of teaching-learning spiritual care should not be to impose the nurse's spiritual, cultural and religious dispositions on patients. But it should be based on caring relationships as a means to facilitate patient's healing and recovery from illness and state of loss of personal control and empower the patient to conduct their daily life processes for health and personhood needs, which are inextricably intertwined with the patient's cultural and spiritual beliefs.

4. Teaching-learning of spiritual care should be directed at developing personal and professional responsibilities and accountability in nursing students in a manner that does not prioritise technical nursing but through promotion of caring-relationships and interpersonal relationships to connect with patients while conveying to the nurse the meaning of health experience and importance of therapeutic environment. Such teaching should increase student's awareness of own personal limitations and discovery of personal and professional values that influence execution of care in a morally sound manner.

5. Nursing education should integrate caring values in a manner that promotes -caring-relationship not only as essential human interaction for holistic nursing; but as an active ingredient in reaching out to human needs through caring-presence and purposeful relationships that cater for individual's beliefs, norms and values that are significant to a patient as a care receiver.

5.7 CHAPTER SUMMARY

Description of selected documents and the process of document review were provided in this chapter. Extraction of the elements representing spiritual aspects was also shown. The integrated discussion and conclusion statements were provided after which the summary of the chapter was provided. The conclusion statements were used as a foundation on which the conceptual framework was developed in chapter six (6).



CHAPTER 6: CONCEPTUAL FRAMEWORK

6.1 INTRODUCTION

This chapter focuses on objective four (4) of the study which was to develop and describe a conceptual framework for teaching learning of spiritual care in the undergraduate nursing programme at a higher education institution in the Western Cape. The chapter presents the process of theory generation through development of the conceptual framework. The conceptual framework was developed through identification of concepts from the empirical data (Chinn & Kramer, 2011) and classification using the survey list of Dickoff, James and Wiedenbach (1968). The classified concepts as shown in Figure 6.1 were then described using dictionaries and thesaurus as a means to contextualise the developing conceptual framework. A brief exposition of the theoretical knowledge that underpins the conceptual framework is presented below.

6.2 THEORETICAL KNOWLEDGE SUPPORTING THE CONCEPTUAL FRAMEWORK

A conceptual framework is understood as a network of concepts that are used to depict comprehensive relationship of a phenomenon through its interlinked counter parts (Jabareen (2009: 51). Concepts in the conceptual framework do not only produce an ‘ideal’ about the phenomenon; however, their significance is creation of universal meanings for effective communication. The conceptual framework was formed from conclusion statements derived from data sources as presented in Table 6.1. Concepts were classified according to Dickoff *et al.* (1968) as explained in section 6.4 and shown in Table 6.2. The purpose of the framework was to organise and arrange identified concepts according to their nature and relationships (Bink, 2011; Dickoff *et al.*, 1968; Burns & Grove, 2009: 147).

6.2.1 Development of conceptual framework

The conceptual framework was formed from concepts that represented complex mental formulation of participants’ empirical experiences. Concepts play an important role in communication and provide pragmatic significance in theory generation (Chinn & Kramer, 2011; Walker & Avant, 2010). Concepts were laid out on A3 paper to illustrate the cause-and-effect, explanatory or descriptive relationships (Chinn & Kramer, 2011). The process of concept identification as described in section 6.3 shows how the researcher arranged the concepts into their typology of relationships. Literature control was then used to support and ground the developed conceptual framework (Burns & Grove, 2009: 146; Chinn & Kramer, 2011).

Deductive and inductive reasoning strategies were applied to derive concepts from the participants' life experiences through thick descriptions of their knowledge and perceptions (Klopper, 2008; Mavundla, Poggenpoel & Gmeiner, 2001: 10). Participants' conceptualisation of spirituality was necessary to support the generated theory in accordance to their social and cultural expectations as they responded to the research question '*how can the practice theory for teaching-learning of spiritual care in the nursing undergraduate programme at a higher education in the Western Cape be generated?*'

The development of the conceptual framework was founded on the notion that various knowledge provide a solid base in theory generation. Chinn and Kramer (2011) view theory generation as a process of analysing knowledge through conceptualisation and structuring of ideas into formal descriptions. These authors believe that knowledge is generated from different sources which include personal, aesthetics, ethical and empirical knowledge Chinn and Kramer (2011). Knowing entails ways of perceiving and understanding the self and the world. However, Chinn and Kramer (2011) and Mouton (2009) argue that empirical knowledge can only reveal a portion of the whole phenomenon under inquiry, hence they advocate for various forms of knowing when generating a theory. In response to this view, the researcher triangulated data sources to elicit different knowledge about the phenomenon under study.

6.2.2 Scientific underpinning to identification of concepts

Jabareen's (2009) classical and probability approaches to identify concepts allowed the researcher to arrange the concepts according to their typology. Jabareen's (2009: 51) scientific approach to conceptualisation was ideal for this study based on the nature of the knowledge that sought to establish abstract, inferential and symbolic meanings of identified concepts. Identification of concepts was challenging owing to different categories of concepts and the concepts themselves which are influenced by terminology and linguistic issues. Chinn and Kramer (2011) support that abstract concepts should be determined by their components of constituent elements; which can then be linked according to their group classification.

Classical view relates to stringent criteria of concepts whilst probability view is more flexible and accepts partial membership of concepts to belong to the same category (Jabareen, 2009; Morse, 1995: 31; Melodie, 2011). The *classical view* was applied to identify concepts from empirical data that clearly represented the participants' views. *Classical view* denotes a constringent positivist's connotation of a concept; which did not accommodate the categorisation of complex human

experiences. Therefore, the *probability view* was accepted as convenient. *Probability view* includes “*exemplar*” and “*prototype*” approaches (Jabareen, 2009: 51; Melodie, 2011: 152). *Probability view* used inferred or implied meaning founded on participants’ conveyed illustrations or descriptions of their understanding (Morse, 1995). It assisted in recognition of inferred significant connotations of data that did not visibly depict definitive meaning. Examples of concepts that were identified through *probability view* include connectedness, belief, believing, inner virtues which include inner-self, inner-peace, inner-values, inner-motivation and inner-emotions as inherent nature of human spirituality among others. The exemplar and prototype views were used in instances where the participant’s voice was vague and lacked clarity or use of a specific term, concept or word to portray universal conceptual meaning. The reason for including both perspectives was to develop an inclusive conceptual framework that would cater for diverse conceptualisation of meanings representing a context-based practice theory; in contrast to a theory which is founded on premise of single factor as argued by Morse (1995).

6.3 PROCESS OF IDENTIFICATION OF CONCEPTS

Conclusion statements that were derived from empirical data from objectives one (1), two (2) and three (3) were systematically reviewed to ensure consistency and congruency in the process of identification of concepts. These statements were carefully examined to identify concepts through their meaning and relevance to practice theory (Chinn & Kramer, 2011; Mouton & Marais, 2012). The process of concept identification was achieved through the steps that are described below:

- ***Reading of the conclusion statements:*** This was done to identify emerging concepts from the summaries from the empirical data. This process ensured logic and consistency in the extraction of the meanings of various concepts. Chinn and Kramer (2011) recommend that concepts should be identified by searching out for words or groups of words that represent objects, properties, or events within the phenomenon under review. Mouton and Marais (2012) support this notion by stating that the process of identifying concepts entails linguistic constructions through which the reality is ordered and categorised.
- ***Generating a list of tentative concepts:*** This process was achieved by use of the prototype and probability view strategies as described under section 6.2.2 above (Jabareen, 2009; Walker & Avant, 2010). Concepts were then sorted and re-arranged according to their interrelatedness (Chinn & Kramer, 2011). Concepts were further coded according to the strength of their meanings and relatedness. Coding aided to reduce the number of concepts to a manageable size.

- ***Key concepts were further reviewed:*** This was achieved by asking questions about the nature of the concepts and their organisation to discern their scope and ascertain which concepts are integral to the phenomenon under study. The “*connotative meaning*” was considered to establish suggested thought, meaning, sense and intention. The “*denotative meaning*” of concepts was also considered to establish its direct specific meaning as distinct from implied or inferred meaning.
- ***The list of tentative key and other concepts were further reorganized:*** Concepts that apparently appeared as main concepts were colour coded. Chinn and Kramer (2011) refer to this step as identifying “major concepts” with “sub-concepts”. This process further showed multiple relationships of major concepts in depicting the phenomenon under study. *A revised list of main and related concepts was put through a further review to ensure rigour.* The main concepts were examined for connotative meaning by checking out what sense of meaning or intention it conveyed (Mouton & Marais, 2012). The dictionary and or thesaurus were used to confirm the meanings of main and related concepts.
- ***Review of “denotative meaning:*** This was done to establish the behaviours, characteristics, actions or activities that were related to the phenomena under inquiry in order to clearly articulate the meaning and to reduce vagueness. Mouton (1996: 182-189) suggests the following guidelines as integral requirement in concept identification.

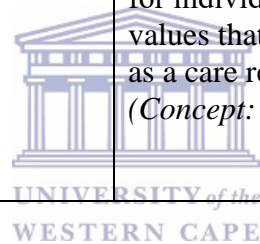
The process of identification of concepts for the conceptual framework was predictive and interpretive in nature as opposed to mere descriptions. This was aimed at allowing unfolding of the theorising process of identifying, selecting and organising the concepts based on their similarities (Melodie 2011: 152). This process of managing the empirical data is supported by Chinn & Kramer (2011) who attest to a need to structure and contextualise a theory. According to Chinn and Kramer (2008: 208) the researcher must create conceptual meaning by identifying and defining the theoretical meaning of the concept and their importance within the theory. Table 6.1 below presents the outcome of the process of concept identification.

Table 6.1 CONCLUSION STATEMENTS FROM EMPIRICAL DATA

Conclusion Statements from Nurse Educators and Clinical Supervisors (Chapter 3)	Conclusion Statements from nursing students (Chapter 4)	Conclusion Statements from Academic Records/ documents (Chapter 5)	CONCEPTS IDENTIFIED
<p>1. Spirituality refers to connectedness and it is an inherent virtue in human beings that expresses a caring value. (Concept: <i>Caring values</i>)</p> <p>2. Practice of spiritual care should be free from factors such as professional boundary and, lack of role models or any unacceptable practices that are contradictory to universal ethical principles and the Spirit of Ubuntu. (Concept: <i>Ethical-based practice</i>)</p> <p>3. Programme outcomes should integrate spiritual care throughout the curriculum and be based on good a nursing philosophy and theory that caters for differences in and between different individuals' cultures, religions and</p>	<p>7. Spirituality refers to connectedness to the invisible higher power and inner-self through a belief system (Concept: <i>Connectedness</i>)</p> <p>8. Spirituality is viewed as an in-born virtue and connectedness to the inner-self through emotions driven by personal motivation and energy (Concept: <i>Connectedness</i>).</p> <p>9. Spirituality provides a foundation for spiritual care and it is connected to a complex belief system that integrates personal, religious, spiritual and cultural beliefs. (Concepts: <i>Belief system</i>)</p> <p>10. Connecting with the patient at a social level is embedded in spiritual value of caring which is demonstrated through relational and inter-connectedness.</p>	<p>13. Spiritual care relates to purposeful communication as an essential non-replaceable nursing responsibility and practice for nurses. Therefore, preparation of nursing students to become skilful communicators should accommodate varied spiritualities and the importance of communication that prepares the nursing students to speak clearly, listen actively as they grow personally and professionally in assertiveness and therapeutic communication with regard to patients' culture. (Concept: <i>purposeful-communicators</i>)</p> <p>14. The starting point of teaching-learning spiritual care should not to impose the nurse's spiritual, cultural and religious dispositions. But it should be based on caring relationships as means to facilitate patient's healing and recovery from</p>	<p>CONNECTEDNESS:</p> <ol style="list-style-type: none"> 1. Connected to inner-self 2. Connected to inner emotions 3. Connected to inner energy 4. Connected to the invisible inborn virtue <p>(Statements: 1, 7, 8, 9, 10, 12, 15)</p> <p>PURPOSEFUL COMMUNICATORS</p> <ol style="list-style-type: none"> 1. Importance of communication 2. Value of communication 3. Skilful communicators 4. Responsible communication 5. Accountable communicators 6. Good character 7. Therapeutic communication <p>(Statements: 2, 4, 5, 13, 14, 15, 16)</p> <p>BELIEF SYSTEM</p> <ol style="list-style-type: none"> 1. Personal beliefs 2. Spiritual beliefs 3. Cultural beliefs 4. Religious beliefs <p>(Statements: 3, 9, 12, 15, 16)</p>

<p>spiritualties. Outcomes should be socially acceptable to universal law of “do no harm” “do good” humanitarian principle. (<i>Concept: Cultural-diversity</i>)</p> <p>4. Teaching and learning of spiritual care should be facilitated in a manner that prepares students on how to instil peace in patients by reversing the de-humanising approaches to care. Through effective communication and relationships that promote spiritual guidance, debriefing, intuition, self-awareness, emotional health and well-being of patients. (<i>Concept: Spiritual care</i>)</p> <p>5. Need for spiritual care is embodied in willingness, commitment, and agreement in gesture or vocalized to engage in spiritual matters where communication is regarded as talking therapy associated with the patient’s feelings of enhanced self-fulfilment, self-satisfaction and self-awareness as well as being in control.</p>	<p>(<i>Concept: Caring values</i>)</p> <p>11. Teaching-learning of spiritual care should be integrated throughout the curriculum and in clinical situations with the aim to limit perceived conflicting nursing perspectives. (<i>Concept: Teaching and learning</i>)</p> <p>12. Teaching-learning of spiritual care should provide spiritual care competence to students and instil the confidence to embark on spiritual matters through integration of caring skills, in a manner that eases and enhances connecting self with others as a means to redress theory-practice gap; through appreciation of own beliefs and values thus counteracting the lack of role models and non-conducive environment. (<i>Concept: Spiritual-care</i>)</p>	<p>illness and state of loss of personal control. Caring interventions should be directed at assisting the patient to conduct the daily life processes for health and personhood needs which are inextricably intertwined with the patient’s cultural and spiritual beliefs. (<i>Concept: Belief-based intervention</i>)</p> <p>15. Teaching-learning of spiritual care should be directed at developing personal and professional responsibilities and accountability in nursing students in a manner that does not prioritise technical nursing but through promotion of caring-relationships and interpersonal relationships to connect with patients while conveying to the nurse the meaning of health experience and importance of therapeutic environment. Such teaching should increase students’ awareness of own personal limitations and discovery of personal and professional values that influence execution of care in a morally sound manner.</p>	<p>CULTURAL DIVERSITY</p> <ol style="list-style-type: none"> 1. Cultural sensitivity 2. Culturally acceptable care 3. Good nursing philosophy 4. Patient-nurse-caring-relationship 5. Caring presence 6. Purposeful caring relationships <p>(Statements: 2, 3, 9, 10, 12, 14, 15, 16)</p> <p>CARING VALUES</p> <ol style="list-style-type: none"> 1. Interconnectedness 2. Social connectedness 3. Inherent human virtue 4. caring presence <p>(Statement: 1, 2, 3, 4, 5, 6, 10, 12, 13, 14, 15, 16)</p> <p>PROFESSIONAL ACCOUNTABILITY</p> <ol style="list-style-type: none"> 1. Spiritual care competence 2. Moral and ethical nursing 3. Personal & professional growth 4. Accountable personality 5. Unconfined spiritual care 6. Ethically acceptable practice 7. Ethical principle of practice 8. Universal humanitarian principles <p>(Statements: 2, 11, 13, 14, 15)</p> <p>TEACHING AND LEARNING</p> <ol style="list-style-type: none"> 1. Curriculum integration 2. Theory-practice gap
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<p><i>(Concept: Purposeful-communication)</i></p> <p>6. Spirituality is an inherent virtue in all human beings and is a precursor for spiritual care. <i>(Concept: Spirituality/spiritual care)</i></p>		<p><i>(Concepts: professional-accountability).</i></p> <p>16. Nursing education should integrate caring values in a manner that promotes patient-nurse-caring-relationship not only as essential human interaction for holistic nursing; but as an active ingredient in reaching out to human needs through caring-presence and purposeful relationships that cater for individual's beliefs, norms and values that are significant to patient as a care receiver. <i>(Concept: cultural-diverse-caring)</i></p>	<p>3. Active teaching approaches 4. Real life learning settings 5. Freedom from conflicting nursing perspectives (Statements: 2, 4, 5, 11, 12, 13, 14, 15, 16)</p> <p>SPIRITUAL CARE</p> <p>1. Spiritual skills 2. Caring skills 3. Spiritual matters 4. Interacting or connecting with others (Statements: 1, 2, 3, 4, 5, 6, 9, 11, 12, 15, 16)</p>
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6.4 PROCESS OF CLASSIFICATION OF CONCEPTS

Dickoff *et al.* (1968) assert that practice theory is a type of theory that is situation producing. Furthermore, these authors argue that practice theory is not only born in practice but it also exists for practical uses. Based on this explicit purpose of a practice theory, Dickoff *et al.* (*ibid*) survey list was used as a strategy to classify concepts. The methodological relevance and clarity of the survey list in isolating and placing concepts within their perspective practical guidelines for practice was the reason for selection for this study. This technique of classifying concepts points to influence of theoretical thinking process when generating a theory. It was therefore, envisaged that the use of the survey list to generate a practice theory for teaching-learning of spiritual care would clarify the required competence on how to teach-learning of spiritual care.

The practical steps in theory generation process as advocated by Dickoff *et al.* (1968) were presented in chapter two (2). The three (3) essential conditions for situation-producing theory highlighted include the following:

Goal content which specifies the aim of the activity: In this study the goal content is integration of practice-theory for teaching-learning of spiritual care in a higher education institution in the Western Cape.

Prescription for activity to realise the goal content: At the outset of activities the researcher assessed the nurse educators', clinical supervisors' and nursing students' understanding on teaching-learning of spiritual care in the undergraduate nursing programme.

A survey list to classify the activities and elements directed at attainment of the goal content: In this study the activities and elements relating to integration of teaching-learning of spiritual care were derived from empirical data. The use of the survey list of Dickoff *et al.* (1968: 21) to classify the concepts was not only appropriate and relevant in classifying the emerging concepts, but it also influenced the researcher to observe:

- Clustering of factors, elements and aspects of the activity that were relevant in production a practice situation whether simple or complex at the conceptual level.
- Usage of literature to appraise the concepts as a necessary step for achieving the overall aim of producing a practice model.

The use of the survey list in this study aimed at classifying the concepts whilst ensuring their peculiarity of relatedness and relevance in establishing how the activities, elements and facts

interact within a particular situation to realise the goal content. According to Dickoff *et al.* (1968) the value of situation producing theory is its adaptability to clinical and practical nursing environments. In this study, the use of the survey list allowed the researcher to respond to the following six (6) questions that point to Dickoff's (*ibid*) six vintage elements:

- 1) AGENT: Who or what performs the activity?
- 2) RECIPIENT: Who or what benefits from the activity?
- 3) CONTEXT: In what context is the activity performed?
- 4) GOAL: What is the targeted outcome of the activity?
- 5) PROCEDURE: What is the guiding procedure, protocol or technique of the activity?
- 6) DYNAMICS: What is the energy source for the activity?

The table below presents how Dickoff *et al.* (1968) survey list was applied to the core concepts of the model.

Table 6.2 Application of Dickoff et al. (1968) survey list on core concepts

Six Survey list questions	Survey list components	Application
1. Who or what performs that activity?	Agent no. 1	Nurse educator
	Agent no. 2	Clinical supervisor
2. Who or what is the recipient of the activity?	Recipient	Nursing student
3. In what context is the activity performed	Context	Nursing education at a Higher Education Institution (HEI)
4. What is the end point of the activity?	Purpose	Integration of spiritual care in the undergraduate nursing programme
5. What is the guiding procedure?	Process	Teaching-learning
6. What is the energy source of the activity?	Dynamics	Commitment

Application of Dickoff et al. (1968) survey list on core concepts

The comprehensive concepts that were identified include the following: connectedness, purposeful-communicators, belief system, cultural diversity, caring value, spiritual care, professional accountability, teaching and learning and commitment.

Figure 6.1 below presents the graphic representation of the process of classification using Dickoff *et al.* (1968) survey list.

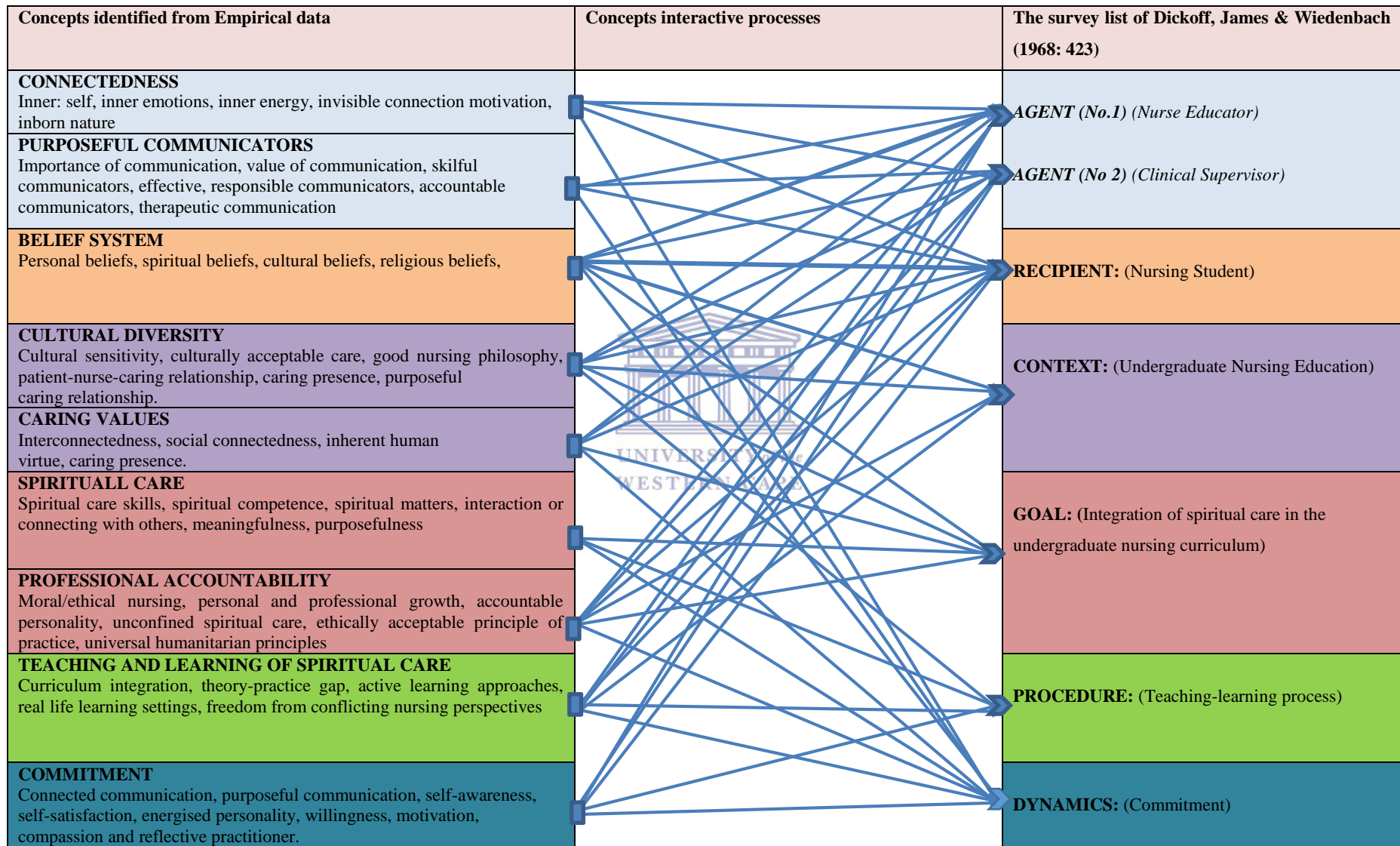


Figure 6.1 Classification of concepts using the survey list of Dickoff et al. (1968)

Deductive reasoning was applied in the process of concept identification and classification. Table 6.1 shows how the process of concept identification was used to develop the conceptual framework; whilst figure 6.1 depicts how the survey list was applied to classify concepts identified from the empirical data. The definitions of core concepts of the conceptual framework are presented below. They include: nurse educator, clinical supervisor, nursing student, nursing education context, integration of spiritual care in the undergraduate nursing curriculum, teaching-learning of spiritual care and commitment.

There are two agents for the model. These will be distinguished as agent one (1) for the nurse educator and agent two (2) for the clinical supervisor. An agent is defined as who or what must perform the activity to attain the desired goal (Dickoff, *et al.*, 1968: 452).

6.4.1 Nurse Educator

The agent is conceived as the person who will meet the learning needs of students or a service to same effect of meeting learning needs of students and attainment of required learning outcomes Dickoff, *et al.* (1968). In this study, the nurse educator who is an agent refers to a person who facilitates students' theoretical learning. In this sense, the description of the nurse educator accommodates the possibility of other factors acting as "agents" in achieving the required goal activity. A discussion on nurse educators is provided in the later section in section 6.5.1.

6.4.2 Clinical Supervisor

In this study, the clinical supervisor refers to a registered nurse that is employed by the university to teach clinical nursing skills. In the school where that study was conducted, the clinical supervisor is primarily employed to facilitate students' clinical learning through accompaniment, clinical guidance and assessment in clinical placement including simulation labs for skills development. She or he may or may not hold a Master's degree but she must be a qualified nurse. A detailed description is provided in section 6.5.2.

6.4.3 Recipient: Nursing Student

A nursing student is defined by the South African Nursing Council (SANC, 2005: 4) as a learner nurse who is formally registered or enrolled with a learning institution; such as a nursing school, nursing college or university school of nursing. In the Act No 33 of 2005, the South African Nursing Council's definition of learner nurse is used as an equivalent to nursing student. However, this study will use the term of student and not learner. A detailed description of the student is provided in section 6.5.3.

6.4.4 Context: Nursing Education in Higher Education Institutions (HEIs) in SA

The context of this study includes entire physical and non-physical organisational matrix where the teaching-learning activity happens. This includes organisational structure and educational climate relating to space, time and political agendas through which teaching-learning of spiritual care will be undertaken. According to Dickoff *et al.* (1968: 428) context relates to non-physical elements required to achieve the goal of the activity; in this case teaching-learning of spiritual care that is as important as the physical elements of the context. Therefore, description of the context includes both concrete and abstract processes for teaching-learning of spiritual care at the nursing school in the Western Province, South Africa. A detailed description of the context is provided in section 6.5.4.

6.4.5 Goal: Teaching or Integration of Spiritual Care in the Undergraduate Nursing Curriculum

Goal refers to the endpoint or terminus or accomplishment of the activity. The goal for this study was to integrate teaching of spiritual care in the undergraduate nursing curriculum. Curriculum integration can be understood as an idea of unity between forms of knowledge and the perspective discipline (Loepp, 1999). Integration of spiritual care in undergraduate nursing programme often requires a team of educators to modify existing curriculum. A detailed description of the goal is provided in section 6.5.5

6.4.6 Procedure: Teaching-learning of spiritual care

Dickoff *et al.* (1968: 430) describe the procedure as steps to be taken towards some accomplishment including the apparatus equipment to be used. A view that considers a procedure as principle, rule, routine or protocol that legitimately governs the activity (the procedure) is acceptable from procedural perspective. However, in this study the procedure refers to the process of teaching-learning of spiritual care in the undergraduate nursing programme. A detailed description of the procedure is provided in section 6.5.6.

6.4.7 Dynamics: Commitment to spiritual care through educator-student interaction

Dynamics refers to the required power source that is required for the activity (Dickoff *et al.*, 1968). The question of whether or not the goal will be achieved is dependable on the dynamics that are at play in the context through which the agent and recipient are engaged. Power source include factors such as chemical, physical, biological or psychological for both agent and recipient or anything that is of part of the context or framework. Whilst other factors may be easier to deal

with, psychological factors can pose challenges owing to abstract attributes such as an individual's willingness and or commitment expressed, increasing personal interest, motivation, self-driven actions in execution of the goal activity. More details on the dynamics are provided in section 6.5.7

6.5 LITERATURE REVIEW TO SUPPORT THE CONCEPTUAL FRAMEWORK

The purpose of the review of literature was to affirm the empirical concepts with knowledge that is already known about the phenomena under inquiry and to ensure rigour (Mouton, 2009; Jesson, Matheson & Lacey, 2011). Mouton (2001) attests that review of literature is a critical step necessary to be taken by every researcher to explore the existing knowledge on the phenomenon under investigation as well as to see other scholars' thoughts on the subject. In this study, literature review was not only undertaken to develop the theory-based meanings and utilisation of the empirical concepts; but it was also to harmonise the conceptualisation of emerging conceptual framework with existing literature. After concepts were identified and classified they were described using literature.

The researcher used a progressive strategy to manage the required reading (Polit & Beck, 2011). This strategy was motivated by acknowledging that good literature review requires thorough familiarity with evidence. This review was aimed at:

- Laying the foundation and context for the study findings as a measure to determine the possible contribution to existing knowledge base.
- To make sense of the findings to strengthen the conceptual framework

Polit and Beck (2008: 109) advise that it is wise to begin the search with a strategy in mind when conducting a literature review. The researcher purposefully selected literature based on its relevance. Both primary and secondary sources were explored. Recent references were used to signal the recent development about that phenomenon under study. Approaches to search for literature are varied, and Polit and Beck (2008) quote Cooper's (1998) approach which includes the following:

- *Searching for references:* through the use of bibliographic data bases.
- *Ancestry approach:* by using foot notes chasing which uses citation from relevant studies to track down earlier research on which the studies are based.
- *Dependency approach:* through which a pivotal early studies are used to search forwards in citation indexes to find more recent studies that cite the original key study.

- *Grey literature*: through which studies with more limited distribution such as conference paper, unpublished reports, and dissertations are sought.

In this study, all four approaches were used. Concepts that had emerged from empirical data in phase one (1) of conceptual framework were used as search terms using Google Scholar. The purpose was to identify published and accredited articles that support the arguments of developing framework. A total of fifty-eight (58) articles were retrieved. The search terms included: “*spiritual care*”, “*spirituality*”, “*care*”, “*caring*”, “*nursing care*”, “*teaching and learning*”, “*undergraduate nursing*”, “*belief*”, “*belief system*”, “*cultural diversity*” “*relationships*”, “*interpersonal skills*” and “*communication*” “*ethical*” “*professional*”. The references and names of authors from the journal articles that were retrieved from Google Scholar were further used to locate more articles, if the article contained significant referenced information. This process expanded the pool of articles for review through locating additional articles.

The initial search was neither exhaustive nor comprehensive. Therefore, the online Smart Search Library strategy was also used to further the search by locating articles by title, author’s name, year of publication and journal from which it was referenced in the initial search round. This was effectively utilised through a small search technique using Boolean search methodology (The Sheppard-Worlock Library, 2012). An asterisk* was inserted at the end of the stem of the word before searching to identify all the words with different “prefix” to a noun, adjective or adverb and or “suffix” but with the same stem. The use of prefix was necessary to form a derivative with related meanings and thus extending the base of the term whilst deepening the understanding of positive and negative connotations of use of the term (On-Line Dictionary.com 2015; The American Heritage New Dictionary, 2005). The use of suffix on the other hand was to track the change of meaning or different usage of the word (Merriam Webster.com, 2015). Searched terms were linked by use of the words “AND” “OR” between search terms (The Sheppard Worlock Library, 2012). The search engines used to access the electronic journals included: Academic Complete Search, JSTOR, PUBMED /MEDLINE. Only full text English articles that covered a period from 2000 to 2015 were included to ensure that only latest documentation and arguments informed the developing model of spiritual care. The description of selected concepts is provided below.

6.5.1 Agent no.1: The nurse educator

The nurse educator was identified in section 6.4.1 as a person who facilitates students' theoretical learning primarily. According to Dickoff *et al.* (1968) identification of an agent often presents challenges that may affect credibility of the theorising process. The primary responsibility of the nurse educator is to provide an appropriate learning environment and opportunities for the students to meet the programme outcomes. The NE should create a learning environment where students are free to learn and develop. The NE is also required to facilitate the students' development and socialisation to the profession of nursing. Other tasks include curriculum design and evaluation and required competence in facilitation, assessment and evaluation of learning (Bruce, Klopper & Mellish, 2011).

The nurse educator functions within the policies and condition of service as promulgated in the South African legislature. Policies associated with teaching-learning in higher education context include the Nursing Act No. 33 of 2005 on the scope of practice for nurses, National Health Act No. 63 of 2003 which provides narrative on service delivery, Higher Education No. 101 of 1997 which defines the health care standards as well as the National Qualification Act of 2008. These are few Acts among others that relate to the SA context of higher learning. Furthermore, the SA Model for nursing education and training as modified by district and PHC approaches should be observed. The table below presents an overview of the complex nurse categories produced within the SA nursing education system, that are prepared to redress health needs and demands for the 21st century as depicted in the Strategic Plan for Nursing Education, Training and Practice 2012/13 – 2016/17 (DoH 2012: 5).

Table 6.3 Nursing Education Programmes and NQF levels

SANC Category	Qualification	NQF level	Duration	Academic Recognition
Registered Auxiliary Nurse	Higher Certificate	5	1 year	NEI- schools, colleges
Registered Staff Nurse	Diploma	6	3 years	HEI- colleges
Registered Midwife	Advanced Diploma	7	1 year	HEI- colleges
Registered Professional Nurse & Midwife	Professional Degree	8	4 years	NEI Universities HEI non universities
Specialist nurse /midwife	Post Graduate Diploma	8	1 year	Universities & HEI Colleges
Advanced Specialist Nurse	Master's Degree	9	1 year	Universities & HEI
Doctorate in Nursing	Doctoral Degree	10	3 years	Universities & HEI

Department of Health (2012:15)

Dickoff *et al.* (1968) provides a critical argument that the agent and the recipient are not in a vacuum or all by themselves in the teaching-learning process. This argument suggests the possibility that the recipient may receive the activity not only from the agent but from other related things or events that are part of the process of the entire learning matrix towards attainment of the desired goal. Dickoff *et al.* (*ibid*) caution that consideration of nurse educator as the only agent is fallacy and noteworthy. Therefore, in this study the nurse educator is not conceived as the absolute agent in attaining the goal activity as such attributes are not limited to the official entity as an agent; but, there are other non-specified factors that need to be taken into consideration. Furthermore, factors such as the internal resources that agents may or may not possess also describe the agent. These *internal* resources include but not limited to teaching skills, personal attitude, and practical technics primarily. The *external* resources are of equal importance; they include institutionalised policies, guidelines and protocols. The arguments of potential non-specified things or events that may produce the desired action, effect or goal suggest that theorists must be thoughtful about such a possibility. In this study, factors including peer teaching, teaching by others, use of text books, computers which were considered as conflicting realities that may influence students' learning other than the official nurse educator (Dickoff *et al.* 1968). Consequently, the researcher asserts that the nurse educator is not the absolute agency for the activity but there are other non-specified factors that need to be taken into consideration.

6.5.1.1 Qualifications of the Nurse Educator

A nurse educator is a registered nurse who has completed a minimum requirement as nurse educator as prescribed by the South African Nursing Council (SANC); regardless of the academic course they follow (Bruce, Klopper, & Mellish, 2011: 108). In accordance with the South African (SA) context, the NE holds a post basic or post graduate qualification as an educator and must be registered with the SANC. For higher education institutions, the NE must hold a Master's degree over and above the post basic professional qualification (Bruce & Klopper, 2010: 2). Internationally, the nurse educator must be prepared at Master's level.

Table 6.4 below presents different academic levels through which the NEs are prepared as well as their prime training institutions.

Table 6.4 South African Nurse Educator Categories

Highest Academic Qualification	Institution where the nursing programme is offered and qualification obtained	Scope of Teaching Practice
NE with Doctoral Degree	Universities Programme: SANC: R118	<ul style="list-style-type: none"> ▪ Undergraduate (BN degree) ▪ Graduate ▪ Postgraduate
NE with Master's Degree: -by course work -by research	Institution : Universities Programme : SANC: R118	<ul style="list-style-type: none"> ▪ Undergraduate (BN degree), ▪ Graduate ▪ Postgraduate
NE with Diploma in Nursing Ed.	Nursing Colleges (public and private) Programme: SANC: R118	<ul style="list-style-type: none"> ▪ General Nursing Diploma, ▪ Enrolled Nursing ▪ Enrolled nursing assistant
R/N Clinical Supervisor with or without preceptor-ship certificate	Nursing Colleges Programme: General nursing	<ul style="list-style-type: none"> ▪ Clinical Nursing Skills

Reference: DoE (1997)

6.5.1.2 Role of the nurse educator

Despite teaching-learning being the primary responsibility of the nurse educator, the patient outcomes are still gold standards for teaching content and clinical skills. The nurse educator as a change agent should engage in personal continuous improvement through scholarship and Evidence Based Practice (EBP); where professional, ethical and legal practice (SANC, 2014) are fundamental to her or his role and function. In the South African context, the nurse educator occupies “a nurse specialist role” and functions as a change agent in highly complex settings with an expectation to create a conducive climate for learning (Bruce & Klopper, 2010). Nurse educator accompanies the student on his or her learning path, intentionally supporting nursing students. The NE actively and effectively guides students’ learning through constructive and reflective learning strategies (Smith, 2001). The role of the nurse educator to formally assess the students’ knowledge affirms the agency responsibility in assisting students to assimilate the relevant content and attain competence (Dickoff *et al.* (1968: 426).

6.5.1.3 Characteristics of the Nurse Educator

The nurse educator must be abreast with the academic knowledge and possess professional teaching skills. In addition, they should be being polite, friendly and approachable and mature to build and maintain good interpersonal and professional relationships with their students. The importance of power shift between the NE and students without losing control enhances the

student-teacher relationship. The teacher-student relationship should represent powerful connection that forms the foundation to student support. Therefore, the NE should be willing to share information and knowledge about life experiences when clarifying certain concepts in order to promote understanding in students. This can be promoted by use of soft skills including warmth personality and good communication. Furthermore, expertise in the practice of nursing education, research and reflective practice better describes an enthusiastic and efficient educator (Klopper, 2009:19). Unique personal attributes or personal characteristics that do not only portray good teaching abilities and problem solving skills; but go beyond personal boundaries such as interpersonal relationships, good listening skills, openness and companionship to others, rescuer necessary for teaching interventions are equally important as they promote deeper meaning and appropriate responses to human needs.

6.5.1.4 Accountability, responsibilities and competence of the nurse educator

The nurse educator is accountable to several legal bodies of which SANC and SAQA are mandatory with regards to how the curriculum outcomes are aligned with the requirements of the National Higher Education, SAQA, NQF in terms of descriptor levels. The SANC prescriptions are directed to the NE competencies and qualifications that relate to philosophical and social issues (Meyer & van Niekerk, 2008: 49). The nurse educator responsibly executes the teaching duty through application of principles of adult and collaborative learning. The NE should possess an increased awareness about the student's spiritual and professional life. In line with the principles of andragogy, the NE allows students to have control over their choices (Bush, 1999). The NE is accountable to her teaching competence in various areas including: (i) *scholarship of teaching-learning and research*: achieved through ethical legal and professional teaching practice (SANC, 2014); (ii) *academic and student management*: which is realised by assessments and evaluation strategies as well as student development and socialisation; (iii) *curriculum development*, through curriculum design and evaluation of the programme outcomes; (iv) *management and leadership*: through function as a change agent and leader; (v) *professional development*: Pursue continuous quality improvement in the nurse educator role.

Each of these domains is vitally important as they together provide a comprehensive scope for nursing education and practice in SA. The curriculum development domain requires the NEs to be competent in designing and evaluating the curriculum taking into consideration relevant educational and curriculum philosophies, ideologies, theories, models and approaches of curriculum development. Curriculum development is a fundamental and comprehensive task that

often involves most academic and professional responsibilities to ensure that the contents, educational strategies, processes and assessments are geared towards ensuring that students' learning is of quality (Meyer & van Niekerk, 2008: 62).

6.5.1.5 Nurse Educator Teaching Competence

The concept *competence* is defined as a holistic unit consisting of a set of minor competencies. Therefore, competence may be construed as a specific knowledge in a concrete subject whilst *competencies* are skills in a *competence* which reveals the relationship between a person and activity (Sandberg, 1994). Despite social evolution in the 21st century posing high demands on professional teaching responsibilities, teachers need to understand that such changes impact on their competence consequently their competencies (Bankauskiene, Augustiniene & Ciuciulkiene, 2005).

The effects of social change on the teacher's competence demands teachers to remain positive about constant change and new levels of required competence (Stoll, Fink & Earl 2003). Minor competencies enable description of the nature and quality of action to be performed by a person. However, a holistic idea of the competence does not only point to knowledge and skills, but it includes personal qualities, values and the ability to implement potential and accumulated experience about the activity (Rainsbury, Hodges, Burchell & Lay, 2002). Teaching competence is a vital process through which the nurse educator selects and orders teaching content whilst paying attention to seamless sequencing, integration, planning of learning opportunities and assessments whilst ensuring horizontal and vertical continuity in students' learning. Teaching spiritual care will require the nurse educator to utilise relevant teaching strategies, technics and processes to ensure student's effective learning.

6.5.1.6 Leadership Competence

The nurse educator should be practically involved in teaching students through role modelling. During accompaniment of the students, the NE should actively and positively influence effective learning in students. She or he must be aware of the students' spiritual standing so that she or he models same for students. She or he should participate in the thinking process with learners, work collaboratively with learners and colleagues (Meyer & van Niekerk, 2008: 84). The nurse educator should consciously, purposively and intentionally intervene in students' learning. She or he should motivate and support students to grow personally and professionally to discover their self-concept and good clinical and self-judgement in making informed decisions. In line with teaching of

spiritual care, the nurse educator needs sufficient opportunity to stimulate and influence students' emotional, social and physical maturity (Meyer & van Niekerk, 2008: 92).

6.5.1.7 Management and Professional Competence

A nurse educator functions under legal and ethical frameworks that guide her or his educational responsibilities. The nurse educator does not only manage teaching functions but performs a range of activities including recruitment and selection of students, handling their grievances, budget and school administration (Bruce, *et al.*, 2011). She or he is equally responsible to instil professionalism to students through teaching of rules and regulations that govern education and practice of nurses; whilst ensuring that the students are able to provide spiritual care to patients. A NE should teach students in a manner that arouses awareness and attention to professional nursing education and practice requirements. According to the conclusion statements on the nurse educator as provided in this chapter under section 6.5.1.8, the nurse educator does not only play different educative roles such as teaching, facilitation, guiding, motivation and support in students' journey; but is also more importantly a spiritual resource person. She or he must be willing to share herself and life experiences with students and others. Her character and role should be guided by the principle of holism when interacting with others. She or he engages in person-centred or human-centred relationships to base teaching interventions with students because she or he understands that individuals are whole-beings made up of body, mind and spirit and who sometimes experience physical, emotional and spiritual needs. The nurse educator is a reflective practitioner who is authentic in her or his interaction with students and others (Schön & Schön, 1993). The NE accepts own brokenness, humanness and fragility which enables her or him to sympathise with those who are burdened with life issues as she or he facilitates change in students and others without denying them an opportunity to take decisions through support and guidance.

The Nurse Educator (NE) is defined as a purposeful communicator and reflective practitioner who plays different educative roles including teaching, facilitation, guiding, motivation and supportive in the students' learning journey. He or she is a spiritual resource person who is willing to share own life experiences with students and others and when so doing the NE uses own self as effective tool to promote spiritual care competence in students. Training students to provide therapeutic communication with patients on matters that are of interest to the patient in contrast to communication directed to medical procedures and interventions.

6.5.1.8 Conclusion Statements on Nurse Educator

- Nurse educator refers to a person who is qualified according to Nursing Act 2005 to teach, facilitate and guide nursing students on both theoretical and practical nursing knowledge.
- The nurse educator plays different educative roles including teaching, facilitation, guiding, motivating and supportive roles in student's learning journey. He or she is a spiritual resource person who is willing to share herself or himself and life experiences with students and others. Her or his character and role is guided by the principle of holism when interacting with others. She or he engages in person-centred or human-centred relationships to base her or his teaching interventions with students because she or he understands that individuals are whole-beings made up of body, mind and spirit and who sometimes experience physical, emotional and spiritual needs.
- The nurse educator should demonstrate unique personal attributes and good teaching skills. Her / his personal characteristics do not only portray good teaching abilities and problem solving skills; but also good interpersonal relationships, good listening skills, openness and companionship to others, rescuer necessary for teaching interventions with students and others. Such character is shown in a manner that she/he embraces the deeper meaning and appropriate responses to human needs.
- The nurse educator is a reflective practitioner who is authentic in her/his interaction with students and others. She/he accepts own brokenness, humanness and fragility which enable her/him to sympathise with those burdened with life issues as she/he facilitates change in students and others without denying them the opportunity to take decisions through her/his support and guidance.

Figure 6.2 below depicts the Nurse Educator in the development of the model.

Figure 6.2 NURSE EDUCATOR

AGENT No. 1:

**NURSE
EDUCATOR**

1. Spiritual competence
2. Good IPS & warm character
3. Teaching & professional responsibilities
4. Spiritual awareness
5. Willing & committed to teach spiritual care
6. Connected to students & others



6.5.2 Agent no. 2: Clinical Supervisor

According to the clinical model for SA, clinical facilitation is comprised of the preceptor, clinical co-ordinator and clinical associates. In this study the term “clinical supervisor” denotes a registered nurse who undertakes clinical teaching as a designated duty primarily and functions at the same capacity as the preceptor. The CS facilitates the students’ learning of clinical skills and assists them in obtaining relevant practical skills or competencies. Issues regarding the clinical supervisor as an agent are not repeated here as these were discussed in section 6.4.1 above. According to Jeggels, Traut, & Kwast, (2010) the concept of preceptor-ship denotes a clinical supervisor who is employed by the hospital management but who can also be accessed by university students while in clinical placement. Different nursing personnel including clinical supervisors, tutors, preceptors, practice staff as well as lecturers, to a certain degree, are often involved in the clinical learning of the nursing student.

In the nursing college setting, nurse tutors take full responsibility for the students’ learning of theory while the clinical supervisors are assigned mainly for students’ learning of nursing clinical skills. They do supervision and mentoring of students in the wards; this includes students from other NEIs of higher learning even though those students would have their own clinical preceptors or teachers from the university for instance. The clinical supervisors may conduct formative and final clinical assessments. Additional benefits from the clinical supervisor is constituted in their ability to orientate staff and newly qualified in-service training and staff development. These standards are used to assess and determine students’ competence. Standards are reviewed regularly with no specific time frame prescriptions.

6.5.2.1 Role of Clinical Supervisor

Clinical learning in the education and training of the nurses forms an integral component in development of nursing clinical skills. Despite challenges that arose from the global landscape of moving of the education of nurses from the hospital-based to university-based education and training resultant in shortage of clinical-sites for placements of student, has warranted increasing need for clinical supervisors as a measure to improve the dire need and malicious effects of clinical training (Walker, Dwyer, Broadbent, Moxham, Sander & Edwards, 2014). Historically, before education and training was moved to higher education, nurses in most countries including South Africa, Australia, to name a few, were educated in an apprenticeship style nursing training model (Knight & Karmel, 2009). This was indeed effective in getting nursing students to attain the competence and professional socialisation required. Despite the role of clinical supervision being

more or less similar to a clinical teacher to some extent, the clinical supervisor's area of expertise is primarily based on clinical expertise. In contrast to nurse educators who teach theory to a larger extent, clinical supervisors accompany students, and assist them with mastery of nursing clinical skills. Their primary responsibility includes assessing and evaluating students' performances of nursing skills.

6.5.2.2 Educational role of the Clinical Supervisor

The clinical supervisor neither holds the same title nor the professional positions as nurse educator even though she or he engages in teaching of students. The nature of teaching duties that clinical supervisors perform may vary slightly from one institution of learning to the other depending on whether it is a higher education institution, public or private nursing college. As depicted in Table 6.2, the minimum requirement for a clinical supervisor with the SANC is registration as a nurse (RN).

Clinical supervisor, like the nurse educator, functions within a teaching-facilitation continuum ranging from pure instruction and facilitation of clinical skills. The Clinical Supervisor's (CS's) facilitation role accounts for a greater area of clinical teaching expertise whereby she or he demonstrates nursing skills, and guides student learning. She or he should model professionalism to students and guide them in work-integrated learning. More importantly she or he is also regarded as a resourceful person for the students. The role of the CS is to create a conducive climate for clinical learning or leaning of skills during accompaniment of the students. The CS must provide support to students and ensure that they are actively involved in their learning. Although the clinical supervisor may perform more or less of the teaching function, her area of expertise is in clinical teaching and learning. They assist students with mastery of clinical skills with the patient in mind as first priority (Klopper, 2009: 4). Their primary responsibility is to accompany students while in clinical placement, assist students to master nursing skills and assess and evaluate performance of nursing skills by students.

6.5.2.3 Characteristics of the Clinical Supervisor

The clinical supervisor should possess good inter-personal and teaching skills. Personal characteristics such as politeness, friendliness, and being approachable do not only indicate maturity and good interpersonal skills but more importantly their strength to engage positively with students during teaching interventions. The CS should also be willing to share information and knowledge, guide and direct learning of students using own life experiences where applicable, to clarify concepts with the purpose of promoting students' understanding. Additionally, creating

a conducive learning environment where students are free to express themselves when they embark on clinical tasks. Good personality and communication skills are of great importance in clinical learning. Being skilled in nursing, IPS including soft skills of warm personality mixed with good facilitation and reflective skills are recommendable for effective constructive learning (Klopper, 2009: 19).

6.5.2.4 Responsibilities and Accountability of the Clinical Supervisor

The clinical supervisor is primarily accountable to the employer. Although the clinical supervisor subscribes to SANC, otherwise the CSs do not directly submit to most of the educational bodies even though their performance may be influenced by such. Similar to NEs, teaching-learning is the primary responsibility of the CSs, and focusing on patients' outcomes that guide clinical teaching standards. According to the South African clinical teaching model, clinical teachers are role players who comprise of nurse educator as specialists or generalist preceptors, clinical supervisors and clinical placement coordinators (CPC). The clinical supervisor function is mainly in clinical placements which include the following: district hospital ranging from small, medium and large institutions, clinics and districts, regional hospitals, central hospital and specialised hospitals such as psychiatric hospitals. Ideally a ratio of one (1) supervisor to ten (10) nursing students is recommended. However, in cases where the ratio of 1:10 is not feasible, a ratio of 1:15 or 1:20 is within an acceptable range. The duties of the clinical supervisor contain a functional component of the institution which varies from academic support, instruction, and auxiliary services. To achieve effectiveness, learning goals for clinical learning should be made clear whether students' clinical placement do not form part of the staff establishment as opposed to the role taking or whether students do form part of the staff establishment. CS should inspire and support students in their learning by maximising exposure to learning events, facilitate the application of theory to practice and critical thinking and support students' emotional needs. They should promote involvement of clinical staff who also role model complex clinical behaviours. They also maintain a close working relationship with academic staff and act as liaison between service and NEI.

6.5.2.5 Clinical Nursing Competence

The clinical supervisor is should not only be practically involved in teaching of students, but should teach by example through role modelling. During accompaniment she or he actively, positively, effectively influences and imparts learning of nursing skills to students. She or he must model the thinking process for learners; work collaboratively with learners and colleagues (Meyer

& van Niekerk, 2008: 84). Similar to what the nurse educator does, he or she should consciously, purposively and intentionally intervene in students' learning in a manner that motivates and supports students to grow personally and professionally; discover their self-concept as adult learners who can use good clinical and self-judgement in making informed decisions in which responsibility and accountability are at the centre. Teaching of spiritual care content provides the clinical supervisor with sufficient opportunity to stimulate and influence students' emotional, social and physical maturity (Meyer & van Niekerk, 2008: 92).

The Clinical Supervisor (CS) is defined a person who has good personal characteristics such as warmth, politeness, friendliness, and is approachable. She or he is a mature person who does not only guides, leads and directs nursing students in clinical learning settings through use of good facilitation, reflective skills and interpersonal skills. But more importantly, the CS engages and is attached with students through spiritual guidance and lead students to deeper meaning which predisposes them engage with and intervene in patient's spiritual matters. At this level of human interaction, inner values such as meaningfulness are more at play rather than merely emotional response.

Figure 6.3 below depicts the clinical supervisor in the development of the model.

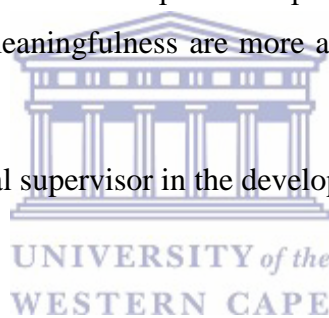


Figure 6.3 CLINICAL SUPERVISOR

AGENT No. 2:

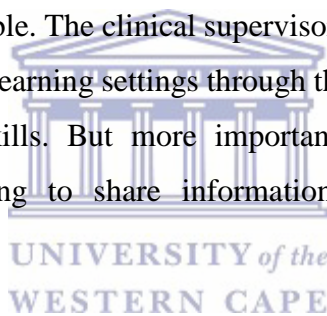
CLINICAL SUPERVISOR

1. Expertise in clinical skills
2. Good IPS & warm character
3. Teaching & professional responsibilities
4. Willing & committed to provide guidance on spiritual care
5. Possess caring values
6. Connected to student & others



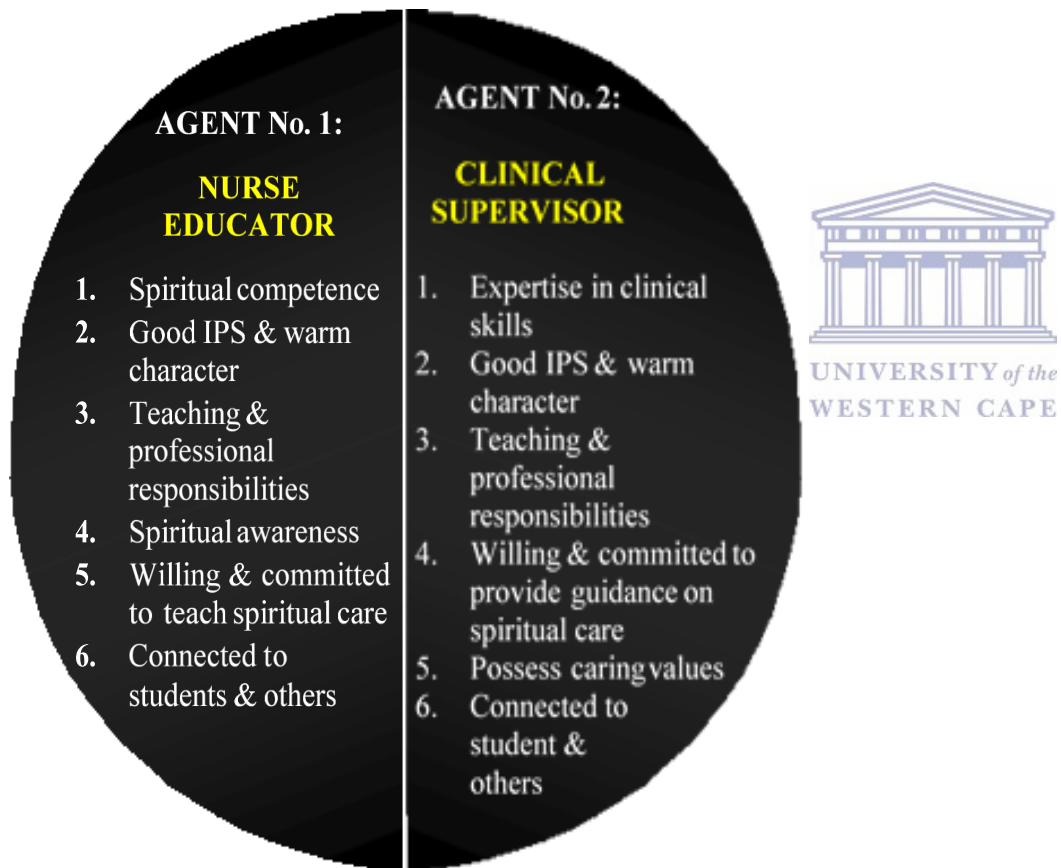
6.5.2.6 *Conclusion Statements on Clinical Supervisor*

- The clinical supervisor is a registered nurse, a clinical supervisor, preceptor, or a clinical facilitator who facilitates learning of nursing clinical skills whether employed in the education institution such as university, college or school. The clinical supervisor's primary area is clinical setting and skills laboratories in contrast to classroom related teaching.
- The clinical supervisor possesses adequate knowledge with regard to nursing skills, nursing procedures, common medical conditions and is familiar with health facility's protocols and clinical guidelines accordingly and medical management of diseases. The CS's clinical expertise is evidenced through demonstration of nursing skills, guiding students' learning and being a role model in work-integrated learning.
- The clinical supervisor should have warm good personal characteristics such as politeness, friendliness, and approachable. The clinical supervisor is mature, guides, leads and directs nursing students in clinical learning settings through the use of good facilitation, reflective skills and interpersonal skills. But more importantly, the CS engages with student interventions and is willing to share information and knowledge using own life experiences.



In line with the building process of the model that was under development, it should be noted that the next figure (refer to Figure 6.4) shows both the nurse educator and clinical supervisor in a position that both occupy in the final model as agents.

Figure 6.4 NURSE EDUCATOR AND CLINICAL SUPERVISOR



6.5.3 Recipient: Nursing Student

According to Dickoff *et al.* (1968: 426) there are many contextual factors that need attention when theorising about the student who is the recipient. Theoretically, this preposition corresponds with the argument that was made against the agent. The researcher welcomes this theoretical understanding because it is in congruence with the innovative student-centred educational strategies and principles. Thereby opposing the traditional notions of the teacher or facilitator is an official custodian of information or learning content. Instead, the teacher is bound to learn new things from teaching-learning context which include learning from the student. In this view, the nurse educators become co-learners with their students.

Therefore, the recipient is not regarded as the only recipient of the activity from the specified agent nor is assumed to receive only from interventions acted on by other relevant agents, for instance medical doctors and physiotherapists. This caution may appear as contradictory to the very purpose of a practice theory to prescribe the intervention for teaching-learning of spiritual care. Dickoff *et al.* (1968) argue that a practice theory should specify everything about the activity through the survey list to ensure that the theory serves the purpose that it was created for. Another point of emphasis is the notion to assume that patients, as recipients, are passive with no actions in them. The authors attest to that oversimplifying live interactions to simple distinctive operations not only is misleading but indicative of a narrowly generalised theory. Instead, theorising about the recipient should recognise other effects in context that equally interact with the recipient besides the specified agent (Dickoff *et al.* 1968: 427). A good theory should acknowledge existence of contradictory and invented situations as a way that reassures the players of the activity and recognition of boundaries.

6.5.3.1 Students' Characteristics

Students are informed by their diverse nature which is influenced by language, culture, religion, socioeconomic standing among other factors. The most appealing status of students in the 21st century is their accepted multi-faceted roles based on andragogical principles (Quinn, 2001). The age span is wide and highly heterogenic in the sense that whilst some students come direct from general education others are not only returning to study life as matured adults who have family responsibilities. All these factors present nursing students as rich sources of experience which assists them in the construction of nursing knowledge, skills and attitudes (Bruce, *et al.*, 2011: 115). The self-concept of individual student influences their self-directedness and purposefulness in learning; it depicts a developed critical-thinking ability (Klopper, 2009: 1).

6.5.3.2 Nursing Students' Responsibilities

As an adult learner, the nursing student is expected to engage in purposeful learning through their mind, body and spirit. In this view, the student is acknowledged as a person who is self-directed, experienced and ready to constructively learn intellectual concepts and experience change and an active construer through active involvement (Klopper, 2009: 7). Based on the principle of andragogy (Quinn, 2001) they are expected to be self-motivated, search for new knowledge and experiences, interact with peers through group work and team working clinical placements.

6.5.3.3 Nursing Students' Attitude

As an adult learner, the nursing student's self-image, self-concept and readiness to learn are primary for a motivated and self-driven learner. If motivated, they engage in goal directed actions where they self-diagnose learning needs, identify effectiveness of learning style and assume readiness to learn (Klopper, 2009: 109) and are vital in student-centred and active learning. According to Schrader (2008) <http://www.apa.org/education/k12/learners.aspx>- shifting of the responsibility of learning from the instructor to the student does not only give them autonomy as adults but they also learn to negotiate for learning issues. Such dialogue empowers them to become life-long and self-directed learners, enhanced activeness and potentiated learners (Schrader 2008). This attitude for learning assists in producing and maintaining the required calibre of professionals that can meet the required knowledge, skills and attitude in the real life employment (Griessel & Parker, 2009).

Another challenge is the quest for employability. Higher education institutions attempt to match the increasing complexity of knowledge, technology and work that most occupations demand (Griessel & Parker, 2009). This means that occupational progression is strongly related to educational progression and the vice versa. Hence the need for life-long learning because education is one of the main ways in which most people attain knowledge (Barnett, 2006). At the university where the study was conducted, nursing students' attitudes is shaped by graduate attributes (GAs) the qualities, values, attitudes, skills and understanding that must be instilled in nursing students. The graduate attributes are institutionalised through the Institutional Operation Plan (IOP) (UWC IOP, 2015-2019). The university's plan is associated with the need for graduate's employability by developing students' consciousness as critical and responsible citizens, contributing to the social and economic development of the nation.

Alignment of the GAs with teaching-learning activities, assessment tasks and learning outcomes include (i) scholarship which requires students to demonstrate scholarly attitude to knowledge and

understanding within the institutional context; (ii) citizenship where students are engaged to become committed and accountable citizens who aspire to contribute to social justice and care and social good; (iii) Lifelong learning which is directed at development of confident Lifelong Learners; achieving through collaborative and individual learning and critical reflection in understanding of the real world. The overarching skills and abilities that are embedded in the GA include: (i) inquiry-focused and knowledgeable through research, (ii) critically and relevantly literate in use of information, (iii) autonomous collaborators who are informed by openness, curiosity and a desire to meet new challenges, (vi) ethically, environmentally and socially aware and active through demonstration of knowledge that is ethically, socially, culturally and environmentally sensitive, (v) skilled communicators who recognise and value communication as a tool for negotiating and creating new understanding, (iv) inter-personal flexibility and confidence to engage and interact with people from a variety of backgrounds.

This is in line with Griessel and Parker (2009) who advocates for integration of graduate attributes in higher education and university academic programmes. The Education White Paper (1997) emphasises that South African higher education institutions should take cognisance to integrate graduate attribute with teaching of science-based and discipline-based subject knowledge. In the SA context, the issue on GAs is not only directed to redress employability issue of the graduate but to questioning low graduating rates (Cloete & Bunting, 2002; DoE, 2001). The La Trobe University implementation of the graduate attributes was to redress information literacy to enhance the search skills and information seeking behaviour as an intentional teaching-learning agenda (Salisbury, Karasmanis, Robertson, Corbin, Hule & Peseta, 2012).

6.5.3.4 Nursing student and activity of learning

According to Barnett (2006:147) learning is viewed as the process of recontextualisation of knowledge which implies that pedagogic teaching-learning methods should assist students to contextualise the nursing-disciplinary-knowledge by relating such knowledge to their field of practice. This is the most important relationship between the curriculum and practice knowledge that can be achieved through meaningful constructivists' influences. The constructivist's approach to learning should be accepted as a manner that makes learning meaningful and directive (Klopper, 2009: 50; Derakhshan & Singh, 2011). Meaningful learning suggests that the student is able to think and engage in the learning process using the problem solving strategies through which students actively construction knowledge (Klopper, 2009: 50).

Muller (2009) argues that structuring of the academic discipline has implications for pedagogic transmission which can be achieved through sequencing and pacing of learning. However, this structuring often poses challenges to a majority of students who need more time than what the curriculum prescribes. Bernstein (2000: 113) argues that knowledge does not only need sequencing but it also needs to be classified based on related epistemic logic inherent to that particular knowledge structure. Furthermore, Bernstein (2000) relates to the process of knowledge translation for curriculum and pedagogic practice not only as the process of framing knowledge or learning content but, also contextualisation. Which entails de-locating knowledge from the field in which it was produced and relocating it into pedagogic discourse. This requires innovative-interactive learning methods which promote the constructionists' approach to learning (Klopper, 2009).

6.5.3.5 Competence and Learning Competencies

Spiritual care awareness, sensitivity and competence are of primary importance for students in order for them to provide effective spiritual care. Constantly, exposure to classroom and clinical learning of spiritual care content will promote spiritual competence which includes core nursing knowledge on various subjects. These are subjects such as professionalism, ethics, leadership, communication, IPS, caring, nursing interventions, teamwork and collaboration, safety, quality improvement and evidenced-based practice of being present. Furthermore, understanding the meaning of suffering which the student can attain at a minimum level in the undergraduate training and refined with time to advanced or proficiency level (Kings College, 2015).

The nursing student is defined as an adult learner who possesses a rich source of experience which makes learning exciting and meaningful in the construction of own understanding. She or he self-motivated and self-driven and engages purposefully in learning through the mind, body and spirit. The nursing student has a good grasp of nursing and other science related knowledge, skills and attitudes which are integrated to a "*belief system*" that the student holds as important for survival as these are intricately woven with the core of the student as he or she partakes in spiritual-based learning to develop good self-concept and image that comprehends the meaning of caring, presence and suffering.

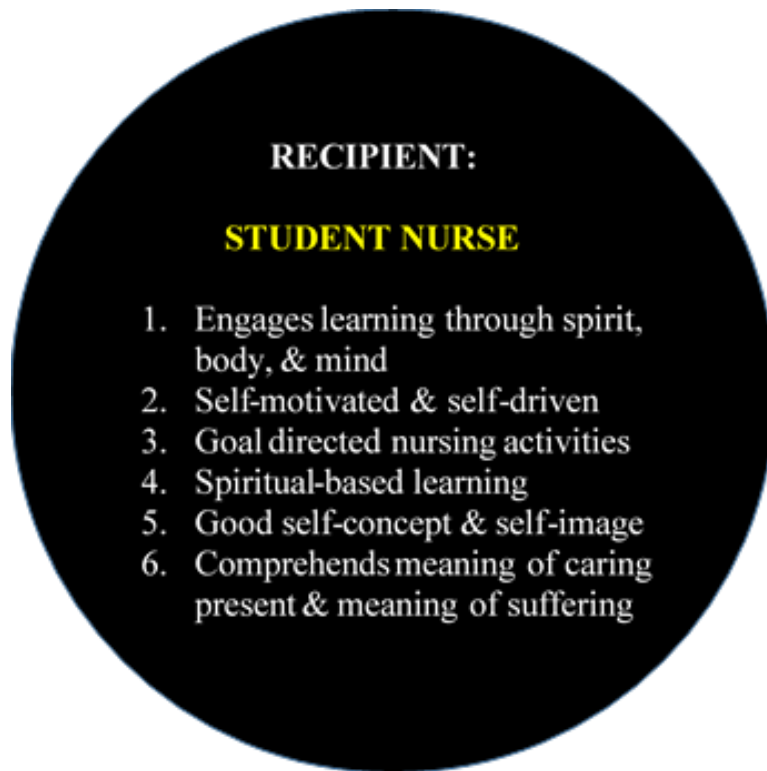
Figure 6.5 introduces the nursing student in the context of the developing model. Previous actors that is the nurse educator and clinical supervisor are shown in semi-circles with fade-shaded colour to show the symbol in inactive state whilst the new symbol is showed in a strong black colour.

This arrangement will continue through-out the process of model development as physically represented.

Figure 6.5 below shows the nursing student in the developing model.



Figure 6.5 NURSING STUDENT



6.5.3.6 Conclusion Statements on Nursing Students

- The nursing student is an adult learner yet in early years in life. Some are adults who are returning to study life. The returning students are not only adults but mature individuals who sometimes have family responsibilities. This positions the nursing student to possess a rich source of experience. The experience makes learning exciting and meaningful while constructing own understanding as the nursing student engages purposefully in learning through their mind, body and spirit; which is evidenced in their good grasp of nursing subject and other science related knowledge, skills and attitudes.
- A nursing student is a self-directed person whose leaning is influenced by language, culture, religion, socioeconomic standing among other factors. The nursing students have rich source of experiences which assist in the construction of nursing knowledge, skills and attitudes; which in turn shapes their good self-concept evidence in self-directedness and purposefulness.
- The nursing student's self-concept influences cascading effects of self-directedness, readiness and willingness to learn which in turn promote purposeful learning and critical-thinking. Therefore, the nursing student becomes self-motivated to search for new knowledge and experiences, interacts with peers through group work and teams in work-integrated learning. The nursing student constructs meaning and learn intellectual concepts by engaging in goal directed learning where self-diagnosed learning needs produce an impetus for further learning, self-monitoring and self-evaluation of own learning.

6.5.4 Context: Levels of the Context

The study context will be described under three levels that impact on the undergraduate nursing programme. The levels include (i) the macro level which portrays geographically national HE system of education in the nine (9) provinces in SA, (ii) the Western Cape Provincial context of education and last, (iii) institutional level of education in the Western Cape. The purpose of describing these levels is intended to portray a comprehensive picture regarding the conditions under which the current study was conducted. When defining the context, different connotations can be elicited. According to Kolver (2015) context can be understood as “a background, environment, framework, setting or situation surrounding the event or an occurrence”. Business Dictionary (2015) defines context as a particular event or situation including its function, purpose and use, and time, the creator and recipient. Yet, the Cambridge Dictionary (2015) refers to context

as the situation within which something exists or happens and that can provide historic explanation.

Dickoff *et al.* (1968: 428) use the term context as synonymous with the terms framework and matrix space, time and structure or non-physical such as policies, protocols, acts and rules under which the activity occurs. Furthermore, the term relates to other things including persons, activities, and how these interrelate to constitute an organism, unity or total experience that defines how things are or should be with in a particular situation.

6.5.4.1 National Higher Education Transformation in South Africa

According to Kok and Blignaupt (2009) the South African population is comprised of 55 million people of diverse origins, cultures, languages and beliefs. The SA demography consists of 79% black-Africans; 9% white; 9% coloured and 2.5% Indian-Asian (Kok & Blignaupt, 2009). A 1.2 million square kilometres of the land area is divided into nine provinces where more than half of the population lives in cities. The country is multi-linguistic with at least eleven languages recognised as official languages. About 40% of the SA population speaks traditional languages such as isiZulu or isiXhosa yet English is the medium of instruction in South Africa, it is the second, or even third language for 63.5% of the students.

▪ Social Characteristics of South Africa Higher Education Context

Living conditions where the rich and poor SA citizens continue to compete for basic living resources is indicative of SA as a developing country. Whilst the political changes attracted new challenges, they are conceived as challenges of political-change. The SA government, through its National Plan (NP), continues to make efforts to address social-ills and inequalities from the apartheid government as evidenced primarily in healthcare and education systems. The SA democracy and policies that are institutionalised to address inequalities in healthcare are varied including Nation Health Act (2003), Traditional Health Act, No. 22 of 2009 as part of welcoming the social change that is sensitive to the people's culture and beliefs.

▪ Context of the General Education System in South Africa

In relation to the SA context where huge economic disparities are a true reflection of the characteristics despite the estimated 23% national budget being spent on the education sector, poverty and other social ills still exist in South Africa. The SA education system, particularly, presents challenges such as schools with sub-standard physical structures and facilities with poor electricity and communication facilities. Holcroft (2004) iterates this with reference to poor

telecommunications, computers and electricity. The relevance of these issues in general education forms the students' educational background which negatively affects their academic performance at higher education institutions.

6.5.4.2 Provincial Context of Higher Education in South Africa

A map showing the geographical location of all the universities in the Western Cape was presented in Chapter 2. The university in which the study was conducted is situated in the Western Cape Province which is the mother province in SA. A general feature in SA education system across provinces is characterized by a pre-democratic conditions where the jurisdiction of the affairs in higher education were handled by the SA government through segregated management where matters associated with Whites, Indians and Coloureds as special groups were handled as such. General affairs on the other hand dealt with matters associated with Blacks and others racial groups in the country (Soudine, 2008). Consequently, this segregation had effects across all sectors including education.

The SA Apartheid Government dates back to beyond 1948 which resulted in exclusive registration of distinctive racial groups in higher education (HE). For instance, the National Party Policies which prevented liberty of registration of students from respective racial group across HE institutions. The language also exerted restriction to some extent. The medium of instruction for certain institutions favoured certain racial groups. For instance, English-based and Afrikaans-based universities were most prevalent as these were the official languages in SA then. According to Soudine (2008), administration of Afrikaans-based universities was prioritised and managed executively as these institutions served the needs of the SA of the time. The other form of segregation was not only the demarcation of core business between the Technicon education and training for skills and the universities being responsible for development of science-based scholarly knowledge but also white universities that were well-resourced with human and material resources.

Post-democratic era: The birth of a democratic government in 1994 marks an era that governs the HE today. Despite the existence of challenges in the post-democratic era, the HE landscape in SA has drastic changes as proposed in the White Paper No. 3 (1997) on transformation of Higher Education. This resulted in the formation of the regional non-statutory bodies which are mandated for consulting, planning and implementing programmes at regional levels (CHE, 2006). The outcome of these series of interventions led to new avenues in SA education which is coined in

the SA's slogan "free education for all". This development was supported by enacted necessary acts, rules, structures and bodies; each having a specific role to play in the HE system of SA. Various acts, policies and rules to standardise the SA higher education system include Higher Education (HE) Act No. 101 of 1997 which is discharged through High Education Quality Council (HEQC), South African Quality (SAQA) Act which is discharged through Department of Higher Education and Training (DoHET), SAQA, NQF Act no.67 of 2008 through the Council of Higher Education (CHE), South African Nursing Council (SANC) and the Nursing Act No. 33 of 2005. Further, SANC plays a vital administrative role regarding rules and regulations, set standards for the establishment and outcomes of nursing education and training programmes, including clinical learning programmes and approval of such programmes that meet the education requirements. The SANC does quality assurance through effective application of the Nursing Act on the scope of practice for nurses (No. 33 of 2005). Other policies include the National Health Act No. 63 of 2003 narration on service delivery, National Qualification Act No. 17 of 2002, Health Act No. 101 of 1997 defining the standards as well as the National Qualification Act of 2008 among the rest of the acts that relate to the SA context of higher learning. Consequently, nursing education is required to apply the SA Model for nursing education and training as modified to district and PHC approaches (DoH, 2012: 5). All these policies, principles and strategic directives are aimed at ensuring good functioning of the HE system (Nzimande, 2009).

▪ **The Current Status is of Universities in SA**

South Africa is viewed as both developed and under-developed country which plays out in varied statuses of economic sustainability, quality and credibility of different universities. On global university ranking at least two or three South African universities are listed (<http://www.africa.com/top-10-universities-in-south-africa>). Whilst there are best universities in South Africa, there are also universities that do not only struggle to meet their academic mandate but are entangled in a country wide poverty due to student who cannot afford to pay the university fees. On the other hand, some universities in SA are believed to offer world-class learning experiences as evidenced by a number of international students from African and abroad.

The struggle for social development in SA did not end with transition from Apartheid to Democratic government but continued in different forms including battle against quadruple disease, economic and emotional freedom among others. Numerous protests under the banner of #Fees Must Fall movement were experience in SA between October 2015 to Sept 2016 country wide. Lack of acceptable intervention by the Higher Education Minister and the SA Government

has crippled academic progress in most universities; where each university is not only left/expected to decide how best it will meet students' need of "no fees" that is #Fees Must Fall Campaign instead of proposed reduced fees and controlled yearly increase. Student views were accepted as legitimate.

Ntokozo Qwabe a Rhodes university graduate with four (4) degrees refers to an unfavourable situation of HE in SA that is characterised by high attrition rates due to a system that often structurally excludes and is not supportive of black students (Seymour, 2015). Ntokozo Qwabe further states that the SA HE system is an unjust system which forces a person to be ultra-resilient in order to make it in SA. While at the university of KwaZulu Natal (UKZN) the Student Representative Council (SRC) collected some funds to assist the students who could not afford to pay their university fees (Singh, 2016), another view from student perspective from the same university students who pointed out to dissatisfaction to SRC leadership for mishandling of funds (Singh, 2016). Despite the fact that this view is skewed away from the #Fees Must Fall Movement it however shows the complexity of the problem in the universities in SA.

Various arguments, analysis and comment have been made on the current SA universities grip on Class struggle emanating from dissatisfaction including fact such as that only sixty percent (60%) of Black SA student survive their first year and fifteen percent (15%) actually graduates (Chetty & Knaus, 2016). This emanates from Class and Racial issues that are play despite previous attempts to redress inequalities through different means. Students' protest to colonial symbols was acknowledge by Professor Adam Habib WITS Vice Chancellor who associated the act with social segregation in the form of alienation and restricted access (Times, 2016). Furthermore, the movement as also associated with the Capitalist-Democracy which propagate limited Scholarship and Student Loans. This political stance leaves academics in particular to resort to a Neo-Liberal Agenda where in which they are discouraged and repressed. The crisis of inequality in HE has escalated drastically and it requires serious consideration (Chetty & Knaus, 2016).

Professor Habib reiterated that students' march to Parliament and Union Building in October 2015 did not only mark the largest student Social Movement in SA but pointed to the required social change. In addition, Professor Habib associate the protest of the SA universities as relating to South Africa's failure to eradicate the disparity of the Apartheid regime and building a collective National Identity through integration of cultural sensitivity. In his view, Professor Habib argued that Historically Black Universities (HBU) and Language are addressed in the SA Constitution. Unfortunately, the disparity of the Apartheid regime and building of proposed collective National

Identity for South Africans were not yet achieved at time of this report. Consequent to this failure imbalance continue between diversity and cosmopolitanism (Habib, 2016). This situation in HE has been accepted by many South Africans as legitimate as they further point to other contributory issues such as poor progress of the academics in obtaining Masters and PhD degrees and career pathing. A way-forward requires universities to emerge in the Public debates to seek possible solution to equity (Chetty & Knaus, 2016).

6.5.4.3 Trends in Nursing Education

Historically, the training of nurses in SA was based on the apprenticeship model (Jackson, Daly, Mannix, Potgieter & Cleary, 2013). This situation is also highlighted by Jeggels *et al.*, (2010) who attest that training of nurses in South Africa traditionally utilised real service settings to support development of the students' clinical skills. However, the situation continued to change with the introduction of health plan 2010 which prioritises primary health care. Through implementation of the National Health Priorities, e-engineering Primary Health Care and National Health Insurance nursing education and practice will continue to develop and promote sustainable change. Although there is a dual system of education where an apprenticeship model is welcomed in South Africa; convincingly, employers' participation remain a challenge based on perceived unreasonable students' work and use of expensive and hazardous machinery that present a potentially unsafe and risky environment (Kolver, 2015). Also, legally, the South African labour dispensation does not fully support this form of labour. However, a modified dual system is employed through universities of technology.

Despite the training of professional nurses being moved from hospital-based colleges to universities in 1985 in South Africa over the past three decades, it has, however, remained regulated R425 of the South African Nursing Council (SANC) (Klopper & Bruce, 2013). The education and training of both theory and clinical nursing is provided in the university and college settings under the quality assurance of the SANC, whilst the Council of Higher Education (CHE) provides accreditation of the programmes. Despite the PHC model preferred and esteemed in SA, its effect in reduction of hospital beds has inversely affected the clinical learning environment (Health Western Cape, 2003:1). Trends in the administration of Nursing Education System resemble the SA administration of General Education System changes which does not pursue effective and necessary curriculum reforms. This gap was witnessed by lack of conducted studies on spiritual care education in the undergraduate nursing programmes were found. On the contrary, global trends show that the spiritual dimension in health care has been shattered. Nursing education

and practice of spiritual-based care was destroyed during uprising of intellectual awakening in the 19th Century. The resultant scientific and technological changes pushed nurses to focus on biological needs in contrast to holistic traditions where emphasis was on whole-person. Political factors played a significant role of spirituality in nursing in eroding the spiritual role in nursing care, eroding the moral character of a nurse in return (Macrae, 2005; Pesut, 2005).

6.5.4.4 *The University School of Nursing*

A university school of nursing from which the study participants was drawn is part of one of the higher education institution in in the Western Cape. The school functions under university management structure comprises of the Vice-Chancellor and Rector who is the Chair, the Vice Rectors; the Registrar, one for academic matters and the other for student development, the deans of the faculties, head of schools, departments, centres and institutes. Other important offices include the Institutional Planning Office (IPO) responsible for quality assurance, Institutional Advancement Office (IAO) for international relations and events, academic planning (AP), Teaching and Learning Unit (TLU) just to name a few (University Calendar, 2015). The university operations are influenced not only by National Policies that serve country wide as presented in section 6.5.4.1 above but also by the institution's operational plan (IOP, 2015-2019).

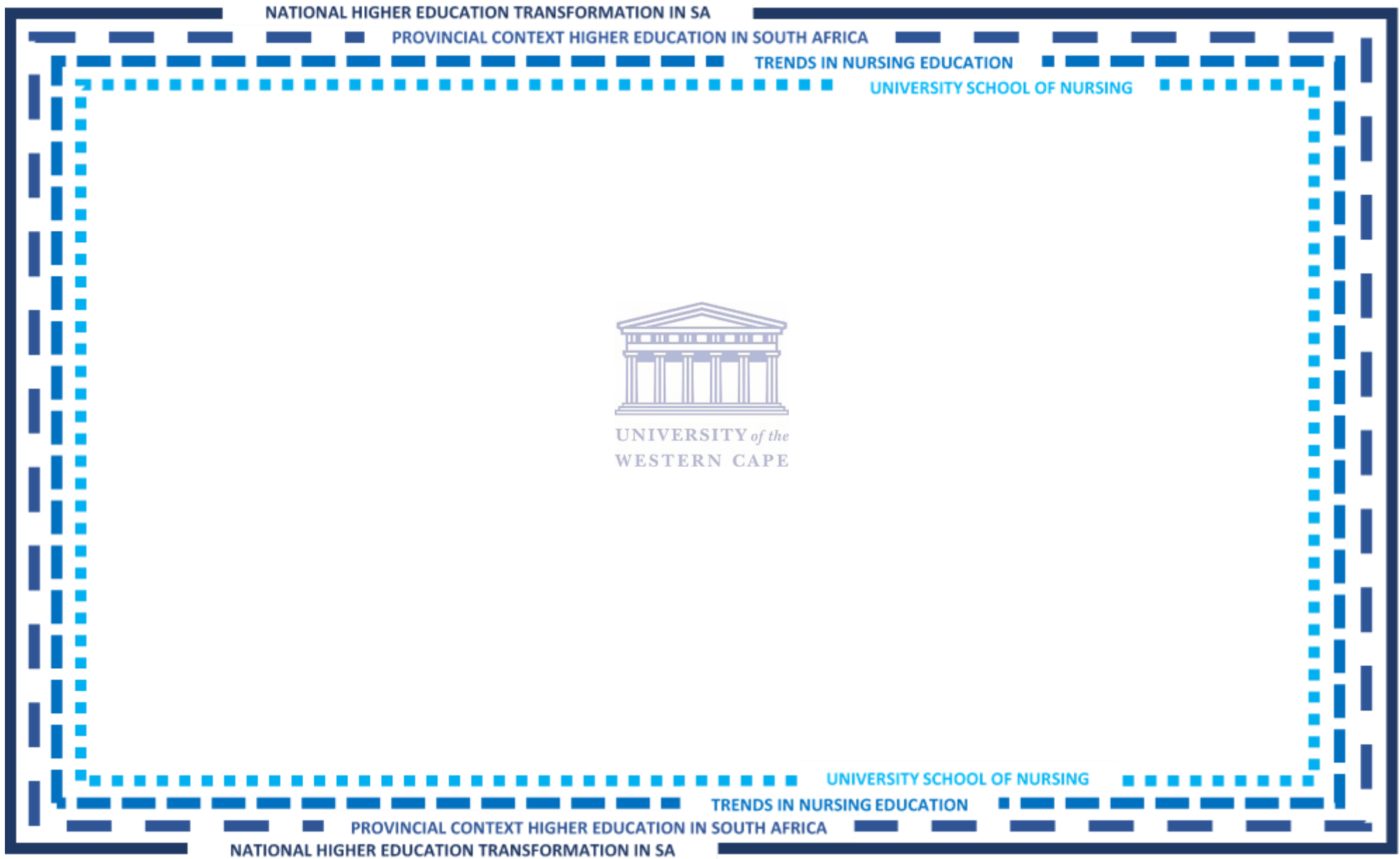
The school was selected as an ideal setting for the study because its viability is its offerings of both undergraduate (UG) and postgraduate (PG) programmes. A new nursing curriculum is underway according to the provision of R174 programme as regulated (SANC, 2014). Despite the SANC's stand on teaching-learning of spiritual care remaining unclear, the change in the curriculum may serve as an opportunity to integrate the spiritual component of care in the education of nurses. Globally, there has been a significant move within the health care profession towards integration of spirituality in education and practice to promote health and prevention of diseases. In principle, nursing education in SA and elsewhere do not reject spiritual care, but challenges do exist in terms of implementation. Despite most nursing models claiming to cater for spiritual care, this claim hardly translates to observable behaviours. Few studies conducted on spirituality in SA (Mahlungulu & Uys, 2004 & Monareng, 2011) attest to the lack of spiritual care as a universal challenge in nursing education.

Context is defined as a background, environment, framework, setting or situation relating teaching-learning of spiritual care. It includes culturally diverse functions, purposes and uses, and other factors that influence spiritual care activities and intervention within education in the undergraduate nursing programme where the nurse educators, clinical supervisors and nursing do

not only regard only their own spirituality and culture as important but acknowledge and accept the existence of other spiritualities and cultures through non-discriminate caring lived out through meaningful relationships, interrelations, and interconnectedness with self and others.



Figure 6.6 CONTEXT FOR NURSING EDUCATION IN SOUTH AFRICA



6.5.4.5 Conclusion statements on context

- Political changes can influence nursing education system as means to promote social change and development through curriculum relevance, reforms and practice of nursing.
- Despite evidence of spiritual care subject being formally acknowledged in nursing programmes in general, it is however not blatantly taught at the school of nursing where the study was conducted. In comparison to international context where significant integration of spiritual care is conceived as a vital aspect in health, healing well-being policies are in place at both national and institutional level.
- Effective teaching-learning of spiritual care subject requires a contextual-based model that is socially, culturally and spiritually sensitive to respond to such needs of SA patients, clients, communities and citizens.

6.5.5 Goal: Integration of spiritual care in the undergraduate nursing curriculum

Prescription of the activity to attain the required goal is as important as the goal. Keeping the desired goal in mind is critical because it influences how the activity can be achieved. Dickoff *et al.* (1968: 428) argue that if accomplishment of the goal was only dependable on the agent as opposed to from the terminus itself, it would be a great mishap in a case where the specified agent does not cause the activity to be accomplished. This argument, on the other hand, shows that the terminus is not only dependable on the agent but also other individuals, events or activities that may influence the student's learning informally. Thus judging what conditions are required for attaining the goal allows the agent to act accurately which Dickoff *et al.* (1968: 429) refer to as a supplement of step-wise action. This view is in line with Griffith's (2006) concept of framing in which knowledge is not only selected but is sequenced and assessed in accordance to the programme rules. According to Griffith (2006), the formal curriculum is the most vital element because it provides the initial statements about the way in which different knowledge domains are classified in a particular programme's design.

Whilst Bernstein (2000) is in agreement with Griffith (2006), Bernstein's focus is on the inappropriateness of learning that occurs where learning competencies are not literally specified but inferred from broad learning outcomes. Bernstein (2000) cautions that where competencies are not specified the tendency will be underestimated. He suggests that learning and assessment of the qualification should be conducted directly against the outcomes in the units of competency. Further, Bernstein (2000) also suggests that the existing 'gap' between formal curriculum

documents, teaching practice and facilitation of learning should be contextualised in official curriculum to address the important aspects of care.

6.5.5.1 Curriculum development

Curriculum development is one of the most vital activities performed by the nurse educator. The NE deliberates about the philosophy of nursing and education that will shape the curriculum (SANC, 2014). More importantly, curriculum development gives the NE an opportunity to decide on the module aims and objectives, determines the content and takes decisions about the module structure. Curriculum development provides a smooth integration of learning context including role players, learning content, process and activities. In contrast to use of module guides as merely to specify the outcomes of training and the criteria that are used to assess whether those outcomes have been achieved or not the curriculum serves as an evaluation tool for effective teaching-learning process. Griffith (2006) argues that conversely the module guide does shape curriculum and has consequences for teaching and learning. According to Griffith (2006) the extent to which students are able to navigate the transition between formal and informal knowledge is vitally important and should be supported by clarity on how the curriculum translates into module guide and vice versa.

The processes of designing and development of curriculum and module guides are the two sides of the same coin; they introduce students to required academic knowledge. Therefore, development of the curriculum should be alternated with monitoring which could take a form of review, and evaluation analysis. Consequent to curriculum design and development, the NE should ensure that module guides are designed and developed in line with the curriculum document. Griffith (2006) regards the module guides as teaching-learning packages that provide nursing students with access to theoretical knowledge. In the current study, review of BN formal curriculum and related academic records was aimed at detecting how the curriculum for BN R425 (Nursing Act 33 of 2005) was organised and how the curriculum outcomes exit level outcomes translated to spirituality and or spiritual care topics, subject or elements in the modules and assessment.

6.5.5.2 Curriculum integration process

Curriculum integration should indicate whether or not it is within or across disciplines or programmes. The integration process can take many forms such as (i) isolation as discipline based, (ii) awareness as cross modules with referencing between subject contents, (iii) Harmonising where informal committees collectively arrange, adapt and connect subject areas to effect student

understanding, (iv) by nesting where individual subject recognises broader curriculum outcomes through generic competencies, (v) enhanced teaching time and tabling through temporal coordination, (vi) sharing discipline, subjects are jointly planned and taught in a similar manner, (vii) correlation, imply integrated teaching through use of illustration from other subject to illustrate the problem, (viii) complementary programme relates to subject-based and integrated teaching on a specific topic or theme, (ix) multidisciplinary involves a number of subjects in a single course with a theme or problem topic as focus, (x) interdisciplinary and (xi) trans-disciplines with an aim to reduce disconnection between subjects. Curriculum integration process in this study will be effected within nursing content, inclusive of all nursing discipline modules. The purpose of integration is to strengthen intellectual vigour and ways of knowing as a measure to serve needs of the society (Irwin, Gounbzouasis, Grauer, Leggo, & Cart, 2006; Loepp, 1999).

6.5.5.3 Approaches to curriculum integration

Curriculum integration can be done at various levels such as discipline-based. Approach to curriculum integration may take different forms such as an integration ladder (Harden, 2000: 34). Approaches to curriculum integration include following, although not limited to, transactional model, integrated curriculum design and additive approach. The latter will be used in this study because additive approach allows integrated content, cultural concepts and perspective to be added to existing curriculum thereby promoting vitality of teaching-learning of spiritual care (Irwin *et al.*, 2006). Therefore, the process of curriculum upgrades will be done by adding new content and or revising existing curriculum.

6.5.5.4 Models to curriculum integration

Whilst the goal to integrate spiritual care in the UG nursing programme provides the agent with intellectual ideas about the end point of the activity in one hand; it also indicates what needs to be done to achieve the goal. Methods to implement the goals must be provided therefore a theme-based model will be utilised to integrate spiritual care subject within nursing education discipline and across nursing student (Azerbarjan & Baku, 2011). Application of the model should provide prescriptive direction for required teaching-learning actions. The nature, type and extent of the teaching-learning activity should be clear to both nurse educator (agent) and student nurse (recipient) who must participate in the process.

Teaching-learning activity will be structured and organised in such a way that it is doable and cost effective for the agent and acceptable to the recipients. The goal aspect of the survey list is very complex in the sense that it requires varied items to be considered to achieve the end-point. These

include acceptance of the activity and intellectual know-how to carry out the procedure. Procedurally, not only appropriate communication and use of language by the agent and recipient will be used to carry out of the activity but they must be informed about required performance standard to attain the goal. Detailed guidelines including rules, principles, protocols and institutional policies that bear influence on the procedure to be performed must be sought.

6.5.5.5 Integrating spiritual care learning in the BN nursing programme

Integration of spiritual care requires attainment of theoretical knowledge and understanding of true meaning of holistic care (Bush, 1998). Students and educators' active participation is vitally important in the learning process. The nurse educator should create a safe space through the use of the small groups in the process of learning to promote group cohesion. The facilitation could focus on creating opportunities for each student to contribute his own views regarding life (Bush, 1998: 22). A conducive learning environment should be promoted through the application of adult learning principles whilst appreciating the uniqueness of each student. The attitude of open and trusting relationship is to be promoted through sharing, class participation, journal entries and dialogue.

Learner characteristics including personal and socio-cultural factors often present unique needs for each student (Bush, 1998). Self-directedness and critical thinking in student's attitude is optimum and helps the student to continue to be interested in the learning topic. For instance, in spiritual care subject the student may demonstrate willingness by sharing own experiences, keeping open dialogue and exploring own thoughts. Brathwaite (2005) related to the impact of learner characteristics such as age, level of education, experience and learning style as important cultural knowledge where culture and language are keys in spiritual subject. Professional characteristics of need for knowledge, skills, encounter and desire and learning style influence learning of spiritual care. This environment brings a process of change through use of PBL, scenarios, valuing student's presence and their contribution, keeping active and motivated through dialog. Students should be allowed to initiate discussion that promotes collaborative learning rather than competition. The focus should be on assisting the students to analyse their learning experiences, by critically reflecting on own personal thoughts, similarities and mutual concerns between students (Bush, 1999).

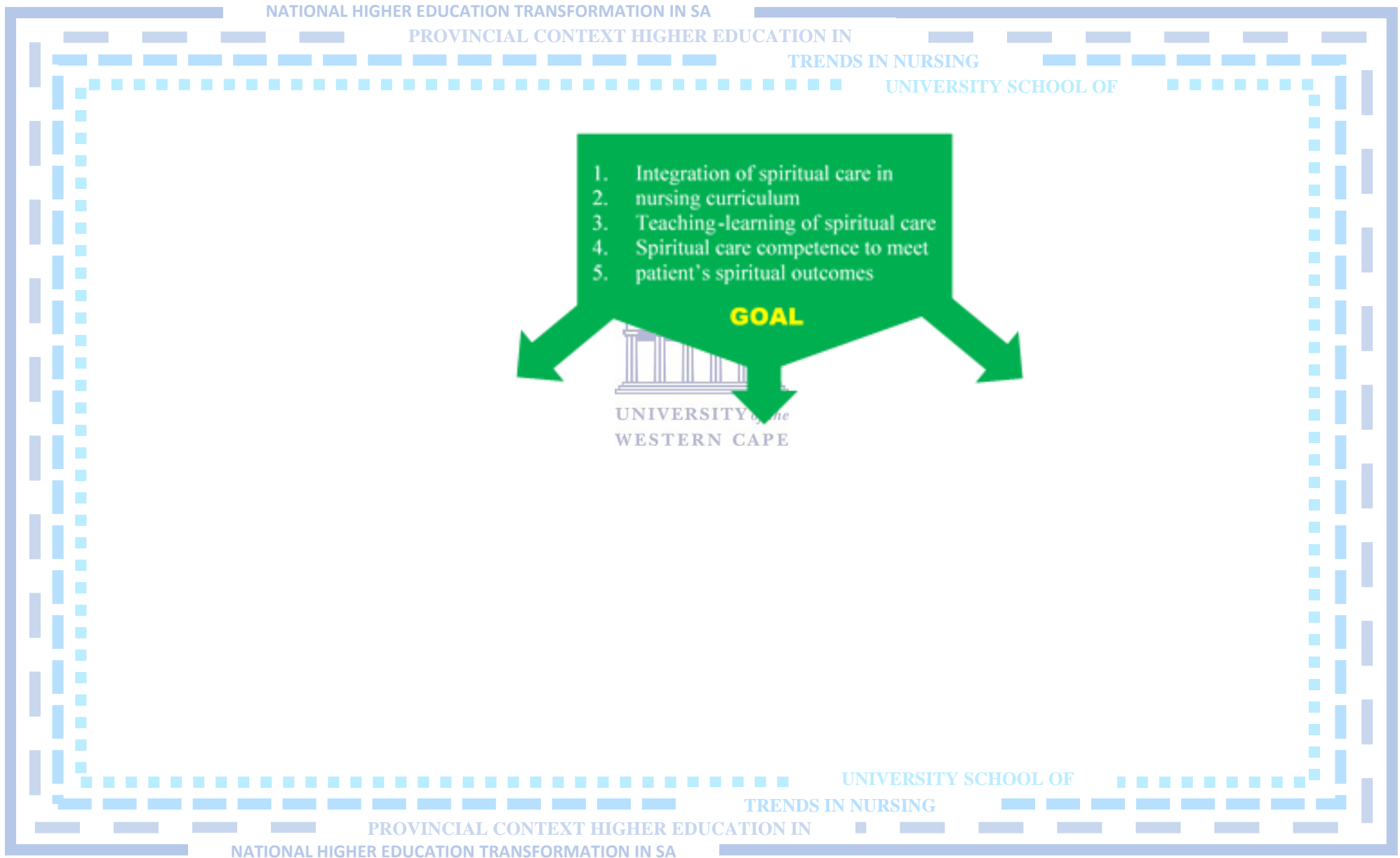
Curriculum integration is defined as a process of developing and organizing the programme or curriculum outcomes and exit level outcomes to be aligned with theoretical spiritual knowledge and skills regarding "*spiritual care*" and "*professional accountability*" indicating the individual's

ability to cater for non-physical human needs that relate to questions, issues or appreciation on existence and living; and, a state of sound moral and ethical practice values that result in a student to behave responsibly, answerable respectively. The goal is presented in the curriculum, module descriptor and assessment. Using an additive approach, the curriculum is upgraded by integrating spiritual content, cultural concepts and perspectives that will assist to promote vitality in teaching-learning of spiritual care in the undergraduate programme.

Figure 6.7 depicts goal in this study. Goal refers to the process of integrating and teaching spiritual care in the nursing curriculum where the agent who are nurse educator and clinical supervisor and recipient the recipient possesses spiritual care competence that promote required patient's spiritual outcomes.



Figure 6.7 GOAL: CURRICULUM INTEGRATION OF SPIRITUAL CARE



6.5.5.6 Conclusion statements on goal of curriculum integration

- Implementation of appropriate approaches, processes and methods of curriculum integration should be considered thoroughly to ensure effective integration.
- Use of additive model to integrate spiritual care subject is supported due to the nature of the topic for integration or content to be integrated.
- It is important that the nurse educator (agent) and student nurse (recipient) should know the purpose and goal (end point) of the spiritual care subject and to consider details on how the procedure (activity) should be carried out at different levels.
- The process and content of teaching-learning of spiritual care should be described regarding nature, type and extent of activity to be carried out.

6.5.6 Procedure: Teaching-learning

Procedures are not directed to themselves as such but they provide pathway towards accomplishment of an outcome beyond the procedure itself. Importance of the procedure lies in observance of the path, steps or pattern according to which the procedure should be performed. The teaching-learning procedure should be detailed sufficiently to guide the agent and the recipient who must perform or carry out the procedure as they interact in teaching-learning process. The teaching-learning process should be founded and guided by educational theories and underpinning philosophy. Teaching-learning process should infuse adult learning principles and educational activities that are directed to promote student's competence and confidence when carrying out learned procedure in real life.

6.5.6.1 The goal of teaching-learning

Dickoff *et al.* (1968: 430) define the procedure and refers to the steps taken which emphasizes the paths, steps or process rather than the outcome of the activity. The process of teaching-learning of spiritual care in nursing should always be goal-oriented. The goal for teaching-learning of spiritual care must be known and clear to both nurse educator (agent) and students (recipients) and be aligned with the programme outcomes. For an example, the goal is to increase spiritual awareness in nursing students. Programme outcomes could be achieved by various sub-related objectives (Narayanasamy, 1999: 275). These may include topics such as self-examination of own spirituality and attitudes in purposeful communication, caring presence, cultural sensitivity, identification of spiritual needs and so on. Spirituality includes one's values, beliefs, subjective,

experience and sense of purpose and direction in life (Burkhardt & Schmidt, 2012: 315). These learning subject matters of spirituality should be incremental into spirituality subject content and the goal to achieve integration of spirituality in nursing could include specific objectives each addressing certain aspects of spirituality. For an example, when teaching communication subject matter, the facilitator provides students with required learning contents or knowledge on the communication topic.

6.5.6.2 Teaching process

Teaching refers to a formal process through which the educator does not only give instruction to the learner on a particular subject matter but also creates a conducive environment for the student to learn effectively. According to Klopper (2009: 75) facilitators of learning should acknowledge the reality that they cannot make students learn but can only motivate students to learn. Learning is a process through which the student's mental ability is applied on learning material with an intention to construct new knowledge. Dunlap and Grabinger (2003) believe in intentionality and motivation principles that can assist students to actively engage with the learning content. Self-directed learning occurs when the student is motivated to learn meaningfully through reflection, independent thinking and critical attitude towards learning (Klopper, 2009: 77). According to this author the role of the study guide must not be underestimated as it is the road map for the student (Klopper, 2009: 76). Therefore, the teaching process should ensure that the study guide is an accompaniment tool which does not only provide general view of the subject content but also provide logical and systematic guidance. Through effective and purposeful communication, the study guide enables students to assume an independent position in their learning.

The educator should create an active learning environment in which students learn effectively. This can be achieved by the provision of clear outcomes-based and goal-directed and specified objectives in the formal teaching of spiritual care. Nurse educators should determine best teaching-learning processes, relevant strategies and techniques to deliver spiritual care learning content. Such teaching process, strategies and techniques should be clearly explained to students so that they too can understand their roles and responsibilities in the learning process. The nurse educator provides students with detailed description or information not only of learning tasks to be accomplished, but more importantly, how the student should effectively accomplish the tasks as well as the getting required apparatus or equipment.

The nurse educator provides students with information and guidance by describing steps and actions that are required for the learning goal Dickoff *et al.* (1968: 430). In this study, teaching-

learning of spiritual care does not only recognise and utilise these educational theories but further requires that students and educators' personal attitudes and behaviours are taken into consideration for teaching and assessment of learning of spiritual care subject. Spiritual care procedures should be designed to prepare student nurses to face the challenge of helping patients with spiritual concerns, issues or needs (Narayanasamy 1993, Bradshaw, 1997). Educators must show students how to care through role modelling and spiritual guidance as these are best ways of teaching spiritual care (Bradshaw, 1997). Ethics and morality of care should be integrated as an approach to teach learning of spiritual (Narayanasamy, 1999).

6.5.6.3 Application

When teaching communication subject, the nurse educator may first present the anatomy of the communication process which includes the messenger, message and recipient as an introductory lesson. Then, the educator builds on this fundamental information by providing associated interventions such as coding, transmission and decoding of the message. When these are understood, the educator may then provide scenarios that will allow students to experience the concept of communication. The process of learning does not only present learning content in an incremental manner building from the most basic content on communication but the learning experience as well. After presenting the anatomy of communication and its processes, the educator can then provide a learning experiences such as role play or gaming to enable student's application of communication; a sub-goal of spirituality. Demonstrable effective versus ineffective and good versus poor communication and related skills that can enhance students' experience of the communication should be added.

During teaching-learning process, the student can be confronted with different scenarios that denote defective communication such as broken trust, conflict, quarrel and misunderstandings as well as good positive communication such as good IPS, polite mannerism, respectful attitude, assertiveness, constructive and meaningful communication. The teaching-learning process for spiritual care should be detailed to guide both the agent and the recipient as they interact in teaching-learning context.

6.5.6.4 Learning process

The learning process for spiritual may be rolled-out sequentially through assessment to identify or diagnose spiritual issues, plan, implement and evaluate learning. Conception of learning as a process of knowledge construction (Klopper, 2009: 50) through which the learner acquires knowledge points to mental processes involved in interpreting and creating meaning of learnt

material. Various learning processes portrayed in numerous educative theories including but not limited to inquiry learning, discovery learning, transformative learning and Kolb (1984) theory of reflective learning and engaging content are directed at promoting active learning. According to Naranayasamy (1999: 275) a teaching model for promoting spirituality in which students go through self-awareness where values clarification exercise and introspection on own and their views on therapeutic relations with others' spirituality should be part of the learning process. Teaching of spiritual care is aimed at caring for the whole person (Narayanamy, 1999: 391). Learning tools such as positive inquiry, meditation, introspection, simulation, gaming and group discussion are relevant in learning of spiritual care knowledge, skills and attitude.

6.5.6.5 Teaching-learning content

The learning content may include topics on spiritual-health and spiritual-crisis continuum. These may include subject matter such as spirituality, spiritual care, spiritual health, spiritual awareness and diagnosing spiritual needs, interventions to spiritual wellbeing, and spiritual distress. The nurse educator must ensure that teaching strategies and techniques are congruent to the nature of learning content. According to Baldacchino (2006) spiritual care competencies should redress the core domains that promote student knowledge through effective communication and active listening. Spiritual care competencies obtained by students through awareness or attentive learning exercises on topics such as therapeutic use of self, affective dimension of the nursing knowledge and nursing process should comprise specific outcomes. Students must further be assisted to obtain competence on spiritual care interventions such as therapeutic nurse-patient relationships, meaning of being available and present to the patient. In cases where a patient requires assistance with religious practices, a student should be able to facilitate attainment the patient's religious requirements or need. This may include a need for quiet time or space (Taylor & Mamier, 2005), helping the patient to complete the unfinished business (Naranayasamy *et al.*, 2004), or making referrals to the chaplain or other health professionals.

Towards completion of the programme, students can be introduced to assurance and quality expertise policies subject for spiritual care. Spiritual care outcomes should cover contents on certain intervention skills such as communication skills, questioning skills, therapeutic touch and or therapeutic use of self, intuition skills versus analytic skills and being present. Self-transcendence is a personality trait associated with spiritual experiences. Self-transcendence is about discovery of one's self as an integral part of the universe; however, on the extreme end it can be associated with psychotic tendencies, such as schizotypic and mania, particularly in

individuals with low and or mood changes (Cloninger, 1993). Despite questionable validity of self-transcendence as a measure of spirituality, literature acknowledges traditional belief as part of spirituality. Concepts that emanated from empirical data which are regarded as core to spiritual car are discussed below with an intention to provide their connotative and denotative meanings.

- **Connectedness**

Connectedness can be defined as a relation between persons, things or events as in the case of one causing the other or sharing features with it (vocabulary.com). It relates to togetherness, closeness or inseparableness. The term in this format is a noun that relates to that which is put together. The adjective meaning is of the concept connectedness refers to the state of being connected. This includes being “united”, “joined” or “linked” with. Connectedness also refers to *having connection, joined together* in a specific manner for example joined together in sequence, linked coherently or orderly. It may relate to family ties or relationships. Connectedness can also be institutionalising, for an example social and professional relationship especially of influential individuals (Collins English Dictionary, 2012). Related forms of connectedness included connectedness as an adverb “*connectedly*”. Connectedness both as a noun and adjective can be applied in different areas including political, social, psychological, and spiritual and many other disciplines.

According to the Encyclopaedia Britannica (2015) connectedness refers to *a mathematical intuitive idea of having no breaks*. This is of fundamental importance because it is one of the few figures that remains unchanged after a homeomorphism process in which the figure is deformed without tearing. A point is called a limit point of a set in the Euclidean plane if there is no minimum distance from that point to members of the set (Encyclopaedia Britannica, 2015). (Britannica, 2015). The free dictionary refers to connectedness as that which is *joined or fastened together, related by family, logically or intellectually ordered or presented*. It is associated or also related to others. Connectedness refers to “*a state of being connected*” (Britannica, 2015). Connectedness may also mean the following: *unification* - a state of being joined together; contact – a state of or condition of touching or being in the immediate proximity; union, *concatenation* - a condition of being linked together as in a chain or series, interconnectedness or interconnection – a state of being together (connected) reciprocally, connection (connexion) refers to relation of an *abstraction belonging to or characteristics of two parts together*, *connection* refers to alliance, bond a connection based on kinship or marriage or common interest, *communication* – a connection that allows access between persons or places, *bridge* – may refer to a functional connotation of the

term, *involvement* - referring to a connection of inclusion or containment, *connection as relevance or relevancy* – refers to relation to something to the matter at hand, *relatedness* - a particular manner of connectedness like relatedness of all living things.

In view of all the possible forms of connectedness found as provided above, the concept connectedness will be used in the developed theory to mean a deliberate interpersonal relationship or involvement between two individuals (who could be the nurse or patient, educator or student or student or patient in a caring environment within the clinical and non-clinical settings with an intention to have or get access to each other's personal space. Connectedness can be depicted in various ways including *connected to God; connected to values*. Also being connected to ethical principles of knowing right or wrong including justice, autonomy, beneficence non-maleficence; basic humanity principles including love, respect, spirit of Ubuntu; gods; rituals; ancestors; other spirits; inner self; deity; values; moral beliefs; nature; internal energy which is displayed as being full of life, hope, motivation which is an indication for willingness or wanting to do something. Motivation is an attribute that can be used to build on and passion; as well as any object that is regarded for the purpose by the person.

Connectedness is regarded as any *personal attachment, personal commitment*, to devote own self to or *being involved* in something. **Attachment** can take many forms including but not limited to *physical attachment, spiritual attachment, emotional attachment* and psychological attachment. A person can be attached or connected to God, higher power, deity, value, inner self, self, belief or an object. Connected to values which may not necessarily be religious beliefs but more of moral beliefs, for an example sound knowledge about and between right or wrong and emotional drives. **An emotion** is defined as a feeling that a person may have against or towards something or somebody. Emotion can be either *positive or negative*. In line or keeping with spiritual care, only positive emotions are associated with spiritual health. Negative emotion is associated with lack or spiritual health but presence of spiritual discomfort, emotional distress. Example of emotional inner peace is an attribute of an emotion. It is also a virtue of spirituality. A person may believe in nothing but he or she is a spiritual being. "*Inner peace*" is conversely related to "*inner spirit*". Emotions connect the person to his/her inner self. Emotions and inner peace are determined by stability of one's personal values and beliefs. Emotions mean a *feeling, sentiment, passion, reaction, excitement and sensation*. The antonym of connectedness is disconnectedness which refers to space which is a union of two disjoint non-empty open sets.

▪ Spirituality

According to Chambers Dictionary (2015) spirituality is defined as the state of habitually or naturally looking to things of the spirit. The applicability of this definition in nursing indicates that the nurse and the patient would need to be habitual or natural in looking at the spiritual issues or factors that interfere with the health and recovery and recuperation of the patient (Schwartz, 1991). Contextual-based findings of the study indicated that spirituality can be defined as all human activities that are seen and unseen that connect a person to his or her own spirit. “Spirituality” as a concept emanates from the term spirit which is a versatile component in a person. Spirituality is a very a broad term that can be related to “*religious spirituality; secular spirituality*” (MacLaren, 2004) or “*person’s and traditional spirituality*”. Spirituality is a complex aspect of human condition or being it may or not include mystical experience (Witte, Van der Wal & Steyn, 2008: 84).

Spirit is the root word for spirituality. Spirit is an inborn virtue through which a person relates to God, higher Power or supreme power or anything else to that effect. It is defined as the value, a life driver within the person. It is the only connection with God; it is the power inside a person. It is an active component through which a person connects to who he or she is; connects to what he or she believes; connects to his or her inner being. Spirituality is not only widely accepted as an integral component of patient care, but also as a foundation on which spiritual care can occur (Highfield, 2000). Despite lack of universal definition of spiritual care in nursing, the spirituality is usually conceived in the context of a holistic notion of the human person or from the perspective of Christian theological tradition (Sanders, 1992). However, Sanders’ (*ibid*) concept clarification marks to a certain extent a breakthrough in this limited knowledge of the spirituality as a working term. The following five main attributes of spirituality identified by Sanders (*ibid*) undoubtedly can assist implementation of spiritual care in the nursing practice. These attributes can be used by nurses as antecedents of spiritual care where *meaning* (the ontological virtue) that is making sense of life situations to discover purpose in existence (life) through the experience (Narayanasamy, 1991)..

Searching for meaning and finding purpose to engage with something is central in spirituality. However, meaning is more crucial because finding out reasons to participate or not to engage is an inseparable attribute of spirituality and therefore spiritual care. The term meaning describes a central idea in a number of coping theories that are relevant for nursing practice. The relevance of meaning in the nursing practice relates to the possibility of the patient to search for meaning in the

event of sickness or illness with an aim to cope through integration and reworking and redefining the past meanings while at the same time looking for meaning in the current life situation (Richer & Ezer, 2000). Meaning can be explained from existential and situational perspectives (Richer and Ezer, 2000). Nurses have more to learn from what the term “meaning” entails and what it can offer to nursing practice. Some view meaning as referring to “an existential” connotation of meaning, not only relating to individualism but also depicting a person’s motivation, force and willingness to understand while going through the experience. Other connotation refers to “situational” situations the appraisal of which could be primary or secondary (Lazarus & Folkman, 1984). Thomson and Janigia (1988) acknowledge that an implicit meaning is personal understanding only significant to the person going through the experience. Meaning means a search for coherence and purpose in life (Yalom, 1982) while it may also be seen as a social construct and identity.

Value (beliefs, norms and standards) that are dearly cherished as truth, credible and worth of one’s thought become an object of focus or behaviour (Stoll, 1989; Uustal, 1992) *Transcendence* experience and appreciation of a dimension beyond I, me and self-connotation which extend self-boundaries (Burkhardt, 1994; Reed, 1991) and openness. *Connecting* through relationships with self, others, God or higher power, and the environment (Burkhardt, 1989; Harrison & Burnard, 1993) becomes a norm rather than a struggle. *Becoming* through which life unfolds and demands reflection-in and on the experience (Burkhardt, 1994) in order to understand and know the situation better. Spirituality can be seen as a sum total of personal collaboration.

Human spirit is a vital aspect of a person that if in good balance with the body and mind can indicate a good state of health. It influences everything else in one’s life including a relationship with God; All humans are born with a spirit. It has no age; it is not measurable and it is embedded to a human being. It is about being connected to something. *Spiritual well-being* defines as the ability to experience and integrate meaning and purpose in life through a person’s connectedness with self, others, art, music, literature and other self (Wilkinson, 2005: 13). It is also acknowledged as spiritual health (Highfield, 2000).

- **Religion**

Religious care can be defined as care given in the context of shared religious beliefs, values and liturgies of a specific faith community (Yorkshire & Humber, 2007: 7). Operational definition of religion includes any activities that constitute religious requirement or personal requirements. *Religious* refer to activities that are related to religion. Religious requirements are prescribed by religious institutions and personal requirement refers to the personalised need to do or get

something. In principles religious requirements when performed they do not only display religious associations but also that which is valued by the person. Examples of religious beliefs are collection of placenta by Muslims after child birth; a religious leader praying for the patient; Bible or Quran reading including praise or worship for certain people. Operational definition of spirituality is *interconnection between two points or connectedness to something or someone*.

Spiritual beliefs come from the spirit and they turn into faith when the belief is on something unseen. Universal connotation of spirituality is its relatedness to beliefs and believing. It is something that holds and builds a character in a person. Spirituality can originate or be influenced by religion. Spirituality is forever developing within a person till death. Spirituality can be demonstrated and shared. It refers or relates to how a person interacts with the outside world, this includes knowing what you do as person and why you do what you are doing. Spirituality provides the foundation for spiritual care in nursing. *Religion* is close to spirituality. Religion refers to individual and community values, beliefs and practice through which a person attempts to fulfil spiritual needs (Highfield, 1992) also as a coping mechanism (Reeds, 1992). Religion and spirituality concepts are frequently inter used with each other.

- **Belief**

Belief can be defined “as power in the form of hope”. Belief is a state of the mind (www.jstor.org/stable/2215473). The term “belief” is sometimes used synonymously with “meaning” due to their defining attributes which are related (Richer and Ezer, 2000: 1108). Relationships in nursing context acknowledge both beliefs and meaning for the nurse and patient in their transcultural-interactive relationship (Leininger, 1995). In this theory, the terms were considered different to each other. Various academic disciplines, including philosophy and psychology and traditional culture, roughly refer to belief as regarding a thing to be true. Beliefs can be *dispositional beliefs or dispositions* to believe. Dispositional beliefs are occurrences that exposes to specific beliefs and a person may not take or consider them as such which means he does not believe. When a person considers them as such, then it means he believes (Schwitzgebel, 2010)). *Disposition to believe* on the other hand is when a concurrent of a belief takes place in a person and everything else affirms that occurrence of the person’s belief (Schwitzgebel, 2010, Rassol 2000). Beliefs are by far more than just that particular belief but they are embedded in systems. When a person believes in something, it is because it fits with the rest of their belief system. This means that any point of view is a small portion that represents the assumptions from which it is based (<http://reallyusefulphilosophy.blogspot.com>).

Beliefs various, they may be absolute relative in nature. *Absolute* belief versus *relative belief*; personal value, cultural value; principle value presents like an iceberg in which most of the viewpoint is hidden. What is worse is it is usually the most important part of the viewpoint which is hidden, namely the assumptions upon which it is based and which are the source of any disagreement. "Dispositional and concurrent belief" is the contextual activation of a belief system in specific thoughts or ideas. It is the source of power in a person; it is power in the form of hope within a person. Belief can be channelled in different ways according to different belief systems. For an example, an Atheist and Agnostic person believes that he or she has power from within own self through how he or she uses one's brain and abilities. *An Atheist and Agnostic belief* is when a person believes in him or her as superior or higher power. An Atheist and Agnostic person can believe through the spirit even though he or she may not necessarily believe in anything seen, unseen or tangible. However, because he or she has "a spirit", she can connect to values and beliefs. It can be relative or absolute. Another form of belief is *belief in nature*; for an example belief in the sea, water, fire, earth and more; *spiritual nature*. The most common belief believes in a supreme power. Belief in a supreme power can occur in many forms including believing in God, gods, deity, ancestors and self. The difference between the latter types of belief in comparison to believing in self and believing in nature is that belief in the supreme power of the unseen personification or an object, for an example believing in karma holds similar value for individual beliefs. Such a belief is not only associated with belief in God and or supreme powers and deities but also belief in culture.

Culture shapes beliefs and meaning as it can be reflected in specific behaviours. Culture has an impact on the certain beliefs pertaining to health and illness (Richer & Ezer 2000: 1113). *Cultural belief* is important as the person believes that it protects him or her from the evil. Other cultural beliefs are *executed in ritual forms or acts* for an example belief in cutting of the vulva majora. For instance, for the Sudanese culture a female is circumcised so that she is less sensitive sexually, prevents foul-smelling discharges and make sex organs cleaner (Williams and Cohen-Dodge, 1993). The use of traditional medicine is driven by a belief that supports most belief systems. A belief can affect how a person interacts with the outside world. A point of contention is the lack of clarity between "*spiritual beliefs*" "*personal beliefs*" and "*cultural beliefs*" in some individuals. *Cultural sensitivity is a part of spiritual care*. Personal beliefs are defined as a person's existing attitude, expectation and values which could be based on previous experience which then become part of that person's cognitive structures (Richer & Ezer, 2000).

- *Caring*

Caring is an active word that comes from the root word “care”. *Care* is defined as an act of taking interest in another’s well-being. Care is a natural instinct which depicts a calling in nursing. The nurse may not necessarily wait for the patient to start talking; as he or she often carry a caring attitude and pays attention to detail. A concerned nurse will always act on behalf of the patient. *She read the notes and she was touched I guess in her heart that is what she means.* A caring nurse is regarded as a good nurse and vice versa. A good nurse genuinely cares despite a lot of problems or hindrances because he or she loves what he or she is doing. A sympathetic nurse will take action of some sort or find out more about what is happening with the patient. Caring can best be demonstrated in a relational stance with a patient or his family. An existential view of caring points to nurse’s advocacy with the patient and family which requires commitment to the other and attention to common existential concerns (Meiers & Brauer, 2008: 110). These authors view caring for other as an obligation and responsibility that supports healing and they call for an absolute obligatory caring which they regard as an ultimate overarching value in guiding nurse’s actions, nothing but good and right for a specific situation (ibid:111). Caring is described as a virtue that originated from the ethical tradition and existential philosophy. It depicts the act of co-construction of meaning while more meaning is discovered in the caring process. Caring is not only a moral epitome for nursing but it requires open-mindedness to respond to the need as defined by the other. This existential connotation of care extends beyond the universal ethical principle which only captures the aspects of the larger moral world in contrast to personalized individual needs which is aimed at promoting human dignity (Meiers & Brauer, 2008: 111). Co-construction of meaning in illness and health is inextricably linked to how humans construct meaning; and for the nurse it may inform about the praxis of caring which is mutually respectful and engaging.

Kotze’s (1998: 7) conception of caring from an anthropological perspective refers to nursing as a human interaction in which the patient (who is being accompanied) comes with the need for help, guidance and care. On the other hand, the nurse (who is accompanying the patient) comes with indispensable role and skills to help, guide and provide care in a therapeutic milieu that is built on trust, understanding and support. Kotze (*ibid*) attest that man’s discovery about himself or getting to know himself is through his fellowship with others or his fellowship-being.

Care can be performed in four analytically separable, but interconnected phases which include “caring about”, “taking care of”, “care-giving”, and “care-receiving”. Care as a practice activity rather than as a disposition is acknowledged because caring about caring may be separated from

the actual act of caring as it is argued by Blustein (1999). In such cases, care remains nothing but an espoused connotation that is not implemented. Another view is that care can be extended to serve different aspects of humanity or human nature for an example “physical care”, caring for the physical body; “spiritual care”, caring for the human spirit component; mental care, caring for the mind component; emotional care caring for emotional aspects and so forth. Based on this understanding, the goal of providing spiritual care should be an interactive and interaction that is geared to cater for a human spirit. It is therefore argued that spiritual care is not only viewed as one of the ways to meet human needs, but also as an active component that has a pivotal role in revitalising the other human components primarily of the body and the mind. Caring is an active concept (Meiers & Brauer, 2008: 112). It means a calling to nursing is when caring comes naturally. Care is a root word from which the term caring originates or comes. General caring refers to an act of care that is rendered without an eminent or indication for need. Levels of care refer to the targets to which the care is indicated.

The term spirituality is derived from the Latin word *spiritus* or spirit; the essential part of the person which controls the mind and the mind controls the body (Baldacchino & Draper, 2006). It refers to a complex of values, attitudes and hopes linked to the transcendent that guides and directs a person’s life (Chinn & Kramer, 2011, Chinn & Kramer, 2008). *Spirituality is defined* differently by different authors. However, some definitions agree that the meaning of spirituality as it is contextualized in this study, acknowledges that spirituality is an essential part of every person which controls the mind and the mind controls the body (Baldacchino & Draper, 2006).

Chinn and Kramer (2011) refer to spirituality as a complex of values, attitudes and hopes linked to the transcendent that guides and directs a person’s life. Pulchalski (2001: 352) argues, until the modern times spirituality was often associated with health care where patients would receive service rather than just fixing the problem. Despite spirituality being is part of every reality through which the inner divinity that is regulated by universal law is embodied from a transcendent God (Macrae, 1995), there are difficulties in implementation. Yardley, Walshem, and Parr (2009) point to some of the barriers to spiritual care which include limited knowledge and skills by facilitators, and attitudes towards spiritual care. According to Macrae (1995) science developed and matured the concept of one perfect God based on Florence Nightingale’s spiritual philosophy of viewing nursing as a search for truth by discovering God’s laws of healing.

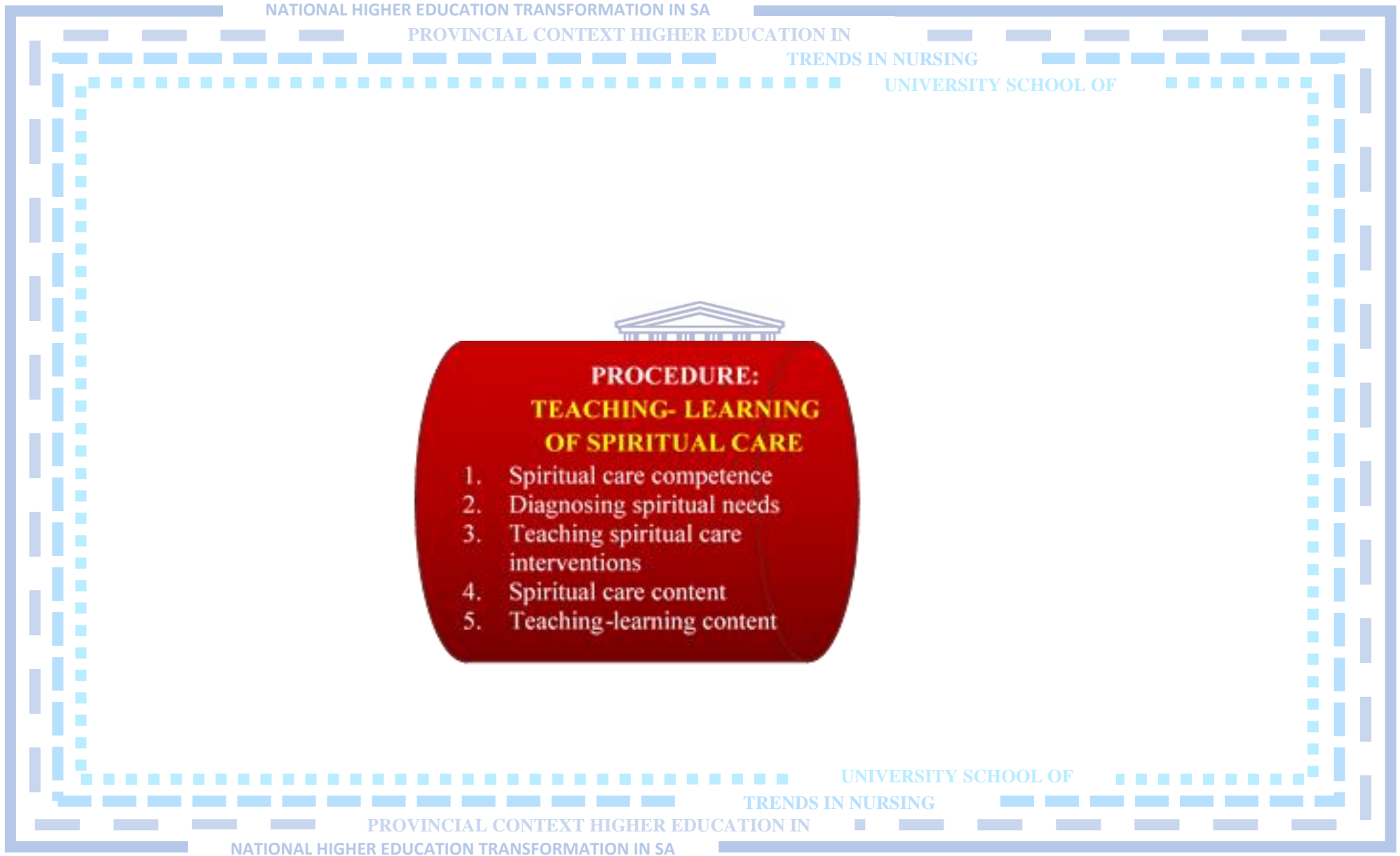
Spiritual care is defined as the care given in connection with an individual’s beliefs on their spiritual life and about their life journey (Yorkshire & Humber, 2007). The definition of spiritual

care provided depicts conception the **NHS MANAGEMENT** (1994) Committee acknowledging a holistic context view as important for both the patients and staff where spiritual, mental and physical health are interwoven and interdependent. Religious care can be offered as part of spiritual care in context to shared religious beliefs, values and liturgies of a specific faith community (Yorkshire and Humber, 2007: 7). It is aimed to assist and accompany the individuals going through experiences of life and death uncertain territories. Spiritual care can be demonstrated as through empathy, sympathy, compassion and related virtues which are very important and essential in nursing. Spiritual care is closely linked to one's belief system thus meaningful spiritual care should be rendered and received in accordance to one's belief or religion. Nurses are morally obliged to provide spiritual care for patients.

Spiritual care in nursing is a service that is rendered by nurses as means to assist the patient maintain his or her spirituality until the patient is able to do so. According to Bukhardt (1989) in order to effectively deal with spiriting with clients, nurses should invest themselves through good listening skills as a significant feature for relationships and experience of connecting with the client. Nurses should intentionally want to be with the client which she called "*being with the client*" which is expected to be part of every nurse-client relationship. Related terms include *spiritual health*, needs, *spiritual* discomfort, *spiritual* crisis and *spiritual* well-being among others. Spiritual health means that there is a balance between the body, mind and spirit; it must be maintained all the times. *Spiritual needs* can manifest in a variable degree, these include spiritual discomfort, spiritual needs, spiritual ill-health and spiritual crises.

Procedure is defined as a process of teaching-learning of spiritual care related contents whereby the nursing student is assisted by the nurse educator/clinical supervisor through the use of appropriate approaches and contextual-based models that is socially, culturally and spiritually sensitive whilst allowing students to actively engage with spiritual-learning content. The student learns how to diagnose spiritual needs and provide spiritual care intervention to patient whilst taking into consideration spiritual and religious beliefs as basis for connecting and caring for the patient. Nursing activities are founded on integrated spiritual knowledge, skills and attitude that promote the nursing student's ability to implement spiritual care in clinical practice while they draw from theory and own experience.

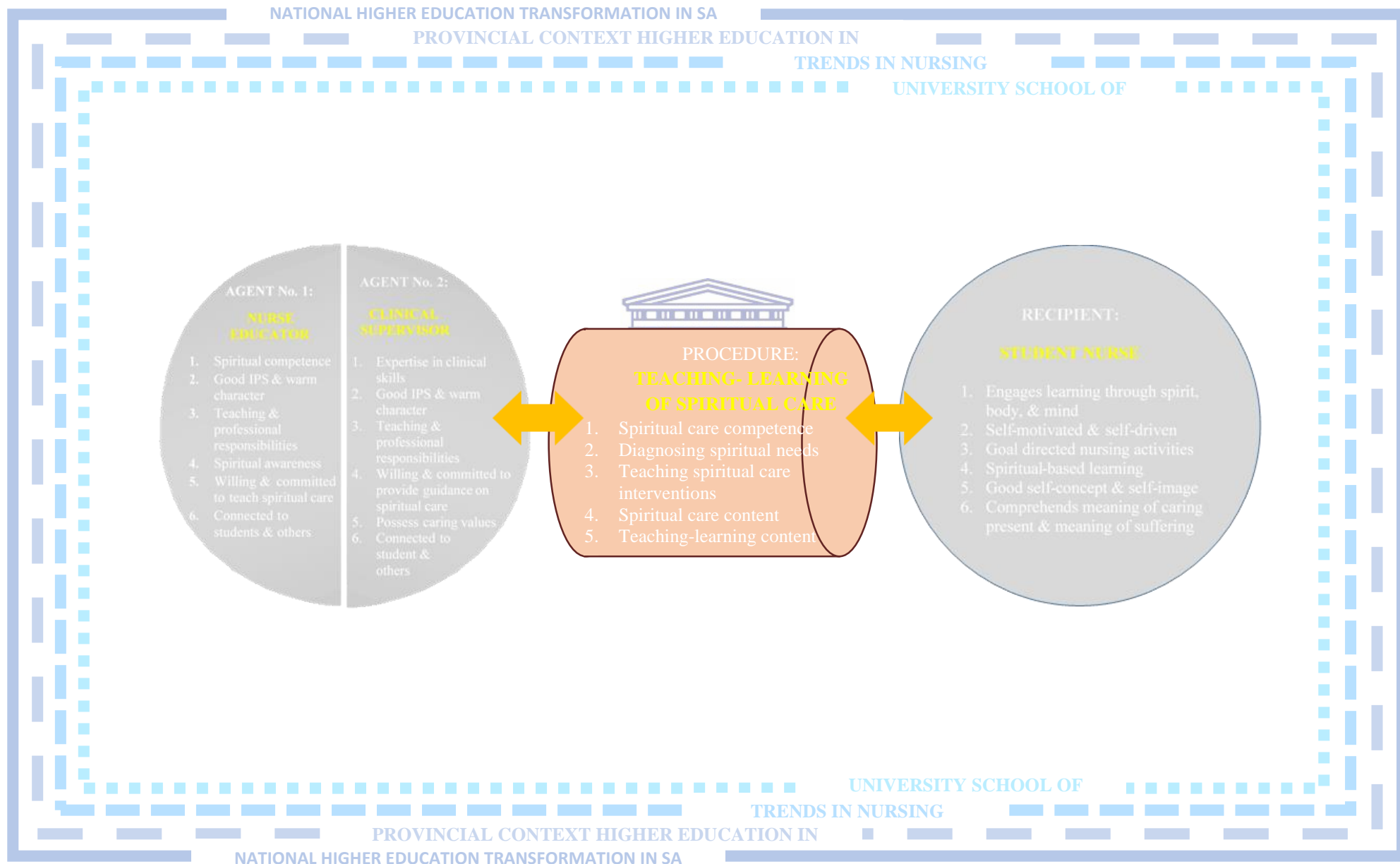
Figure 6.8 PROCEDURE: TEACHING-LEARNING OF SPIRITUAL CARE



The next figure 6.9 presents a double headed arrow that connects the teaching-learning process with the nurse educator or clinical supervisor and nursing students. The arrows are double headed to depict a dual process and direction between the agent who teach theory and the agent who teach practical skills and the nursing student who is the recipient of the teaching activity. Although usually, it is the agent who initiates the teaching-learning interaction and process, in this model the two-way process allows the student to also initiate the process by asking questions or seeking clarity on certain areas of the learning content. The model permits both the agent and recipient to be in a position to initiate the process of learning and teaching.



Figure 6.9 INTERACTION BETWEEN SPIRITUAL CARE TEACHING PROCESS AND CONTENT



6.5.6.6 Conclusion statements on teaching-learning of spiritual care

- Learning content should address topics across spiritual-health and spiritual-crisis continuum. Teaching content should not be prescriptive to allow agent's and recipient's energies to emerge naturally; through application of spiritual care competence.
- Spiritual care learning competencies should be arranged according to complexity and difficulty index per year level of the training programme. Incremental competencies should build on prior knowledge to enhance learning experience; for an example simple spiritual care content and interventions which are easy to identify for junior levels and more intense content and spiritual knowledge such as patient's need for meaning for existence and use of self as therapy for senior levels.

6.6 Dynamics: Commitment

Dynamics refers to all required power sources for realisation of the activity. Power sources can be chemical, physical, biological or psychosocial for the agent, recipient or any part of the framework which is responsible for attaining the activity. The goal of teaching-learning spiritual care should be mutually shared between the agent and recipient. They should engage in an energised environment with purposeful and meaningful interactions in which love and willingness, among other features, demonstrate commitment to the activity. The goal for which the agent and recipient perform the activity requires power sources for its attainment. Despite the nurse educator (agent) and student (recipient) being aware of the goal contents, their force at work (dynamics) can positively or negatively affect performance of the activity if it is inappropriately applied.

Teaching-learning of spiritual care should not only require the agent and or recipient to be enthusiastic in performance of the activity but they should be skilful to undertake necessary steps towards performance of the activity. Should the agent and or recipient experience internal or external hindrances, they may lose power and commitment to sustain and pursue the goal. Internal challenges may result from lack of know-how and process-related limitations to perform the activity. Providing details of the procedure to achieve the goal allow the nurse educator (agent) and student (recipient) a sense of understanding of the task that needs to be done for the attainment and sustenance of the activity.

Both the agent and recipient need to be motivated. The agent may motivate the recipient through praise and complement for work performed. Recognition for academic and personal

performance should be built into the performance appraisal system for the activity. The agent who is the nurse educator may observe, guide, assess, appraise, commend and recommend cause of action for the recipient who is the student to promote effective teaching-learning of spiritual care. Motivation principles can assist to keep both actors willing and committed to pursue the goal (Chapman, 2008).

These power sources will be associated with the roles of each part to ascertain their strength. For an example, activity of the agent who is nurse educator will include planning and designing of the curriculum, effective offering and delivery of the module or subject matter and enthusiastic interaction with students. Physical energy would relate to accessibility and availability to students' needs and including their own learning needs on the spiritual care subject matter. Such expectation is equally expected from all parties and under all the possible power sources. Self-satisfaction and goal attainment within energised-interactive processes is one of the desired outcomes for teaching-learning of spiritual care in the undergraduate nursing programme. The six vantage items in Dickoff *et al.*, (1968) survey list have been discussed and highlighted in relation to their theoretical connotation and their applicability to the current study. The following sections address the process of review of literature to support emergent concepts of the conceptual framework.

6.6.1 Conceptual foundation of commitment

Commitment as a concept can be perceived as having diverse sense and meaning. The term can only be fully experienced by the person going through the process of commitment in contrast to an on-looker or observer. Despite the concept of commitment having been analysed and related theories developed, the notions of the concept may still pose challenges in grasping the depth and breadth of its meaning. In the section, the term commitment is discussed with an intention to describe how it relates to the theory of teaching-learning of spiritual care in the undergraduate nursing programme.

The concept can be defined or described as both an adjective and a verb. The attributes of commitment are at times used as equivalent to the concept. Other synonymous of the term include devoted, committed, and devoted to something. A committed person is heartily or fully disposed to that which he is committed to. To be wholeheartedly or whole-hearted about something, means to be enthusiastic about, abiding with, ardent, authentic, enthusiastic, sincere, abiding, candid, committed, complete, dedicated, determined, devoted, earnest,

emphatic, enduring fervent, frank, genuine, heartfelt, hearty, impassioned, never-failing, passionate, real, serious, steadfast, steady, sure, true, unfaltering, unfeigned, unqualified, unquestioning, unreserved unwavering, warm, zealous, abiding, determined emphatic enduring, consigned, delegated, directed, discharged, dispatched, emitted, ordered, posted, transmitted, transported, betrothed, engaged, affianced, obliged, beholden, binding, indebted obligated, pledged and contracted (Dictionary.com, 2015).

As a verb, it means to work hard, to address, be diligent, be industrious, bear down, bend, buckle down, commit, concentrate, dedicate, to devote to direct to, give to, give all one has got, give the best shot, make effort, to peg away, persevere, select and give a responsibility, accredit, allow, appoint, ascribe attach, attribute, authorise, cast, charge, choice, commission, commit, credit, delegate, deputise, designate, empower, entrust, hang on, hire, hold responsible, bequeath, give in a will, bestow, commit, endow, entrust, grant, impart, legate, pass on, transmit and will. The list is endless. In view of implications of commitment as prevailing dynamic environment for the developed model for teaching-learning of spiritual care in the undergraduate nursing programme, theoretic foundations are necessary to guide the teaching-learning process. The nurse educator and the student should use the pedagogical principles in a manner that co-create the energised environment that inspires energies in the teaching-learning and practicing of spiritual care. In view if of the synonyms of the concept commitment as given above, show that commitment is an inside and personal virtue. Some theories of commitment support this view in many different ways. Some of the theories of commitment are explored to establish their relationship of the prescription of the model of spiritual care.

6.6.1.1 Theoretical basis of commitment

Croson (2007: 199) distinguishes between the theories of reciprocity and altruism that is needed for commitment. Croson (2007) argue that traditionally individuals care for their consumption primarily whilst on the other hand Sugden (1984) argues that the principle of reciprocity acts as a constraint on traditional utility maximisation which denies individuals to free ride whilst others are contributing. Further, reciprocity models consistent with observed philanthropic behaviour such as that when others are contributing, however the intended behaviour might be a means to or for tax evasion (Bordignon, 1993). Their students showed diverse outcomes; each theory partly supported the principles argued while concurrently refuting part of those the principles. The results indicate the complex nature of the concept commitment.

Whilst the findings indicate that an individual's own contribution and his beliefs of the contributions of others in his group are consistent with theories of reciprocity and inconsistent with traditional self-interested theories or theories of commitment or altruism. Other comparison where an individual's own contributions versus the actual contributions of others in his group, the results were the same in that subject and demonstrated that the reasons for participation in the first place may not be to give as such but to avoid certain financial fines or business related expenses (Croson, 2007). In yet another comparison where the type of reciprocity was the focus, they found that "median reciprocity" was evidence of behaviour where an individual try to match contribution of the group. Such contribution was viewed as simply a median contribution of the rest of his group, rather than the minimum or maximum. These findings indicate the role played by humans and the influence that humans have on each other.

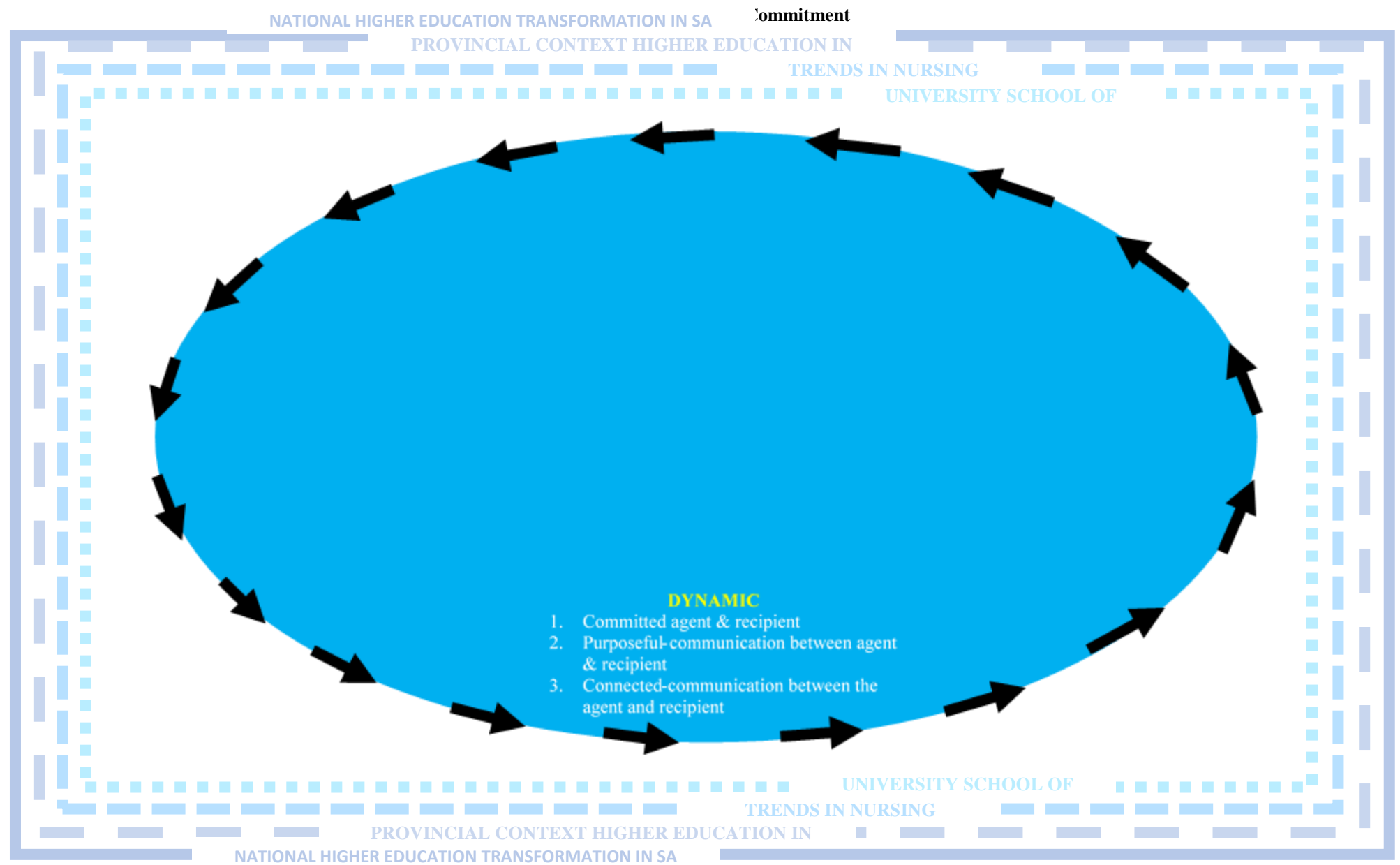
6.6.1.2 Principles of commitment

Contextual and dynamic factors may positively or negatively influence implementation of spiritual care. Authors including McSherry and Draper (1997) argue that such factors, whether extrinsic or intrinsic which include social, cultural, religious, political, socio-economic, managerial and educational, may prevent or promote effective integration of spiritual care based on knowledge and acceptance of spiritual care by nurse educators and practitioners. Curriculum revision and modification is necessary to comprehensively integrate spiritual care in the nursing programme (McSherry & Draper, 1997: 414; Narayanasamy, 1999). Models of care should be varied and dynamic to allow each individual to bring their own notion of caring to patient care. This can help nurses to explore and define their work as not restricted to a set of prescribed order of being. Use of spiritual care teaching model such as ASSET model for auctioning spirituality and spiritual care in education and training has proven possibility of teaching-learning of spiritual care in nursing (Narayanasamy, 1999).

Commitment is defined as an interactive relationship and engagement between the educator (agent) and student (recipient) on teaching-learning of nursing activities or discussions pertaining to spiritual matters and spiritual needs of the patient primarily. This engagement must be shown by commitment from both the agent and recipient through their willingness, purposeful, meaningful connected and energises communication during teaching-learning process in class and outside teaching-learning context.

Figure 6.10 presents the dynamics in which the goal activity of teaching-learning of spiritual care occurs. The nature of the dynamics of the model required for successful implementation of the model includes commitment through purposeful and connected communication.





6.6.1.3 Conclusion statements on commitment

- The nurse educator/clinical supervisor and student must be motivated mutually to perform required tasks and activities during teaching learning of spiritual care.
- The nurse educator/clinical supervisor and student must interact purposefully and meaningfully based on mutual acceptance, loving, commitment, and willingness to share personal experiences which in turn will energise the teaching-learning environment.

Figure 6.11 represents the model that was developed in Chapter six (6), and it is now shown to provide explicit picture to support how the theory was refined from the developed model. The strong colours of the model depict the entire active state of interactive processes of teaching-learning process of spiritual care in the undergraduate nursing programme. The blue coloured oval shaped background indicates the dynamics in which all the role players are part of and teaching-learning activities. The black single headed arrows represent the motion of activities that take place within interactions. Although the arrows are in one direction, it does not mean that the activity is initiated in one spot or by a particular role player. However, this is an indication that there is continuity in interaction between the participants who deliberately charge the environment through purposeful commitment and connected communication between the agent and recipient as they engage in spiritual matters.

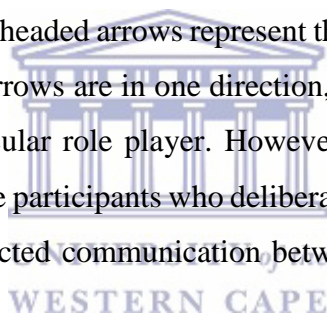
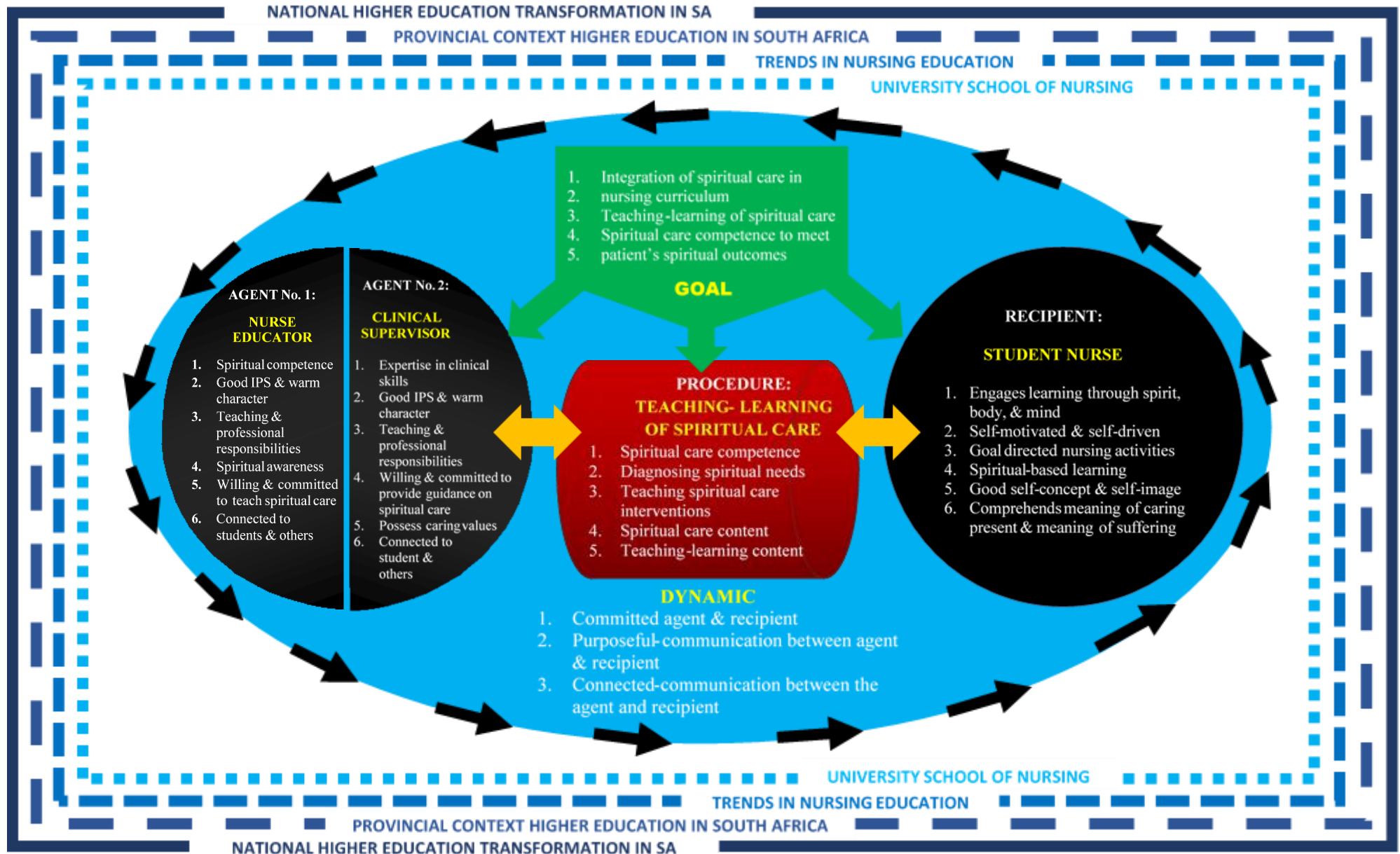


Figure 6.11 MODEL OF THE PRACTICE THEORY FOR THE TEACHING-LEARNING OF SPIRITUAL CARE IN THE UNDERGRADUATE NURSING PROGRAMME



6.7 CHAPTER SUMMARY

This chapter discussed the conceptual framework and the core concepts that were identified from the conclusion statements derived from empirical data. Identified core concepts were classified using the survey list of Dickoff *et al.* (1968). A comprehensive literature review was conducted to describe the identified concepts which formed the basis of the emerging practice theory for teaching-learning of spirituality in the undergraduate nursing programme. Conclusion statements deduced from identified core concepts were presented at the end of the Chapter three (3), four (4) and five (5) respectively were then put in Table 6.5.



CHAPTER 7: **THEORY DESCRIPTION, EVALUATION, AND CRITIQUE**

7. 1 INTRODUCTION

This chapter provides a discussion on theory description which is phase two (2) step two (2) of the research study. Description of emergent theory is presented incrementally to permit the reader's understanding of the substance and beliefs on which the emergent theory is based. Aspects that are addressed include assumptions of the emergent theory, description of the theory and evaluation and critique of the theory. Other aspects that are provided include purpose, context, overview of the theory, structure of the model, definition of concepts, structural form of the model. After which the relational statements of the generated practice theory are described and explained. The chapter summary is provided after theory evaluation and critique are addressed.

Table 7.1 below presents the conclusion statements that were derived from the conceptual framework (CF) in Chapter six (6). These conclusion statements were not only used to describe the theory but they were also used to describe in depth the relational statement with the aim to support the emergent theory.

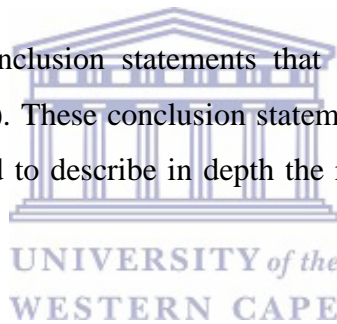


Table 7.1 CONCLUSION STATEMENTS FROM THE CONCEPTUAL FRAMEWORK

AGENT: (Nurse Educator/ clinical supervisor)	RECIPIENT: (Student Nurse)	CONTEXT Diversity of Nursing in Education in Higher Education	GOAL Integration of spiritual care in the curriculum	PROCEDURE Teaching-learning of spiritual care	DYNAMIC: Commitment
<p>1. Nurse educator refers to a person who is qualified according to Nursing Act 2005 to teach, facilitate and guide nursing students on both theoretical and practical nursing knowledge.</p> <p>2. The nurse educator plays different educative roles including teaching, facilitation, guiding, motivating and supportive roles in student’s learning journey. He or she is a spiritual resource person who is willing to share herself or himself and life experiences with students and others. Her or his character and role is guided by the principle of holism when interacting with others. She or he engages in person-centred or human-centred relationships to base her or his teaching interventions with students because she or he understands that individuals</p>	<p>8. The nursing student is an adult learner yet in early years in life. Some are adults who are returning to study life. These may not only be just adults but mature individuals who also have family responsibilities. This position makes the nursing student a rich source of experience which makes learning exciting and meaningful in construction of own understanding. She or he engages purposefully in learning through their mind, body and spirit. Have a good grasp of nursing and other science related knowledge, skills and attitudes.</p> <p>9. A student nurse is a self-directed person whose leaning is influenced by language, culture, religion, socioeconomic standing</p>	<p>11. Political changes can be effected through nursing education system as a means to promote social change and development through curriculum relevance, reforms and practice of nursing.</p> <p>12. Despite evidence of spiritual care subject being formally acknowledged in nursing programmes in general, it is however not blatantly taught at the school of nursing where the study was conducted. In comparison to international context where significant integration of spiritual care is conceived as vital aspect in health, healing well-being policies are in place at both national and institutional level.</p> <p>13. Effective teaching-learning of spiritual care subject requires a contextual-based model that is socially, culturally and spiritually sensitive to respond to the</p>	<p>14. Implementation of appropriate approaches, process and methods of curriculum integration should be considered thoroughly to ensure effective integration.</p> <p>15. Use of appropriate approaches and models to integrate spiritual care subject is supported due to the nature of the topic for integration or content to be integrated.</p> <p>16. It is important that the nurse educator (agent) and student nurse (recipient) should know purpose and goal (end point) of the spiritual care subject and to consider details on how the procedure (activity) should be carried out at different levels.</p> <p>17. The process and content of teaching-learning of spiritual care</p>	<p>18. Learning content should address topics across the continuum of spiritual-health spiritual-crisis continuum. Teaching content should not be prescriptive to allow agent’s and recipient’s energies to emerge naturally.</p> <p>19. Spiritual care skills and competencies should be arranged in a manner that allows the student to attain competence in providing spiritual care.</p> <p>20. Competencies should be arranged according to their complexity and difficulty index per year level of the training programme.</p> <p>21. Incremental competencies to enhance learning by building on prior knowledge e.g. simple spiritual care content and interventions</p>	<p>22. The nurse educator (agent) and student (recipient) should be mutually motivated to perform in the teaching-learning activity of spiritual care.</p> <p>23. The nurse educator (agent) and student (recipient) should purposefully and meaningfully interact through mutual acceptance and sharing where love and willingness among other good human virtues demonstrate commitment to the activity that keeps the environment energised.</p>

<p>are whole-beings made up of body, mind and spirit and who sometimes experience physical, emotional and spiritual needs.</p> <p>3. The nurse educator should demonstrate unique personal attributes and good teaching skills. Her / his personal characteristics do not only portray good teaching abilities and problem solving skills; but also good interpersonal relationships, good listening skills, openness and companionship to others, rescuer necessary for teaching interventions with students and others. Such character is shown in a manner that she/he embraces the deeper meaning and appropriate responses to human needs.</p> <p>4. The nurse educator is a reflective practitioner who is authentic in her/his interaction with students and others. She/he accepts own brokenness, humanness and fragility which enable her/him to sympathise with those burdened with life issues as she/he facilitates change in students and others without denying them the opportunity to take</p>	<p>among other factors. The nursing students have rich source of experiences which assist in construction of nursing knowledge, skills and attitudes; which in turn shapes their good self-concept evidence in self-directedness and purposefulness.</p> <p>10. The nursing student's self-concept may influence cascading effects of self-directedness, readiness and willingness to learn which in turn promote purposeful learning and critical-thinking. She or he is self-motivated to search for new knowledge and experiences, interacts with peers through group work and teams in work-integrated learning. The nursing student must be self-directed, experienced, ready to construct meaning and learn intellectual concepts as she or he engages in goal directed learning where self-diagnosed learning needs produces an impetus for further learning, self-monitoring and self-</p>	<p>needs of SA patients, clients, communities and citizens.</p>	<p>should be well described regarding nature, type and extent of activity to be carried out.</p>	<p>such as attending to patient's religious needs which are easy to identify to more intense content and spiritual knowledge the patients' need for meaning, for existence, use of self as therapy to the patient and being present for the patient.</p>	
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<p>decisions through her/his support and guidance.</p> <p>5. The clinical supervisor is a nurse, registered nurse, a clinical supervisor, preceptor, or a clinical facilitator who facilitates learning of nursing clinical skills whether employed in an education institution such as a university, college or school. The clinical supervisor's primary area is clinical setting and skills laboratories in contrast to classroom related teaching.</p> <p>6. The clinical supervisor should possess adequate knowledge with regards to nursing skills, nursing procedures, common medical conditions. To be familiar with health facility's protocols and clinical guidelines according to SA Clinical Guidelines and medical management of diseases. This must be evidence through demonstrates nursing skills, guiding students' learning and role model in work-integrated learning.</p> <p>7. The clinical supervisor should have warm good personal characteristics such as politeness, friendliness,</p>	<p>evaluation of own learning.</p>				
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and approachable. She/he is a mature person who can guide, lead and direct nursing students in clinical learning settings through the use of good facilitation, reflective skills and interpersonal skills. But more importantly the CS engages with students through learning interventions and is willing to share information and knowledge using own life experiences.					
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7.2 ASSUMPTIONS OF THE THEORY

The assumptions of the practice theory refer to belief statements that guide the theoretical reasoning of the emergent practice theory. These statements of belief are not necessarily scientifically proven but they are important to ground how spiritual care phenomenon was understood by the participants in relation to the world around them of which they are a part of (Bendassolli, 2013). Assumptions of the theory provide context-based knowledge necessary in the understanding and interpreting the emergent practice theory. The theory-generative design was used in this study to provide clarity and describe existing relationships about spiritual care phenomenon (Tech, 1992). The primary interest of the study was to understand the spiritual care phenomenon hence an inductive approach was used (Bendassolli, 2013). The inductive approach to theory-building process was applied through themes, categories and patterns that were generated inductively from the empirical data. After which a deductive process was used to identify concepts and statements from which relational statements were formed. Linda, Phetlhu and Klopper (2014) agree to the use of literature when generating a theory. Hence the theoretical frameworks of Chinn and Kramer (2011) on the process of theorising, conceptualising major concepts; Dickoff et al., (1968) classification of concepts as well as designating theory levels (Walker & Avant, 2011) were used in this study.

Furthermore, Chinn and Kramer do not only support the idea that assumptions should be clearly stated; but, they advise that assumptions may be expressed as actual assertions which later become known during the experience in the study. Alternatively, assumption may be inferred assertions of value positions which depict the upheld connotation about what is conceived as acceptable regarding the phenomenon under study. This view was shown in a practice model that was developed by Bodrick (2011) on the role of the liaison nurse in ambulatory care context of a Middle Eastern Teaching Hospital. The theorist's philosophical stance in the current study was evidenced in the assumptions of the generated practice theory which prescribe the environment under which spiritual care should be taught and learned.

The assumptions that support the emergent theory are presented below:

7.2.1 Assumptions of the emergent theory

Spirituality is a vital aspect inherent in all humans that when nurtured, it promotes the humane-nature which is expressed as Spirit of Ubuntu.

Spiritual need is a unique patient's need that may emanate from lack of personal control caused by ill-health and suffering. Such a need may instil feelings of hopelessness, despair and to some extent it may cause the patient to feel less human resulting in loss of human dignity.

A student is new in the profession of nursing; therefore, in addition to the required competence in nursing skills, management of medical problems they must be trained in handling of the patient's spiritual matters.

Life experience of the nurse educator can be utilised through sharing of own life to engage students on deeper levels of spiritual matters which otherwise the student might overlook.

Spiritual care process should consider the state of incompleteness of humans which denotes room for development, change, and maturity as the person transcends through the life experiences to discover openness, hope, meaning, and purposefulness in life.

The environment in which spiritual care is provided should be an energised and harmless space for nursing practice that demonstrates genuine interest in self and others, non-judgemental attitude that liberate the psychological, emotional, cultural and spiritual aspects of being human.

Spiritual health is demonstrated through inner peace, inner strength, intrinsic motivation that comes with intrinsic worth of being human which indicates a person's ability to maintain balance between inner and outer demands of life.

Relational caring in nursing coexists with purposeful and effective communication through active listening, non-judgemental attitude based on awareness of incomplete state of self and others within the nursing interactive context with patients and others.

The premise on which the above assumptions of the theory were based are presented below to show how these premise relate to the empirical data from which they were derived during the process of conceptualising the theory (Bendassolli, 2013).

First premise: The nurse educator's life experiences play a pivotal role in students' spiritual education and guidance by sharing of own life experiences whether good or bad as a teaching strategy; therefore, the educator is assumed to be a type of a person that is not only willing to teach spiritual care but who, by virtue of being matured is willing to lead students in life lessons. The nurse educator engages with students to instill curiosity and a sense of inquiry by delving on deeper life issues that promote the discovery of truth and cultivate spiritual health competence in

students in understanding that spiritual skills are important life skills at any point in time in a person's life.

Second Premise: Human-being are always in a state of being incomplete in different areas of life. The human state "incompleteness" denotes an ever present need to develop, change and mature. The emergent theory assumes that the man's state of being "incomplete" permits him or her to *transcend* through life experiences. Therefore, it is only when the *intrinsic values* are acknowledged positively that they bring a sense of purposefulness as a unique virtue necessary to accomplish great exploits. Through understanding of own state of "being incomplete" the student becomes willing, aware and motivated to interact or help others . By so doing the student engages with inner values that bring growth and development while stirring up the inner peace and hope, meaning and purpose in life.

Third premise: Clinical health settings presuppose that the nurses are in a "*power position*" which is acknowledged as the extension of the clinical environment; through which the nursing student can liberate the patient's psychological, emotional, cultural, spiritual and physical aspects. Therefore, the nursing student should ensure that the environment where spiritual care is provided is *energised* with *demonstrable genuine interest* in self and others. Professional and spiritual principles should be balanced to allow the nursing student and patients to engage on spiritual matters without ill-feelings or taking an offense. Instead the environment should promote *openness, caring, non-imposing* and *non-judgemental* attitude.







Fourth Premise: Spiritual health is conceived as *inner peace, inner strength, intrinsic motivation* that come with *intrinsic worth* of being human. This is demonstrated through a person's ability to maintain balance between *inner* and *outer* demands of life where *inner demands* represent individual needs for both the nursing student as *spiritual care-giver* and patient as *spiritual care-receiver*. Should the inner needs which represent *spiritual health* be ignored can lead to *spiritual discomfort, psychological distress* and *spiritual crisis* in severe situations. The outer needs which are health needs which often addressed are equally important in holistic care. The emergent theory will assist both teacher and student on teaching and learning of spiritual care respectively (Ross 1996; van Leuween (2002).

Fifth Premise: *Relational care* is characterised by *purposeful communication* between the nurse educators / clinical supervisor and nursing student which later develops between student and patient. Relational care is manifested where *active listening* and willingness to care for the patient is deliberate to promote *effective communication* and *non-judgmental* attitude due to *awareness of*

incomplete state of self and others during the interactions. Nursing care plans must clearly indicate an understanding and acceptance of different *values, beliefs, norms* and *traditions; where a patient list of felt needs are integrated to health and medical patient needs*. Such nursing practice accepts *caring presence* as the most vital aspect of nursing where the student is not only readily available but engages in *therapeutic use of self* while accompanying the patient through the journey of finding meaning of suffering, purpose in life and the reasons to live. Communication is conceived as the main tool through which the spiritual care-giver ‘the nurse’ and spiritual care receiver ‘the patient’ are connected.

The central assumption of the emergent theory assumes that spirituality and spiritual care are virtues that can stir individual’s willingness to extend him or her-self in helping or meeting other people’s needs. The NEs and CSs engage in a dynamic, constructive and energised encounters with nursing students using effective teaching approaches to cultivate inner virtues in students in the form of love, compassion, creativity and centeredness which may be used by students to strengthen the patient’s character and increase endurance thresh-hold in adverse situations. Thus preventing psychological, emotional and spiritual hurt and trauma that result from adverse experiences (such as ill-health and unfamiliar hospital environment). Inner values can prevent loss of control which could harm patient’s respect and self-esteem.

Figures 7.1 below presents the legends that constitute the developed model and depicts how the model relates to the emergent practice theory for teaching-learning of spiritual care in the undergraduate nursing programme at the higher education institution in the Western Cape.

	Agent 1: Nurse Educator
	Agent 2: Clinical Supervisor
	Recipient: Student nurse’s characteristics, attitudes, responsibilities and spiritual care competence
	Agent / recipient in an inactivated phase to depict a building up process in which new survey list items are added to the model as it is being developed
	Context: Political transformation in South Africa
	Context: Higher Education in South Africa




	Context: Nursing education in South Africa
	Context: University of the Western Cape
	Goal: Curriculum integration in the UG nursing programme
	Double headed arrows: Interactive teaching-learning process between the nurse educators and students
	Procedure: Teaching-learning of spiritual care in the undergraduate nursing programme
	Dynamics: Commitment, Purposeful communicators
	Single headed arrows: Demarcating dynamics for teaching learning of spiritual care within the school level

Figure 7.1 Legends for the model

7.3 DESCRIPTION OF THE THEORY

Emerging theory is described using the components for model description according to Chinn and Kramer's (2011: 186) conceptualisation process. These components include the purpose, context, overview, structural form, process description and relational statements of the model. Conclusion statements from the survey list were presented in Table 6.1 and these were used to provide description of the emerging model.

7.3.1 Purpose of the theory

The ultimate purpose of generating the theory was to integrate the teaching-learning of spiritual care in the undergraduate nursing programme. The process of generating the practice theory was grounded on contextual-based knowledge to guide the nurse educator/clinical supervisor and nursing student on how to engage in teaching-learning process whilst observing all relevant factors depicted in the context in which they find themselves. The goal of the practice theory is to guide practice in teaching-learning of spiritual care in the undergraduate nursing programme at a higher education institution.

7.3.2 Context of the theory

The generated theory is intended to inform and guide nurse educators/clinical supervisor and students on how to engage in teaching-learning of spiritual care in the undergraduate nursing

programme. The context of generated theory subscribes to the view that spiritual care is an inherent virtue that every individual has; which may enhance internal stability if it is nurtured accordingly. The theory postulates spiritual care as relating to purposeful interaction and communication between individuals; where spirituality is expressed through inner beliefs, values and emotions and being present. Spiritual care is demonstrated through acknowledging self and others. Spiritual care should be directed to other's spiritual health and well-being; and it must be supported by an energised environment. Spiritual care can be demonstrated through genuine interest to self and others with an aim of finding and instilling meaning and purposeful experience for both the care giver and care receiver. The developed model responds to identified need to assist South African nurses and patients to heal from the social ills secondary to the social struggle of pervert and mal-socialisation of the Apartheid system. Furthermore, it can also assist South African nurses and patients in handling the burdened of quadruple diseases by increasing individual's endurance to handle sickness and its effects that depletes and drains the inner energy of affected individuals. Renewed spirituality would be of great importance to individuals who are neither infected nor affected; to become pillars of support to those infected and or affected.

7.3.3 Overview of the theory

The section was intended to describe the core attributes of the theory and to show how theory components form synergy in functioning and processes of the practice theory. Spirituality and spiritual care phenomenon was viewed as the most indispensable elements to which all other aspects of the model were linked.

Spirituality was conceived as a precursor for spiritual care and it should be cultivated in nursing students to promote willingness, commitment, and agreement whether in gesture or articulated to engage in patient's spiritual matters. Spirituality was also conceived as connectedness with inner-inherent-virtues in human beings which give expression to caring. Communication is most effective tool used to identify spiritual care needs and provide therapeutic-talk to enhance the patient's feelings of self-fulfilment, self-satisfaction and self-awareness. In view of the vital role played by spiritual care in health and healing, nursing programme outcomes should integrate spiritual care in the undergraduate nursing curriculum; based on appropriate nursing philosophy and theory that caters for differences in and between different individuals' cultures, religions and spiritualities. Programme outcomes should be socially acceptable according to the universal law of "do no harm" "do good" humanitarian principle.

Spirituality is associated with complex beliefs; and it emanates from varied belief system that can be expressed through personal, religious, spiritual and cultural practices. Connectedness also relates a relationship with the invisible Higher Power through in-born virtues that makes the individual's inner-self. The inner-self finds its expression through a belief system which is personified as person-driven-energy and inner-motivation. Connectedness self and Supreme Power provides good basis for spiritual care. Therefore, nursing practice that allows the nursing student to connect with the patient at a social level indicates the value place on spirituality and spiritual care. Freedom to practice spirituality and spiritual care in nursing can be achieved where professional boundary is reduced whilst lack of good role models and unacceptable practices contrary to universal ethical principles and the Spirit of Ubuntu are eliminated.

Teaching and learning of spiritual care should be facilitated in a manner that prepares students on how to instil peace in patients by reversing the de-humanising approaches to care. Through effective communication and relationships that promote spiritual guidance, debriefing, intuition, self-awareness, emotional health and well-being of patients. Nursing student should understand that purposeful communication with a patient is essential and non-replaceable value in nursing practice (Freshwaters, 2005). Educating the nursing students in skilful communication should accommodate diverse spiritualities. Nurse educators' and clinical supervisors' should ensure nursing students are prepared to speak with clarity and listen actively which in turn will increase their assertiveness in therapeutic communication and growth.

Teaching-learning of spiritual care should be integrated throughout the curriculum and in clinical situations with the aim to reduce perceived conflicting nursing perspectives. Spiritual care competency should instil the confidence in nursing student to embark on spiritual matters through integration of caring skills, in a manner that eases and enhances connecting self with others as means to redress theory-practice gap. Through appreciation of own beliefs and values thus counteracting the lack of role models and non-conducive environment. The starting point of teaching-learning spiritual care should not impose the nurse's spiritual, cultural and religious dispositions. But it should be based on caring relationships as means to facilitate patient's healing and recovery from ill-health and state of loss of personal control. Caring interventions should be directed at assisting the patient to conduct the daily life processes for health and personhood needs which are inextricably intertwined with the patient's cultural and spiritual beliefs. Involvement of nursing students in providing spiritual care will instil professional responsibilities and accountability in them in a manner that does not prioritise technical nursing over caring-relationships and interpersonal relationships. Instead, such teaching will increase the students'

awareness of own personal limitations and discovery of personal and professional values that influence execution sound caring-presence.

7.3.4 Structure of the theory

According to Chinn and Kramer (2011: 185) the developed model provides the structure of the overall view about the relationship between concepts and statements. The structure further provides directional relationship which is critical to prescribe, direct and demarcate required actions between the agent and recipient. It also provides a layout of all required components which in this study was integration of spiritual care in the undergraduate nursing curriculum. Thus the structure of the practice theory covers the goal which is integration of spiritual care, procedure for teaching-learning of spiritual care and relevant processes, dynamics in which all parties are committed and energetic to be involved teaching-learning of spiritual care as well as the context where activities for teaching learning of spiritual care is presented. A detailed discussion on the structure of the theory is provided in Section 7.5 below.

7.3.4.1 Definition of central concepts of the theory

The major and related concepts identified from the empirical data and concept classification as shown in Table 6.1 that was undertaken by using the survey list of Dickoff, James and Wiedenbach (1968: 423) are described below in accordance to how they were developed. The related concepts are used to provide clarity of the major concepts as they are defined.

- **Nurse educator (Agent 1)**

The Nurse Educator (NE) is defined as a purposeful communicator and reflective practitioner who plays different educative roles including teaching, facilitation, guiding, motivation and supportive roles in the students' learning journey. He or she is a spiritual resource person who is willing to share herself or himself and life experiences with students and others and so doing uses own self as an effective tool to promote spiritual care competence in students. Training students to provide therapeutic communication with patients on matters that are of interest to the patient in contrast to communication directed to medical procedures and interventions.

- **Clinical supervisor (Agent 2)**

The Clinical Supervisor (CS) is defined a person who has good personal characteristics such as warmth, politeness, friendliness, and is approachable. She or he is a mature person who does not only guides, leads and directs nursing students in clinical learning settings through use of good facilitation, reflective skills and interpersonal skills. But more importantly, the CS engages and is

attached with students through spiritual guidance and lead students to deeper meaning which predisposes them engage with and intervene in patient's spiritual matters. At this level of human interaction, inner values such as meaningfulness are more at play rather than merely emotional response.

- **Nursing student (Recipient)**

The nursing student is defined as an adult learner whose possesses a rich source of experience which makes learning exciting and meaningful in the construction of own understanding. She or he self-motivated and self-driven and engages purposefully in learning through the mind, body and spirit. The nursing student has a good grasp of nursing and other science related knowledge, skills and attitudes which are integrated to a "*belief system*" that the student holds as important for survival as these are intricately woven with the core of the student as he or she partakes in spiritual-based learning to develop good self-concept and image that comprehends the meaning of caring, presence and suffering.

- **Cultural diversity and caring values (Context)**

Context is defined as a background, environment, framework, setting or situation relating teaching-learning of spiritual care. It includes culturally diverse functions, purposes and uses, and other factors that influence spiritual care activities and intervention within education in the undergraduate nursing programme where the nurse educators, clinical supervisors and nursing do not only regard only their own spirituality and culture as important but acknowledge and accept the existence of other spiritualities and cultures through non-discriminate caring lived out through meaningful relationships, interrelations, and interconnectedness with self and others.

- **Curriculum integration (Goal)**

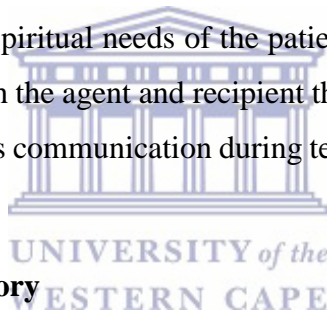
Curriculum integration is defined as a process of developing and organizing the programme or curriculum outcomes and exit level outcomes to be aligned with theoretical spiritual knowledge and skills regarding "*spiritual care*" and "*professional accountability*" indicating the individual's ability to cater for non-physical human needs that relate to questions, issues or appreciation on existence and living; and, a state of sound moral and ethical practice values that result in a student to behave responsibly, answerable respectively. The goal is presented in the curriculum, module descriptor and assessment. Using an additive approach, the curriculum is upgraded by integrating spiritual content, cultural concepts and perspectives that will assist to promote vitality in teaching-learning of spiritual care in the undergraduate programme.

- **Teaching-learning (Procedure)**

Procedure refers to a process of teaching-learning of spiritual care related contents whereby the nursing student is assisted by the nurse educator/clinical supervisor through the use of appropriate approaches and contextual-based models that is socially, culturally and spiritually sensitive whilst allowing students to actively engage with spiritual-learning content. The student learns how to diagnose spiritual needs and provide spiritual care intervention to patient whilst taking into consideration spiritual and religious beliefs as basis for connecting and caring for the patient. Nursing activities are founded on integrated spiritual knowledge, skills and attitude that promote the nursing student's ability to implement spiritual care in clinical practice while they draw from theory and own experience.

- **Commitment (Dynamic)**

Commitment is defined as an interactive relationship and engagement between the educator (agent) and student (recipient) on teaching-learning of nursing activities or discussions lessons pertaining to spiritual matters and spiritual needs of the patient primarily. This engagement must be shown by commitment from both the agent and recipient through their willingness, purposeful, meaningful connected and energises communication during teaching-learning process in class and outside teaching-learning context.



7.3.4.2 Structural form of the theory

The purpose of the theory structure is to shape perceptions of reality about the theory conceptualisation. It is, therefore, a powerful tool in construction of meaning by translating abstraction to reality.

Essentially, the emergent practice theory prescribes the required actions in integration of spiritual care in the undergraduate nursing programme. Chinn and Kramer (2008: 58) and Walker and Avant (2011: 18) maintain that the practice theory enhances goal-oriented practice which is manifested in “nursing-in-action”. Practice theory is distinctive to a particular goal to be achieved within the context of nursing as a practice discipline. The aim of the current study was to generate a practice theory for teaching-learning of spiritual care in the undergraduate nursing programme at a higher education institution in the Western Cape. The dynamic factor that is required to recognise the emergent practice theory is “commitment” where communication is intentional, purposeful, and connected between the nurse educator/clinical supervisor and students are primarily. Commitment is a pre-requisite necessary to achieve integration of spiritual care in the undergraduate nursing programme.

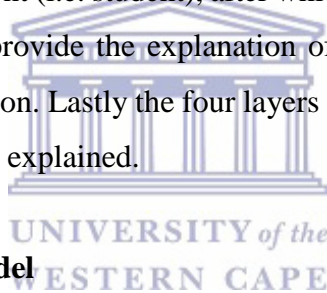
Emergent theory provides room not only for the “agent” to initiate learning process, but also accepts “undefined agents” who may unavoidably and unintentionally influence the teaching-learning of spiritual care. The dynamics of a committed agent and recipient is necessary to achieve “purposeful” and “connected” communication in order to enable the agent and recipient are to facilitate spiritual care successfully. The agent brings along spiritual competence, personal attributes such as good interpersonal skills, professional responsibility and commitment to teach spiritual care and to connect to the student. Connection between the “agent” and “recipient” promotes cultivation of the caring values which are essential when providing spiritual guidance. On the other hand, the recipient engages in goal directed learning activities which are not only influenced by awareness about spiritual subject; but, are also acknowledging good “self-concept” and “self-image” grounded on wholesomeness where body, spirit and mind are equal in appreciating the meaning of caring and suffering.

Chinn and Kramer (2011: 80) when describing the structural form of a theory alert that the description of a theory may not necessarily fit into one structure because theory could be expressed in several ways. These authors clarify this possibility by pointing to competing structures that cannot be reconciled into a single discernible sculpture. Therefore, it should be noted that while concepts may not inevitably fit into a coherent structure to represent their essence and relationships their presence is vital. Based on these loop holes in conceptualisation, all concepts that were identified in emergent practice theory were defined in section 7.4 not only to affirm their origin from empirical data but also to show their functional use within the theory. These concepts were also diagrammatically presented in chapter six (6) in view of the emergent practice theory for teaching-learning of spiritual care.

The description of the theory using the diagrammatical structural form of the model relates to how the components of the model relates to the practice theory in accordance to the six vintage criteria of Dickoff *et al.* (1968: 423). The features of the practice theory are therefore, in keeping with the six vintage factors of Dickoff survey list (Dickoff *et al.*, 1968) as presented in Chapter 6 in Table 6.2 and Figure 6.1. Nursing student and teaching learning process are central factors in the emergent theory as these form the fulcrum to which all other factors are linked. The structural form of the theory is further described below in relation to the following aspects namely;

- (i) structure of the theory (i.e. through a physical layout of the diagrammatical representation), and

- (ii) process of the theory: This does not have a starting point through which the process begins or ends at. This means that there is no distinct direction that the process of teaching-learning of spiritual care follows; because the process is not rigidly linear fashioned in real implementation. However, the implementation of the process of the practice theory for teaching-learning of spiritual care is inherently case specific. This means that in cases where the goal of integrating spiritual care is new in the curriculum the explanation can commence from the outer to inner context; followed by explanation of any factor that is suspended within the three (3) layers of the context and immersed in the dynamics of commitment.
- (iii) For the sake of explaining the process of the current theory; the goal activity of the survey list of Dickoff *et al.* (1968) will mark the point of departure. The **goal** which is to integrate of spiritual care in the undergraduate nursing programme at the higher education institution in the Western Cape, followed by the procedure of teaching-learning, then the recipient (i.e. student), after which the agents 1 and 2 (i.e. NE & CS). The process will then provide the explanation of the dynamics of commitment and purposeful communication. Lastly the four layers of the context where spiritual care is taught and learnt will be explained.



▪ **Structural form of the model**


This section presents the description of the illustrative structure of emergent model for teaching-learning of spiritual care. According to Chinn and Kramer (2011: 81) the structure of the model provides an overall view about the relationship between concepts and statements. The structure further provides directional relationship which is critical to prescribe, direct and demarcate required actions between the agent (teachers) and recipient (nursing students). The model which resulted from the conceptual framework that was developed and described in Chapter 6 was presented at the beginning of this chapter. The purpose was to remind the reader of what the constituents of the model were and how it looks.


The structural form of the model is presented below starting from periphery to the innermost of the model.


Quadrilateral layer represents the context of the model

The model is situated within HEI in the Western Cape Province. The model is encapsulated under four *quadrilateral* facet layers. These four layers denote influential relationships between

and across layers. The model is represented under four areas that influence the teaching-learning environment for nursing education. Thus the four layers directly and indirectly relate to each step and phase in the education process. Each layer and dimension of the context of the model is clearly demarcated by solid and dotted lines respectively.


The 1st solid navy blue lines as illustrated by a [] This is the most outer layer representing SA political context. The solid line depicts restricted interaction and influence by external factors governing higher education programmes in SA.



The 2nd navy-blue dotted lines as illustrated by the following symbol [] Moving from outer to inner part of the model demarcates the Higher Education (HE) context in SA. HE context is typical with its governing bodies set out in the Higher Education Act of 1997 as promulgated.

The 3rd bluish dotted lines as illustrated by the following symbol [] Moving inwardly this demarcates the National Nursing Educations context in SA.







The 4th innermost light blue dotted lines as illustrate by the following symbol []

It demarcates the context of the university where the study was conducted in the Western Cape. All dotted lines imply possible interaction between different layers or dimensions adjacent to each other in the context. In the next section, the model is described according to its process structure. The four layers of the context of the model have been described. Now other structures that are parts of the model will be described below.

The educator (Agent 1) illustrated by the following symbol [] is the first black semi-spherical graphic or semi-circle on the left side of the CS semi-circle and UWC context which represents the nurse educator who is the initiator of the education process.

- **Clinical supervisor (Agent 2)** illustrated by the following symbol [] is the second semi-spherical black spherical graphic or semi-circle on the right side of the NE semi-circle and left side of the university context as representing the nurse educator who is the initiator of the education process and the clinical supervisor who is the facilitator of integration theory with practice.
- **The teaching-learning (procedure)** illustrated by the following symbol [] The red cylinder object represents the teaching-learning process. It connects directly to three

items namely (i) the nurse educator on the left (ii) student nurse on the right and (iii) goal of curriculum integration from the top.

- **The nursing student (recipient)** illustrated by the following symbol []
The second black spherical graphic object or circle on the left side in university context represents nursing students.
- **The goal is illustrated by the following symbol** []
The goal is to integrate spiritual care in the curriculum, influence the nurse educator, teaching–learning process and students respectively.
- **Commitment is the dynamic** as illustrated by the following []
The purple rectangle area spreading entirely across and towards the innermost space of the model represents the area of commitment. This is a dynamic environment where all the agents interact. The agents include the nurse educator who is the agent; student who is the recipient; teaching-learning process which is the procedure. These components directly interact with a dynamic environment. The other three context layers namely: SA political, HE context and Nursing Education context in SA indirectly interact with the dynamic environment.
- **Double headed orange arrows** illustrated as the following symbol []
The double headed arrow connects the teaching-learning process with the nurse educator or clinical supervisor and nursing students.
- **The black single-headed arrows** illustrated as the following symbol []
The black solid single headed arrows demonstrate the direction of the process of teaching-learning of spiritual care of the emergent model.
- **A gray shaded circle** illustrated as []
The grayish spherical object or circle demonstrates both the agent and recipient in in-active state where focus at the point in time is on other aspects of the model agents, to note is that they are presented for completeness' sake.

7.3.4.3 Relational statements

Relational statements are the essential in theory generation because they are the ingredients that assert the association between two or more concepts in the process of constructing a scientific body of knowledge (Chinn & Kramer, 2011; Walker & Avant 2011: 59). Furthermore, Walker and

Avant (2011: 197) claim that the process of theory generation occurs subsequent to major concepts being identified and described as done in Chapter 6. This process is followed by the development of explicit relational statements and concepts. The relational statements and concepts were then examined closely to determine further relational associations. In so doing, Walker and Avant (2011: 198) suggest that the empirical support for the relational statements should be assessed and indicated. Therefore, the relational statements that are presented below were deductively derived from the concepts which were identified from the empirical conclusion statements. Each concept was defined and described with the aim to portray its functional associations within the emergent theory.

The numbering of the conclusion statements from which the relational statements were derived is indicated at the end of each relational statement as cross-referenced in Table 6.5.

The relational statements do not only depict the functional structure of the theory, but show how they relate to the assumption from which they were derived. The assumptions are not only central to the theory but underpin the concepts on which the theory is founded. The purpose of relational statements is therefore, to provide meaning and understanding on how theory factors relate to each other (Chinn & Kramer, 2011: 180; Walker & Avant 1988: 19). Relational statements do not only assert a relationship between two or more concepts but also indicate their interpretable nature of relationships, direction and interaction between goal activity and objectives of the theory. Whilst demonstrating existing association such as the cause and effect of concurrent occurrences and consequential occurrences, the relational statements serve the core function for which the theory was generated.

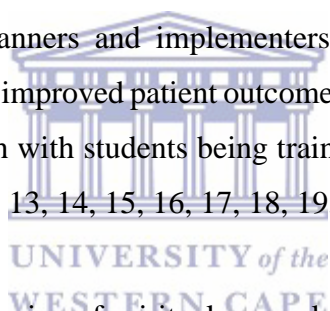
Below are relational statements that were derived from their contextual relationship of concepts through an iterative deductive–inductive reasoning process.

- The teaching of spiritual care in the undergraduate nursing programme exists as an intervention whereby the nurse educator who is a reflective, resourceful practitioner demonstrates unique personal attributes such as good interpersonal relationships, effective listening skills, openness and companionship when engaging in her role of facilitation, guiding, motivating, supporting and sharing of own experiences with nursing students based on the principle of holism as a way to promote person-centered and human-centered interactions, ensuring the integrity of students and patients through acceptance and understanding wholeness of own-self and sick individual as comprised of body, mind and spirit who also have feelings [Statements: 1, 2, 3, 4, 5, 6, 7, 10,12, 13, 16, 17 and 23].

- The teaching-learning process of spiritual care is characterized by interaction between the educator and nursing student where the teacher imparts and the learner receives the skills, knowledge and attitude in assessing spiritual health, identifying spiritual needs and providing spiritual care in the form of learning activities with the aim to promote spiritual health and the patient's integrity without denying the nursing students the opportunity to respond in a moral, ethical and cultural-based actions; through support and spiritual guidance by the educator who instills value judgement and problem solving skills to students in a manner that embraces deeper meaning of ill-health and suffering which in turn assist the student to express appropriate responses to spiritual needs as a critical human needs [Statements: 1, 2, 3, 4, 5, 7, 9, 10, 13, 16, 17, 18, 19, 21 and 23].
- Spiritual competence in spiritual care is characterized by the nurse educator's and students' acceptance of spiritual care being a vital aspect in health and acceptance of self and others incompleteness, brokenness and humanness that leads to understanding of the role of spiritual well-being in relation to ill-health and human suffering within the context of nursing education and possesses the practical skills, knowledge and attitude to exhibit competence within the practice of nursing [Statements: 2, 3, 9, 10, 12 and 13].
- The nursing student is conceived as an adult learner who has a positive self-concept, readiness and willingness to learn spiritual care and is self-driven to search for knowledge, participates in group-work of spiritual care related experiences as a self-directed learner and accepts peer-learning and peer-teaching during work-integrated learning as effective learning methods influenced by language, culture, religion, socioeconomic factors among others [Statements: 8, 9, 10, 13, 16, 22 and 23].
- The purpose and goal of spiritual care curriculum integration is evidenced by detailed procedure on how to formally integrate previously acknowledged spiritual care and deliberately teach spiritual care in the education of preservice nurses based on the nursing scope of practice and policies that formally recognise and conceive spiritual care as a vital aspect of nursing as executed through implementation of appropriate spiritual models, approaches, processes and methods that promote spiritual assessment, planning, and context-based interventions [Statements: 12, 13, 14, 15 and 16].

- Spiritual care learning process is exemplified by that it should address spiritual topics across the spiritual-health spiritual-crisis continuum. Learning content should not be prescriptive to allow agent's and recipient's energies to emerge naturally. Spiritual care learning content is introduced in a way that promotes the attainment of spiritual care skills and competencies with time in accordance to their complexity and difficulty in line with the level of the education and training which permits the students to construct new spiritual care knowledge from existing knowledge and belief systems in order to become competent in providing spiritual care [Statements: 3, 4, 7, 8, 9, 10, 13, 16, 17, 18, 19, 20, 21, 22 and 23].

- The nursing education context is exemplified by a curriculum that is dynamic by the means of its constant response to social, cultural and spiritual needs of health care end-users and ongoing reforms that are relevant to national and local political and social changes executed by curriculum planners and implementers through nurse educators who are mutually motivated towards improved patient outcomes related to physical, social, cultural, religious and spiritual health with students being trained to follow suit [Statements: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22 and 23].



The practice theory for teaching-learning of spiritual care acknowledges the potential influence of power relations between the role players such as the NE and nursing student which later might be transmitted and occur between the nursing student and the patient. Therefore, it is advisable that the NE/CS and nursing student should be mutual aware of the negative factors such as lack of know how to engage in spiritual matters and other process related limitations. Whilst they promote the positive factors such as enthusiastic performance, self-motivation and purposeful caring actions. On the contrary be cautious about the negative factors that might jeopardise attainment of the goal activity.

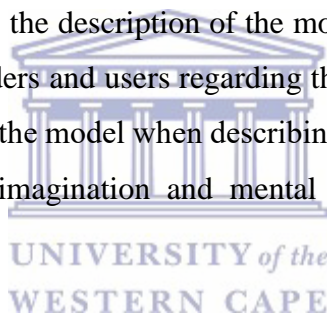
Based on assumptions presented about the power sources is the dynamics of the practice theory for teaching-learning of spiritual care in nursing, the following relational statement is claimed that both the NE and nursing student are mutually commitment in the execution of the goal activity which is teaching-learning of spiritual care. Awareness about the attainment of the goal content where self-motivation, purposefulness and meaningfulness during teaching-learning interactions

based on mutual acceptance and sharing of life experiences when providing spiritual care guided by love and willingness that demonstrate individualised commitment and energised environment [Statements: 2, 3, 4, 6, 8, 9, 10, 13, 16, 22 and 23].

7.3.4.4 Description of the process of the theory

- Process of emergent practice theory

This section present description of the process of the practice theory. The goal of the theory is to integrate spiritual care in the nursing programme. The research was conducted to with the aim to generate the practice theory for teaching-learning of spiritual care. The process of the theory is described in accordance to the model that transpired in Chapter six (6). Chinn and Kramer (2011: 80) argue that knowledge often results in different information processing. Based on this notion, interpretation of competing structures of the model may inevitably be irreconcilable into a single discernable connotation. Therefore, the description of the model in Chapter seven (7) was aimed to shape the perceptions of the readers and users regarding the generated theory according to the researcher's worldview. Following the model when describing the theory will enhance the mental functioning including mentation, imagination and mental visualization in understanding the theory.



Description of the process of the theory is a means of articulating the model for practice theory for teaching-learning of spiritual care in a manner that reflect the core values of the theory in nursing as a profession. This articulation also shows the extrinsic value that conveys the science aspect of nursing as the core attribute that the emergent theory has contributed in development of the body of knowledge within the nursing profession (Walker & Avant 2011: 4). This function of describing the process of the theory is also acknowledged by Chinn and Kramer (2011: 3-5) who conceive it as grounding of empirical knowledge in the profession of nursing as underpinning science which is expressed in the form of a practice theory. Consequently, the accompanying statements of facts, descriptions and/or interpretations of phenomena are believed to be true assertions of the generated theory.

The view that processes for developing nursing knowledge are based on transmitting patterns of knowing that are interrelated and emerge from the experience (Chinn & Kramer, 2011: 11). These authors assert that nursing knowledge acquire its richness, depth, and meaning from such

experience. Furthermore, the attributes of process description in nursing knowledge development include conscious problem-solving, logical reasoning within a contextual background so that the application of knowledge should reflect awareness of the reasoning process, as well as the experience of nursing as a practice discipline. Thereto, Chinn and Kramer (2011: 224) purport that one of the features of nursing research is theory-generating primarily than theory-validating of scientific knowledge.

Process description that follows presents a series of processes, events or occurrences that depict the course of action in the practice theory for teaching-learning of spiritual care. The process description is therefore a series of events or development that reveals a course of action in the practice theory for teaching-learning of spiritual care in the undergraduate nursing programme at a particular university in the Western Cape as presented in Figure 7.1 and section 7.3.

Cultural diversity and caring values were conceived as prerequisite for the *context* where spiritual care is taught and learned in the undergraduate nursing programme in a higher education institution. The required change covers the external and internal *context*. The need for planned curriculum integration of spiritual care will be influenced by transformative policies, rules and procedures that support spiritual care as illustrated in the context of the model.

The solid black semi-circles or semi-spherical objects situated on the left end represent the *nurse educator and clinical supervisor*. Aspects including qualifications, characteristics and activities in teaching-learning process are addressed. Each item in the circle was described at length under the section on conceptual framework in chapter 6. Whilst the circle depicts its independent function, it is however connected to the student who is next in the process through a two-way arrow which denotes a two-way relationship. *The nurse educator* influencing teaching-learning process and in turn the process of teaching-learning influences the nurse educator. *The nurse educator* is also influenced by the educational goals through the curriculum.

Despite one direction demonstrated by one-headed arrows depicting one-way process between the nurse educator and goals as implied, an abstraction of a two-way relationship is acknowledged at this point of the process. This denotes the influence of the curriculum on the educator's teaching activities. This theory acknowledges that no entity can operate solely as an ivory tower. *The nurse educator* communicates with respective bodies and implements necessary procedures, policies and rules from curriculum design (including macro-curriculum, meso-curriculum and micro-curriculum levels) and course offering. *The nurse educator* interacts with Higher Education (HE)

ACT for education processes and SANC Regulation No. 425 for content and professional qualification. Lastly, the nurse educator interacts with nursing students teaching them to become competent in spiritual care. In addition to cases where external or international factors or forces that may influence the SA education are the characteristics and competence of a nurse educator as discussed under conceptual framework in Chapter 6. In the case where the *nurse educator's semi-circle* was shown as light shaded grey during the conceptual development process, it was indicating a shift of focus from the nurse educator at that point in time which was to give attention to the next item of the model. The other semi-circle or semi-spherical object is the *clinical supervisor* who is involved with clinical teaching and facilitation of students' learning of nursing skills.

The next structure of the model is the red cylinder which represents *teaching-learning process*. Teaching-learning process is the core of the entire theory which connects the curriculum goals and the outcome of spiritual care outcomes through the nurse educators and students' interactions. The double headed arrows between the nurse educator on the left and student on the right indicate a dual effect between the learning process and nurse educator and student respectively. A one headed arrow from the goal to the red cylinder indicates the goal influence on *teaching-learning process*. Whilst the goal to integrate spiritual care in the nursing curriculum exerts influence on teaching-learning process, the reverse is true where feedback through module evaluations are conducted and can in turn affect modification of the goal. *Teaching-learning process* can also influence both nurse educator and student's behaviour modifications. The use of selected spiritual content and teaching-learning methods and techniques respectively also affects the nurse educator and student. The teaching-learning process is rolled-out through the four step levels of nursing which are assessment, planning, implementation, evaluation and documentation.

The student nurse interacts directly with the goal above and learning procedure on the same plane. This is significant in the sense that a self-motivated and self-driven student can learn effectively without the nurse educator (the agent). This argument is in line with Dickoff *et al.*, (1968) who attest that a known agent may be replaced in the process of goal activity. *The nursing student* indirectly interacts with the nurse educator who in this way is conceived as a facilitator rather than instructor. However, this positioning of the nurse educator does not defile the value that she or he has in the student's learning process but depicts expected relational process between educator and learning process. *The student nurse* is immersed in the university context which is an immediate learning environment. In the case where the student's circle was shown grey, it was because at

some point in the conceptual development it indicated that the focus of recording was no longer on the nurse educator per se at that point in time but on the other item of the model.

The goal of the model is student's competence in assessing, diagnosing and interventions of spiritual care. The curriculum integration process will function as the support on which the entire spiritual care teaching-learning processes mounted. Initially, the curriculum integration process will involve educators, as consensus is achieved later student nurses will also be involved in the process. The curriculum integration process will occur through curriculum integration approaches, models and processes. This goal of spiritual care will be achieved through activities such as consultations, workshops and meetings between nurse educators. A common understanding in teaching-learning and nursing practice philosophy will be agreed upon after which the goal of integrating spiritual care in the curriculum will be actioned. The goal will be actualized through curriculum outcomes and learning objectives shared between nurse educators and students.

The dynamics is represented through commitment, purposeful communication, and connected-communication. The commitment of the actors will be determined by the level of personal motivation, self-driven action or involvement as impetus towards teaching-learning of spiritual care. These power sources will be associated with the roles of each part to ascertain their strength. For an example, activity of the agent who is a nurse educator will include planning and designing of the curriculum, effective offering and delivery of the module or subject matter and enthusiastic interaction with students.

7.4 Evaluation of the theory

According to Fawcett (2005: 53) the evaluation of a nursing theory can be accomplished by comparing its content with certain criteria. The ultimate aim of credibility of a practice theory is to determine whether the content is appropriate for use in clinical conditions. Meleis (2007: 242) concurs with the perspective of Fawcett (2005) that criteria are required for comparing the content of a nursing theory; this claim is also supported by Chinn and Kramer (2011: 197) who state that this can be done through critical reflective questions on a nursing theory. The questions these authors pose were not only accepted long ago (Barnum, 1998) as methods for evaluating theories as depicted in nursing literature; but have continued to be supported as valuable tool for this purpose (Alligwood, 2014; Fawcett, 2005). Meleis (2007: 242) affirms that the set of questions provided by Chinn and Kramer (2011: 197), would guide the evaluation of integrated knowledge, and confirm that the questions are driven by the approach to the definition of a theory as it contains a creative and rigorous structure of ideas that projects a tentative, purposeful and systematic view

of phenomena. Apart from these definitions by nursing theory experts (Fawcett 2005, Meleis, 2007, Chinn & Kramer, 2011), the approach to evaluation of the theory applied in this study followed three (3) steps that are outlined below:

- An initial appraisal to ensure face validity by requesting feedback as evidence of acceptable content through the following (i) the literature, (ii) representatives of the relevant populations, and (iii) content experts (Burns & Grove 2005: 377). Also, the aspects of trustworthiness were used for this initial appraisal as described in Chapter one (1).
- Conceptualisation guidelines as provided by Chinn and Kramer (2011) were adapted for use in this study.
- The adapted steps of the evaluation framework of a nursing theory by Fawcett (2005: 53), were modified for use in this study by omitting criteria that were included by Chinn and Kramer (2011) or irrelevant in a practice theory.

The justification for using such an approach to evaluate the practice theory was based on the following aspects:

- Use of the components of trustworthiness which were aligned to the study activities as the researcher creatively applied elements of scientific integrity as discussed in Chapter one (1), section 1.10
- Chinn and Kramer's (2011) criteria for evaluating theory which were congruent to the approaches for model description as discussed in this chapter.
- Fawcett's and Meleis's expertise were characterized by mutual reciprocity and collegial critique of each other's stances on nursing and nursing knowledge (Fawcett 2005: 10; Meleis 2007: 242). Their respective work on evaluation criteria were credible and based on the refinement obtained over the years from on-going peer critique. However, this study only used Fawcett (2005) and Chinn and Kramer (2011) as they were deemed sufficient based on the evaluation criteria that scrutinise the relationship between structure and function of the theory.

7.7.1 Appraisal of the theory

Measures for trustworthiness that were mentioned in chapter one (1) and discussed in chapter two (2) were applied in this section to show how they effectively shaped the empirical process. The initial appraisal of theory generation was guided by the components of trustworthiness that are

discussed in Chapter one (1), section 1.10.5. At the outset of generating the conceptual framework in Chapter six (6), it became apparent that the contents of the conclusion statements from in-depth interviews and focus group discussion techniques combined with document review in Chapter five (5), responses in chapter three (3) and chapter four (4) had elements of input. The conceptual framework was crafted and symbols were sketched to graphically illustrate what was emerging from the empirical data. An initial set of figures that portrayed the fundamental concepts were produced.

These sketches were shared with the supervisors who gave feedback and advised accordingly. The sketch of the full model was shared with the nurse educator participants during member checking sessions with the view to seek their opinion on the emerged theory. Their input was valuable as they indicated that the theory at that state did not clearly represent spiritual care context which in their view was less relevant to spiritual care phenomenon. The theory then was revised to make the spiritual care essence more visible. The components of *trustworthiness* (usefulness) were realised as follows by submitting initial and subsequent sets of the model figures to supervisors for critique and feedback. *Credibility* (truth-value) and member checking and feedback from supervisors and use of ethical research was observed. *Transferability* (applicability) was ensured wherein some of the study respondents were not only colleagues, but nurse educators and clinical supervisors who are with familiar with academic programme development and nursing clinical practice respectively. *Dependability* (consistency) in as far as to the scientific inquiry is concerned was maintained by initiating the appraisal process through which the researcher to ensured that the sketched content was representative of the concepts in the study and congruent to context of the study participants and setting. *Confirmability* (neutrality) as affirmed through member checking feedback the final model diagrams were clear and were readily discernible as well. This initial appraisal was valuable because it revealed what needed to change. Essentially, the process of model development evolved through scientific methods, tools and techniques retained through scientific rigour for the research process and study findings.

7.7.1.1. Application of evaluation criteria according to Chinn and Kramer (2011).

Chinn and Kramer (2011) propose five (5) components for use when evaluating a theory. These are (i) clarity, which includes semantic and structural clarity, and semantic and structural consistency, (ii) simplicity (iii) generality, (iv) accessibility, and (v) importance.

CLARITY OF THE THEORY:

Clarity of the model refers to how well the theoretical components and related figures can be understood, and the consistency of the concepts in relation to semantic clarity, semantic consistency, structural clarity and structural consistency (Chinn & Kramer, 2011).

- a) **Semantic clarity:** Semantic clarity refers to how understandable and coherent the definitions of concepts are in articulating the established empirical meanings within the theory (Chinn & Kramer, 2011). In essence, semantic clarity would convey the essence of meaning so that the reader would envisage a similar empirical reality when the definitions of the concepts are read because they would portray comprehension of both the specific and general features of the described concepts that include the contextual sense of meaning.
- b) **Semantic consistency:** Semantic consistency is a feature of theory wherein the concepts in the theory are used with congruency and harmony with the definitions of the concepts, the purpose of the theory and in accordance with the stated relationships between the concepts (Chinn & Kramer, 2011).
- c) **Structural clarity:** Chinn and Kramer (2011) indicate that structural clarity is closely associated with semantic clarity in that it refers to how understandable and coherent the connections and logical reasoning are in relation to the descriptive elements of emerging theory.

STRUCTURAL CONSISTENCY

Structural consistency pertains to the various structural forms that are used to illustrate the general profile of the descriptive elements of the theory for the purpose of providing a conceptual map to enhance clarity and comprehension (Chinn & Kramer, 2011). In effect, structural consistency can be used as a guide for discussions on structural clarity and consistency and semantic consistency aimed at overall clarity to avoid ambiguity in understanding the theory and be useful in stimulating new ideas or discussions in relation to nursing experiences on the basis of the theory.

SIMPLICITY OF THE THEORY

The simplicity of the model refers to the number of elements in terms of descriptive aspects in relation to the concepts and interrelationships that should be kept to the lowest level of complexity without loss of core meaning (Chinn & Kramer, 20011). The desirability of simplicity or complexity is relative to the contextual situation being portrayed wherein the value of the

simplicity or complexity of the theory is embraced by the level of understanding of the various concepts and their interrelatedness within the theory.

GENERALITY OF THE THEORY

The generality of the theory refers to its breadth of scope and purpose that appraise the broad range of empirical experiences to a range of concepts and interrelated applications in healthcare practice (Chinn & Kramer, 2011). The theory is therefore taken to have ideas that are arranged to facilitate general application to pertinent healthcare professional team members, but has sufficient application to nursing as a discipline while it addresses broad general concepts of individuals, health, environment and society.

ACCESSIBILITY OF THE THEORY

The accessibility criterion expounds on the extent of identifying empirical indicators for the concepts in relation to the extent for which the purpose of the theory can be achieved through explanation of an aspect of nursing practice (Chinn & Kramer, 2011). Empirical indicators are defined as perceptually accessible experiences that can be used in nursing practice to assess the phenomena that the theory describes and that can be used to determine whether the purposes of the theory are realised in a manner expounded in the theory. The authors assert that increasing the complexity within theories leads to increasing empirical accessibility, and that as sub-conceptual categories are clarified, the empirical indicators become more precise. In qualifying this assertion, it is stated that empirically accessible theories that provide a conceptual perspective on clinical practice may not need an emphasis on empirical accessibility. However, in specific reference to the latter, Chinn and Kramer (2011) point to the purpose of the theory in that if it were to be used to guide research, then empirical accessibility would be essential. Whereas if the theory is to shape clinical nursing practice, then the concepts need to be empirically accessible within the clinical setting for which they create conceptual meanings.

IMPORTANCE OF THE THEORY

The criterion on importance of the practice theory is closely linked to the clinical value or practical significance within the targeted area of nursing practice, which is not limited to current applicability but has a futuristic and pragmatic value for contributing towards a desired vision of where the theory is able to lead practice (Chinn & Kramer, 2011). The central question that is

asked is whether the theory creates understanding that is important to nursing and is valued on one or more of the following levels as important to nursing as a discipline:

- a) guides research and practice in the discipline of nursing.
- b) generates radical new ideas of nursing, health, and caring.
- c) differentiates the focus or nature of nursing from other service professions.

Innate in the evaluation process on the importance of the theory are the professional and personal values in relation to the central question, and the argument of discernment as to whether a theory had achieved its intended professional purposes.

7.7.1.1.1 Evaluation synopsis using the criteria of Chinn and Kramer (2011: 198 -205)

In their latest work, Chinn and Kramer (2011) refer to similar criteria of congruence to evaluate the theory. In this study, this process of theory evaluation was realised as an iterative process in which model description also serve as a process of theory refinement. Table 7.1 below provides a synopsis of the evaluation review with comments to refine the theory.

Table 7.2 Synopsis of the evaluation of the model using the criteria of Chinn and Kramer (2011)

Criteria for evaluation and comments from review
<p>1. Clarity</p> <ul style="list-style-type: none"> ▪ Core and main concepts were defined in depth to portray a descriptive clarity and vividness ▪ Figures that were illustrating progressive process of development of the model from concepts identification and classification were smoothly crafted to produce the clear and observable connectedness in relationships and congruency of the developed model and explanation of the practice theory for teaching-learning of spiritual care in the undergraduate nursing programme at an institution of higher learning in the Western Cape Province, South Africa. ▪ Language editing of this thesis was conducted by a professional Language Editor to enhance clarity
<p>2. Simplicity</p> <ul style="list-style-type: none"> ▪ The building process of the model as depicted in figures 6.2, 6.3, 6.4, 6.6, 6.7, 6.8, 6.9. and 6.10 shows how the incremental process was used to progressively build the model, and progressive and incremental process of concepts identification, classification and definition or clarification and their relationships in concepts and statements of developed theory. ▪ Description of the model and providing its assumption, and purpose enhanced understanding of the purpose of the of use of the model on real practice of teaching-learning of spiritual care in which it is necessary for the purpose of explaining the main concepts, their interrelatedness and contextual setting.
<p>3. Generality</p> <ul style="list-style-type: none"> ▪ Description of the main concepts and relationships which were refined in an iterative process as figures and tables were added incrementally for clarity, providing a basis for other nursing educators, practitioners or researchers to make generalisations based on the transpired process and study findings.

<p>4. Accessibility</p> <ul style="list-style-type: none"> ▪ The concepts in this model can be used as empirical indicators for nursing practice of the teaching-learning of spiritual care due to the detailed descriptions of the model that are founded on empirical evidence in this nursing study and the literature. ▪ The definitions and meanings of the concepts, even though they are contextualised within a specific geographical location in the Western Cape, South Africa, these were validated through literature review and included world-wide experiences about the phenomenon under inquiry.
<p>5. Importance</p> <ul style="list-style-type: none"> ▪ The evidence of fewer studies conducted in the South African context regarding spiritual care in nursing education indicates the need for the current study. This was also evidenced by the gap in empirical studies to respond to teaching-learning of spiritual care in the undergraduate nursing programme. It is believed that the outcome and findings of the current study will inspire nurse practitioners, administrators, educators, and researchers not only to assess and critic the developed practice theory but they will also pursue means and ways to develop and expand the nursing scientific base and evidence in response to the practice nursing teaching and practice. ▪ The developed practice model for teaching-learning of spiritual care will yield its benefits and potential for implementation in nursing education of nurses in the Western Cape, South Africa. Further research, especially regarding integration of spiritual care, would need consistent checks and balances to ensure effective implementation and progress. ▪ The practical value of the nursing model is that it can be used to operationalise the functional role of the NEs and CSs in engaging with the nursing students in learning spiritual care in the undergraduate nursing programme in the Western Cape, which with time should be expected to spread to the entire provinces of South Africa.
<p>Summary comment</p> <ul style="list-style-type: none"> ▪ The newly proposed nursing curriculum for the undergraduate nursing programme does not spell out clearly the role that spirituality and spiritual care in nursing practice and health care play. This is evident by prioritisation of “ethics” and “research” subjects over spiritual subject in the new R174 curriculum evident in credit allocation. Whilst prioritisation of ethics and research are welcome and significant in nursing, it is however surprising and raises legitimate concern as to why these subjects (i.e. ethics and research) are made more visible in the curriculum (through increased credit allocation across the four (4) year levels of the programme). The proposed change is substantial in contrast to the allocation of other subject content in the curriculum. ▪ It is believed that if nurses agree that patients can or may sometimes experience person-hood needs that do not require nursing, medical interventions and administration of pharmaceutical but simply therapeutic touch, presence and talking with patients while under their care; then nurses should consider providing spiritual care at meso-curriculum and micro-curriculum levels. Because the SANC espouse holistic nursing of which spiritual care is a critical aspect, guidelines at macro curriculum and policy level are lacking. ▪ Advocate for the national integration of spiritual care with relevant stakeholders and policy makers will be initiated in pursuit of integration of spiritual care in nursing education, practice and research.

7.7.2 The modified steps in the evaluation framework by Fawcett (2005)

The modified steps from the Fawcett (2005: 53) evaluation framework were selected, mindful of the evaluation criteria on clarity that are found extensively in Chinn and Kramer (2008), and congruent to a clinical nursing practice setting. The criteria selected include (i) explication of origins, (ii) comprehensiveness of content, (iii) logical congruence, (iv) credibility of the nursing model, and (v) contributions to the discipline of nursing.

- ***Explications of origins:***

The evaluation for this criterion includes explicit identification of the author's beliefs and values aimed at obtaining information on the philosophical foundations of the theory and any particular focus on any aspect of nursing practice that is emphasized in the nursing theory. The scholarly expectation here is that the work of scholars has been cited (Fawcett 2005: 53).

- ***Comprehensiveness of content:***

In this evaluation criterion, the emphasis is placed on the breadth and depth of content. This includes concepts of a nursing meta-paradigm to include human beings, the environment, health and nursing, as well as the existence of relationships between concepts. Furthermore, the criterion includes whether the guidance given for practice situations is adequate and broad enough to span a range of activities that are pertinent to the focus area of nursing practice for which the nursing model has been developed (Fawcett, 2005: 54).

- ***Logical congruence:***

The criterion on logical congruence evaluates the internal structure of the nursing theory. This action occurs using the cognitive ability of judging the congruence between the content of the theory and the stated philosophical stance of the researcher. Integrated in judging the theory on this criterion is congruence on nursing knowledge or world views and how consistently this is handled and whether or not different schools of thought have been translated into one congruent frame of reference for use in nursing as a discipline (Fawcett, 2005: 54).

- ***Credibility of the nursing model:***

The last criterion for the evaluation of a nursing theory relates to determining its credibility and acceptance within the practice setting and within the clinical population. Credibility of a practice theory is implied by way of appropriate and relevant empirical substance from the literature so that the guidance of nursing activities in practice is based on empirical evidence related to nursing knowledge in the disciplines. Three (3) subclasses of this evaluation are specified by Fawcett (2005: 55). They are:

- (i) social utility of the theory that is linked to how the nursing model can be applied in nursing practice, which may include specialised education or up skilling on interpersonal and psychomotor elements of nursing actions;
- (ii) social congruence of the theory is appraised by determining whether the nursing activities described in the nursing theory are harmonized to the nursing practice setting of the healthcare environment and the healthcare team, which means that the goals and outcomes of nursing interventions are consistent with the realities of the socio-economic factors that impact healthcare; and

(iii) social significance of the theory relates to the social value of the nursing theory with attention on the health impact on the particular population who are the recipients of nursing activities described in the nursing theory, which also value the input of nurses in the related practice setting. Contributions to the discipline of nursing: This final criterion of Fawcett (2005: 57) pertains to judgments made following a comprehensive review of the literature regarding the concepts and content of the nursing theory. Fawcett cautions judgments made by the comparison of different nursing theories, and advises that a nursing theory is best critiqued on its individual basis.

7.7.2.1 Evaluation synopsis using the modified steps in the framework of Fawcett (2005)

The evaluation synopsis is presented using the evaluation steps that were modified from Fawcett's (2005: 53) framework. The application of the modified evaluation framework by Fawcett (2005) is presented below in Table 7.2.

Table 7.3 Synopsis of the evaluation of the model using the modified framework of Fawcett (2005)

Criteria for evaluation and comments from review
<p>Step 1: Explication of Origins</p> <ul style="list-style-type: none"> The philosophical standpoints underpinning this model and the research process were initially unclear and confusing to the researcher, but engaging with the design in an attempt to find clarity the researcher discovered research steps of the research phase were overtly accounted for and not visibly discussed as part of theory building process which initially caused lack of clarity in the process of the design. The research phases and steps were revised to provide better understanding of the philosophical underpins. The research process unfolded this phase became clearer as to how it contributed to the process of theory generation in line with other theorists such as Dickoff <i>et al.</i> (1968), Chinn, Walker and Avant (2011) which were viewed as forming synergic and synchronised science philosophy in generation of the practice theory for teaching-learning of spiritual care.
<p>Step 2: Comprehensiveness of content</p> <ul style="list-style-type: none"> The practice model provides comprehensive descriptions on teaching-learning of spiritual care in the undergraduate nursing programme in the Western Cape in South Africa. Guidelines for operationalising the model were detailed and cater for every step including teaching, learning and clinical practice of spiritual care by nurse educators and nursing students respectively. The use of Dickoff <i>et al.</i> (1968) survey list provides means to comprehensively cater for the goal activity in a manner that makes it clear what role each aspect of the survey list brings in achieving the goal content.
<p>Step 3: Logical Congruence</p> <ul style="list-style-type: none"> The study design was anchored by experts in theory generation, each one proving a clear direction as to how the study unfolded. The theoretical perspectives include (3) main nursing theory experts were used, i.e. Dickoff, James and Wiedenbach (1968), Chinn and Kramer (2011) and Walker and Avant (2011). These perspectives were reformulated and transformed to reflect the single perspective for teaching-learning of spiritual care in the undergraduate nursing programme in the Western Cape in South Africa. The application of the iterative process of reasoning strategy by Creswell (2011) and Chinn and Kramer (2011) enhanced congruence data analysis. Further frequent consultations with the supervisors and member checking continued to shape the findings and outcomes of the study.
<p>Step 4: Credibility of the nursing model: social utility, social congruence, social significance</p> <ul style="list-style-type: none"> Credibility of the model: The developed model is a model accepted as credible because credible theory building strategies and procedures were used. The combination of different framework including Dickoff <i>et al.</i>, (1968) concepts classification, Chinn and Kramer (2011) inductive-deductive reasoning to conceptualise and structuring of the model as well as Walker and Avant to assist in the determination

<p>(prior to embarking in the theory-development process) level of the theory required for this study; which was practice theory as depicted in figure 2.1 in chapter two. The relevance of utility of the model is assured by application of the Dickoff, James and Wiedenbach (1968) survey list and guidelines for operationalising the model according to Klopper's (2009) model from constructive learning for teaching-learning process and model by Ross (2004) for practical application of spiritual care in the clinical practice.</p> <ul style="list-style-type: none"> ▪ Social utility, congruence and significance: The model was developed from the emic perspective. This means that the model will not only be user friendly but is socially and culturally acceptable to the users and most possible for the patients who are the end uses of the model; because the patients are from the same community as the participants that were part of the development of the model.
<p>Step 5: Contributions to the discipline of Nursing</p> <ul style="list-style-type: none"> ▪ The value of the developed practice theory on teaching-learning of spiritual care will assist nurse educators and nursing students in the Western Cape primarily and in SA as a whole. The value of this nursing model on which the theory is founded bears its significance in teaching-learning of spiritual care based on clarity of the model through interaction of the elements as described by the survey list (Dickoff, James & Wiedenbach, 1968).
<p>Summary comment</p> <ul style="list-style-type: none"> ▪ The use of the traditional research methods for data collection based on the emic perspective which was aimed at obtaining relevant information that would assist to improve the practice of teaching learning of spiritual care; as well as the use of theory-generative process enhanced generation of a practice theory for teaching-learning of spiritual care in nursing education. The findings of the study are accepted as credible based on varied factors as provided in steps 1- 5 above as guiding framework for evaluation of the model according to Fawcett (2005).

7.7.3 Theory refinement

McKenna and Slevin (2008: 168) specify that theory testing research is designed to determine how accurately the depiction of the real-world phenomena is portrayed in theory. According to Dickoff et al. (1968) practice theory does not need to be subjected to testing because practice theory gets validated through its use which in turn provides continuous development and advancement of that particular theory. This study generated a practice theory based on empirical evidence, which, according to Dickoff James and Wiedenbach (1968), does not need testing. Theory testing falls outside the scope of this study hence theory testing was not conducted.

7.8 CHAPTER SUMMARY

In this chapter, the model was presented and described using symbols and graphics. The evaluation of the model was conducted using key elements of trustworthiness that were linked to scientific integrity, and reviewed using selected evaluation criteria by Fawcett's (2005) nursing theory. The guidelines to operationalise implementation of the practice theory for teaching-learning of spiritual care in the undergraduate nursing programme in the higher education institution in the Western Cape South Africa were not formulated as part of this study. However, the guidelines will be formulated as post PhD project outside of this study. Chapter eight (8) presents guidelines for implementation of the practice model and measures for model operationalisation, evaluation of the study after which the limitations, recommendations and conclusion are also provided and the researcher's reflexivity are briefly discussed.

CHAPTER 8: EVALUATION, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION OF THE STUDY

8.1 INTRODUCTION

The chapter provides a reflective evaluation of this research process. After which the recommendations, limitations and conclusion of the study are provided. The evaluation will focus on the experiences of the researcher and lessons learned from conducting the study; as well as issues and challenges that were encountered. The solutions that were applied to counteract challenges will be provided as a means to contribute to the scientific body of knowledge on spiritual care in nursing. The researchers, theorists and colleagues can use the report on the study process finding to allow sharing of the knowledge and understanding of spiritual care. The areas that form part of this evaluation include: the research approach, design, methods and procedures will be addressed after which the limitations, recommendations, conclusion would be provided.

8.2 EVALUATION OF THE STUDY

The five standards of evaluation of the empirical studies according to Burns and Grove (2009) were used. The evaluation tool is methodological and systematic arranged in a manner that allowed the researcher to objectively examine the study. The five standards of the tool include the following criteria: (i) descriptive vividness, (ii) methodological congruence, (iii) analytic and interpretive congruence, (iv) philosophical or theoretical connectedness, and lastly, (v) heuristic relevance.

Table 8.1 below is provided to show how the five standards of Burns and Grove (2009) were used in this evaluation.

8.2.1 The rationale for evaluating study

It is the responsibility of every researcher to ensure that the research findings are credible and acceptable. This evaluation of the study is intended to provide critical reflection on the research process as undertaken both as researcher and theorist particularly on theory-generation process. The evaluation is reflective with the intention to review the challenges, problems, and potential treats to the empirical process and to provide alerts on issues to be avoided in future studies.

Table 8.1 below presents the actual evaluation process to show how the evaluation was conducted. The evaluation standards were arranged in criteria that address a specific aspect of the research process (Burns & Grove, 2009). The questions of the evaluation tool are provided as appendix 26.

8.2.2. Evaluation of the study

The critique process for qualitative studies by Burns and Gove was used to evaluate the current study. The evaluation process included the five criteria standards of Burns and Grove (2009). They include: (i) descriptive vividness, (ii) methodological congruence, (iii) analytical and interpretative preciseness, (iv) philosophical or theoretical connectedness, and lastly, (v) heuristic relevance. Action that were taken under each standard are provided in the table. Table 8.1 below presents the actual evaluation process.

Table 7.4 A synopsis of the evaluation of the study according to Burns & Grove, 2009)

CRITIQUE PROCESS FOR QUALITATIVE RESEARCH ACCORDING TO BURNS AND GROVE (2009)
CRITERIA AND GUIDELINES FOR EVALUATION AND EVALUATOR COMMENTS: A SELF EVALUATION
STANDARD 1: DESCRIPTIVE VIVIDNESS:
<p>a. The significance of the study was clearly described, pointed at the benefits of the findings to the profession of nursing education and practice as presented in Chapter One under section 1.6.</p> <p>b. The purpose and objectives of the study was described in detail and supporting arguments provided to support the need and the aim of the study. These arguments were provided under ‘Background’ and ‘Context’ of the study to show how they form basis on which the research question was founded.</p> <p>c. The feedback from the promoters of that study assisted in improving these arguments at proposal stage which was continued through-out the different phases and stages of the research process, including interpretation of the analysed data an report writing. The arguments were refined accordingly to attain vividness to the researcher and readers with the aim of ensuring the credibility of the study process as argued in Chapter 2 table 2.6 under criteria and strategies for trustworthy according to Krefting (1991).</p>
STANDARD 2: METHODOLOGICAL CONGRUENCE
Substandard 2.1 Adequate Documentation of the Participants
<p>a. The participants were described in Chapter Two under Tables 2.2 for nurse educators, 2.3 clinical supervisors, 2.4 nursing students and 2.5 academic records. The diverse data sources were required to give the information according the different data information that was intended to respond to the study question. This has contributed to the rich description of the data from the different sources and provided the evidence base for the practice theory.</p> <p>b. Purposive sampling was used as a scientific criteria to select the participants. This means that all the participants were selected on the similar basis which was relevant knowledge and experiences about the spiritual care in nursing education and practice.</p> <p>c. The challenge of unfamiliarity of the participants with the phenomenon under inquiry was critical as they had been drawn from the same institution which potentially compromised the power to generalise the findings to other similar contexts. Therefore, the readers, researchers and anyone who wants to use the findings of this study should take the risk and work out the generalisability to their context. Nevertheless, the detailed</p>

description of the setting as provided in Chapter Two under section geographic setting in 2.3.1; university context in 2.3.2 and context of the school of nursing in 2.3.3 where the study was conducted ensured that the findings of the study were contextually founded.

Substandard 2.2 Careful Attention to the Procedural Approach

- d. Theoretical and philosophical assumptions of the study were identified by the researcher as presented in Chapter One under sections 1.8 which addressed meta-theoretical assumptions.
- e. Theoretical assumptions including Klopper's (2009) constructivists' model for teaching and learning and Ross's (1994) model for implementation of teaching-learning of spiritual care both were used to guide the implementation of teaching and learning of spiritual care in nursing. Whilst Burkhardt's (2008) theory for nursing practice was used to guide the nature of the spiritual subject matter required for the curriculum and implementation in teaching practice.
- f. The relationship between the participants and the researcher was positive as this was confirmed by the turnover of people who volunteered to participate especially the nursing students who volunteered to participate in the study.
- g. The research questions and interview questions were asked in a manner that enhanced the inquiry by obtaining the required answers for the research question. The nature of the phenomenon under inquiry encouraged participants to express their beliefs, values and perception regarding spiritual care in nursing education.
- h. Data collection process and methods were described sufficiently as discussed in Chapter Two section 2.4.1.1.4
- i. Questions (g), (h) and (i) were not addressed in this evaluation as these aspects were not applicable to current study.

Substandard 2.3 Adherence to Ethical Standards

This standard addresses ethical requirements to be met in scientific studies.

- a. The participants were informed that they could withdraw from participation at any time if they felt like doing so. The participants were protected from potential emotional and psychological harm by not calling them with their real names. Electronic files were encrypted with password to protect data and confidentiality of the participants. Hard copy data-files were locked up in a cupboard. These records were kept for five (5) years after the study was published after which they would be destroyed or discarded.
- b. Participants signed informed consents before data was collected as an ethical measure and principle to avoid coercion to participation. Permission to conduct the study was sought by obtaining institutional consents from the Faculty and Senate Research Committees prior to data collection.
- c. Scientific honesty was discussed in depth in Chapter One under section 1.11.5 to show how the study and researcher's integrity were maintained. The Code of Ethics by Beauchamp and Childress (2009) was used the researcher conducted that study in an ethically sound manner. Furthermore ethical principles guided the researcher's activities and interventions as safe guarding participants were informed verbally and in writing about the interest of the participants telling them about their rights for participate and to withdraw without providing justification.

Substandard 2.4 Auditability

This standard traces the ability of the study activities to affirm the authority of the study and credibility of the findings. This standard is addressed in the process of the study as indicate in Chapter Two under Table 2.6 which provides the criteria and strategies for trustworthiness.

- a. The *referencing system* was used to acknowledge the sources and to avoid plagiarism. This was also to ensure that the arguments were with acceptable standard of scientific research and nature of the phenomenon under inquiry. The *empirical excerpts* provided a rich in support of the findings of the study as the transcripts were handy in yielding thick descriptive data that showed how the participants perceived the phenomenon of spiritual care in the nursing programme. *Direct quotations* from the original transcripts of each data source were recoded with a research code which made the administrative duties easy as there was not research assistant to assist with the task.

- b. The *inductive and deductive processes* that guided decisions in identifying, describing, and analyzing the core concepts and conclusion and relational statements provide an audit trail used in the process of generating the practice theory for teaching-learning of spiritual care in nursing programme. *Appendices 1 to 26* which are provided at the back of this report are guarantees a traceable research process, hence they can be used to affirm existence of specific research activities.
- c. There was a challenge in use of the focus group as data collection method for the clinical supervisors as planned. The changed of the method to individual interviews was caused by the difficulty in getting the clinical them together. Notwithstanding the potential challenge with sample size relating to the issue of representativeness which was methodological skewness.

STANDARD 3: ANALYTICAL AND INTERPRETATIVE PRECISENESS

- j. The *inductive and deductive processes* were used to develop the categories, themes and study findings on which the bigger picture of the practice of teaching-learning of spiritual care in nursing could be understood. Thereby, giving clarity on abstraction and inferred notions on the phenomenon under study; different knowledge sources are considered as crucial when generating a practice theory. Scientific context of knowledge that underlie the conceptual framework and theory was ensured by keeping a clear mental picture of the entire process between concepts in different worlds as discussed in Chapter Two under reasoning strategies in section 2.6. The evidence of which was shown in analytical preciseness that resulted in generated practice theory.
- k. Member checking was used to validate the results from the empirical data before the findings could be used to inform the developed model and latter emergent theory.
- l. The independent coder analysed the data concurrent with the primary researcher. The differences in codes were reconciled successfully as these were minimal and insignificant.

STANDARD 4: PHILOSOPHICAL OR THEORETICAL CONNECTEDNESS

- d. The connectedness between philosophical and theoretical aspects of the study was established as early as in the proposal stage where assumptions of the researcher were presented under meta-theory on the four fundamental concepts and theoretical assumptions where three (3) theoretical models namely; Kloppers constructivists learning, Ross's execution of teaching of spiritual care as well as Burkhardt's theory for practice of nursing were acknowledged in Chapter one (1) under section 1.8.1 and 1.8.2. Furthermore, these models also relate to the developed model of teaching-learning of spiritual care and emergent theory.
- e. The conclusion statements and related statement are connected to the phenomenon of spiritual care as known to the participants. Which showed the importance of spiritual care in nursing and the conditions under which teaching-learning of it can be attained. Also, indicating what personality types that can be effective in attaining the goal activity of integrating teaching-learning of spiritual care in the undergraduate nursing programme.
- f. The philosophical and theoretical standpoints adopted in this study described and affirmed in Chapter Seven sections 7.3 description of the theory and 7.4 evaluation of theory using criteria Chinn and Kramer (2011), Fawcett (2005) respectively.

STANDARD 5: HEURISTIC RELEVANCE

Substandard 5.1 *Intuitive Recognition*

The use of the qualitative approach for the study promoted implementation of the emic view principle when collecting the data. This view was accepted based on its relevant perspective to collect and obtain rich from participants own voice. The emic view in data collection did not only ensured that the findings of the study were a true reflection of the participants and thus acceptable., but more importantly the participant identify with the phenomenon being reported; because the participants' experiences were used to develop and describe the model for teaching-learning of spiritual care in nursing which specify the goal activity with the context of SA in relation to nursing education, practice, and research.

Substandard 5.2 *Relationship to the Existing Body of Knowledge*

This section provide evaluation on the following: (i) examination of existing body of knowledge and differences of conducted studies, (ii) the contribution made by this study to existing body of knowledge.

(i) EXAMINATION OF EXISTING BODY OF KNOWLEDGE:

The dearth of contextual-based scientific studies in formalised teaching and learning of spiritual care in the Western Cape SA provided an opportunity to conduct the current study by tapping into traditional, aesthetical, scientific, cultural, and spiritual based views on the phenomenon of spiritual care in nursing and portrays it as a critical aspect in holistic care. The unique knowledge of the study is concretised in resultant new insights as presented below. The problem statement presented the comprehensive gap, omissions and inconsistencies that exist in the contextual-understanding of spiritual care in nursing.

(ii) CONTRIBUTION OF THE STUDY TO EXISTING BODY OF KNOWLEDGE:

The ultimate aim of a doctorate is to contribute to the body of science of the discipline. Throughout the study, the researcher was intensely aware of this. It was accomplished by creating new knowledge through in depth analysis, emerging new knowledge, new thoughts and new insights obtained from the empirical data. The empiric data was used to embed the practice theory in, by using the framework of Dickoff *et al.*, (1968). The findings of the current study accepts the philosophical distinction between the concepts “being- human” and “human-being”. The subtle difference between these two terms that are close to each other is manifested in their existence, in which the state of “being-human” acknowledges the “incompleteness” in or of human-being. While “human-being” denotes a simpler connotation of a man as a living organism giving no specific criteria and or any essence to link with the complex inner-self that links the man to his or her own spiritual-being. This distinction between “human-being” from “being-human” was based on the fact that a “human” is forever in a state to discover something in life. The findings of this study highlights this distinction and relation to the role of each term in nursing care. Hence the contribute to existing knowledge by bringing this distinction as new insight for consideration when providing holistic care which is claimed to be less holistic in the absence of spiritual care. Perhaps, the assumption about Maslow’s Theory of the Hierarchy of Needs which points to incremental needs of humans from physical to self-actualisation as denoting the levels of human existence in which self-actualisation is the highest level that is all encompassing. In contrast, to the findings of this study the practice theory for teaching-learning of spiritual care should not be seen to be at tame plane as that of Abraham Maslow because it is the Humanist assumptions regarding human existence. But, it is on “Spiritual” plane which is different entirely from physical existence which are both part human beings that may constitute other human needs.

Substandard 5.3 *Applicability to Nursing Practice, Research, or Education*

- a. The findings of the current study have immediate relevance to the understanding of spirituality and spiritual care pedagogy in nursing education. The discussion that is provided on the limitations and recommendation thereof, of the study connects the findings of the current study with practice of education and research (current and future) of the nursing profession.
- b. The findings of the current study are valid as long as they are acceptable to the participants who contributed to its generation, however, on the other hand it is equally acceptable that this generated theory my not hold the truth to the future generations who may consider the developed theory as futile. This provision is in line with Walker and Avant (2011) who attest that theories are not immutable.
- c. Suggestions towards this evaluation standard is provided later in this chapter under the recommendation section.

SUMMARY COMMENTS

The theorist of the generated practice theory subscribes to the golden rule that knowledge is not immutable for qualitative studies. Therefore, the risk of transferability of the findings of the current study on practice theory for teaching-learning of spiritual care in nursing rest entirely to the researcher, theorist or nurse educators including educationist who may want to use this theory to examine the contextual settings to which these findings are intended to be transferred to, to ensure the theory usability.

8.3 LIMITATION OF THE STUDY

The limitations that relate to technical aspects were insignificant and managed successfully as the study progressed. The technical limitations that were experienced related to time factor and sample size. Each of these factors is discussed below.

8.3.1 Limitations related to time factors:

Time factor affected different aspects and phases of the study process. Firstly, timing of the authorisation of the study compromised accessing the final year nursing students who were finishing the programme at end of that very year by which the researcher was authorised to collect data. It was therefore a challenge to get them on a focus group hence only one focus group that could be accessed and interviewed, it was the very last day on which the class was on campus in that particular year. Despite discussions that were active and vibrant with the very group, however, the fact that only one (1) focus group was interviewed in that particular year level points to a potentially missed information even though data saturation was reached. However, according to research principles an acceptable saturation point can be achieved after two (2) or three (3) focus group discussions. Secondly, the academic-semester activities negatively influenced accessing the clinical supervisors especially from the third year level as they were already engaged with programme orientation. Clinical supervisors who were disseminating into different directions to clinical placements as allocated could not be collectively gathered. The study's data collection timing also had its time frame towards completion and thus time was limited. Compromise could not be accommodated and hence the researcher went ahead and collected data from the participants that were available.

8.3.2 Limitations related to the sample size

Despite the fact that the study's sample size was adequate and acceptable for a qualitative study, it was noted that the sample size for the clinical supervisors was almost the same as the NE size yet these samples were drawn from different population sizes. The causes for the discrepancy in the sample sizes between these data sources were based on the change of data collection method for the clinical supervisors from focus group to individual interviews. Therefore, it was no longer possible to get the clinical supervisors to participate in groups discussions but as individual interviews, this change was somewhat a benefit to the study in the sense that more people participated. On the contrary, the issue raises a question of unbalanced sampling in contrast to nurse educators who were drawn from a much smaller population.

8.3.3 Participants unfamiliarity with the phenomenon under inquiry

The participant's unfamiliarity with the phenomenon under inquiry due to knowledge deficit posed a challenge in varied ways as most participants were not quite sure about the contents of the spirituality subject. Participants assumed that religious practice and knowledge were equivalent to spirituality. This was obvious with the nursing students. Consequently, the topic of spirituality and spiritual care created challenges to most participants who obviously needed some orientation to the discussion and interviews with regard to what was expected of them. Despite the researcher's claim on the challenge and its shortcomings, the challenge was ethically, professional and adequately handled. However, different views may fault such an occurrence as potentially biased.

8.4 RECOMMENDATIONS FOR THE STUDY

These recommendations draw from the results of the study, and are based on the gaps identified by participants (educators and students) as perceived. Generally, the findings recognise the inequities in nursing education and practice which were assumed to result from lack of proper educational preparation. Participants pointed to contextual factors responsible for forbidden spiritual care in nursing. These include a view that spiritual matters are not only a personal but also private and therefore un-accessible in many instances. However, participants recommended that nurses should be involved in patients' spiritual matters and provide spiritual care; just as nurses are involved in health care they should conceive the holistic view of nursing by incorporating spiritual care.

8.4.1 Need for curriculum reform in nursing education

There is a dire need for education and spiritual care practice in nursing. Consequent to the identified need, nurses should be introduced to spiritual care in time. Therefore, preregistration nursing programmes should expose nursing students to knowledge that promotes understanding spirituality and its traditions in nursing. Learning processes such as values clarification, spiritual guidance, self-reflection are increasingly being part of the training and education programmes for nurses where nursing values such as caring, respect and religious tolerance and reflection are valued and taught.

8.4.2 Need for curriculum reform

Nurses need to recognise that spirituality is a normal course of being human in human beings' life path. The nurses' moral obligation to provide "care", demands and certifies nurses to consider patients' holistic needs when under their care. Nurses should conceive "care" or "caring" as more

intense in addressing health needs as opposed to nursing tasks which can be performed without personal involvement. Spiritual care is a specific strategy to address patients' felt needs and it can prevent patients from being isolated, marginalised or medicalised. Therefore, spiritual care can liberate the patient from potential exploitation and loss of integrity. If nurses accept that sometimes a patient may have problem(s) that do not need medical, pharmaceutical, technical nursing attention but purely spiritual (van Leeuwen, 2008, p. 15); therefore, every nurse should be willing to be equipped to provide primordial spiritual care. The same was pointed out by student participants who emphasised the need to differentiate between Biblical or religious spirituality from other [primordial] spirituality which is a condition that supports all humans to reach their full potential. This kind of spiritual care is basic and humane and therefore nurses should avoid institutionalised social and political contexts that jeopardize humanity. It is therefore argued that praxis at individual and collective levels should acknowledge and address such injustices through reflection and action, sharing insights, experiences, possibilities for change may intensify, grow and develop positive results; that is freedom for all (Chinn & Kramer, 2011). The findings of this study suggest that curriculum reform can be achieved through various interventions at macro, meso and micro levels of curriculum development and implementation for education of nurses. A visible and clear philosophical stance should be taken as measure to ensure universal implementation of spiritual care at various points of nursing education practice of nursing. Based on the generated theory this can be achieved from the study findings that were influence by the conclusion statement from the conceptual framework, the developed model and generated theory.

8.4.3 Recruitment and selection of students

Many authors attest that practice of spiritual care is largely dependent on the attitude of the individual health worker (Pulchalski, 2006; McSherry, 2008). This is in keeping with the participants' suggestion to reconsider serious methods for recruitment and selection of nursing students with the intention to find individuals who are readily willing to care for the sick person. Among other things that were suggested as good indicators of a caring value is evidence of involvement with helping people prior to becoming a nursing student. Participants mentioned possession of a basic level of First Aid Certificate, voluntary work as a home-based carer or working in the old age homes and so forth as indications that can be used to select appropriate individuals for education and training for nursing practice. This recommendation challenges the status quo with regards to current selection criteria and procedures for nursing students. This

means that personal virtues such as eagerness or willingness to learn, kindness, readiness, positiveness, centredness are viewed as prerequisite attitude and behaviour to deal with a sick person. A selection test in a form of Multiple Choice Questions (MCQs) or a narrated self-reporting and self-reflection was also suggested as potential strategies.

8.4.4 Need for more research in spiritual care in nursing

Many authors have made some reference to the need for more research in the area of spiritual care in health and healing. Therefore, it is recommended that nurses in nursing practice and education disciplines should take a firm stand in response to the need for spiritual care. Conducting research will assist the nursing profession not only to assume a clear position on the subject of spiritual care, but more importantly adequate research will increase the nursing knowledge and competence.

8.5 SUMMARY OF THE CHAPTER

This chapter addressed the evaluation, limitation and recommendation of the study. As laid out in the table 8.1 the standard of research study evaluation tool by Burns and Grove (2009) was used.

8.6 CONCLUSION OF THE STUDY

This study was motivated by the observation that despite good nursing education programmes in attempts to meet the patients' care needs, a gap still exists in rendering nursing services that truly address holistic needs of the patient. Promoting one's spirituality within a nursing paradigm can be one way to promote and optimise health, particularly in response to illness. In view of the study findings a need for the theory for teaching-learning of spiritual care in the undergraduate nursing programme in a university in the Western Cape, South Africa is acknowledged. Nurse educators should acknowledge that holistic approaches will never be truly holistic unless the patients' spiritual needs are taken into consideration; as this is the best way to ensure that all human needs are taken care of. Acceptance of "wholeness" nature of patients warrants that nurses and educators should attend to the holistic view of patient needs; because patients' holistic needs are essentially critical for optimum health. The findings of the current study, therefore makes a unique contribution to the existing body of nursing knowledge on the phenomenon of teaching-learning of spiritual care in the undergraduate nursing programme in the Western Cape, claiming that humans (*including patients, clients, nursing students, nurse educator and clinical supervisor*) are primarily incomplete Beings who are always in a state of "being filled spiritually" and "empowered" from within. This inside power in humans influences all other areas of the "human-

being” (noun) through the process of being-human (an action verb for active process of becoming). And, by so doing the “human-being” (noun) can be allowed to transcend into new human experience as they journey in life in a manner that energises the entire human (the person) and thus become positive-minded (adjective) person who lives freely, purposeful, meaningful and appreciated life and understand the need to share herself or himself with others in “Soli Deo Gloria”.

[Soli Deo Gloria is a Latin term for Glory to God alone]



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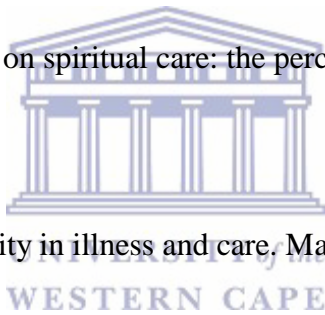
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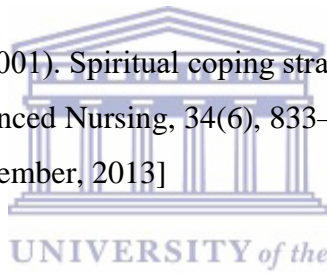
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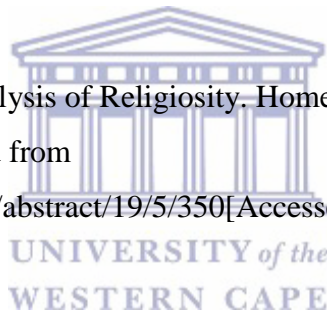
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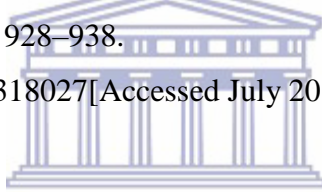
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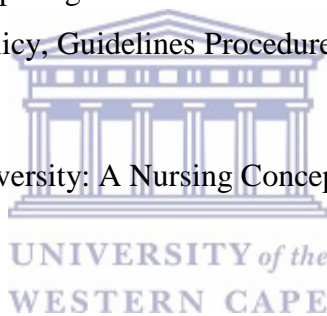
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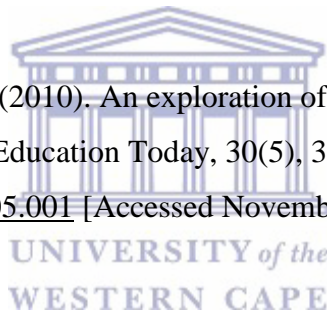
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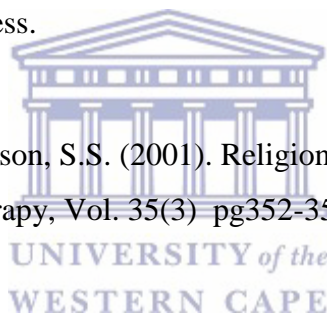
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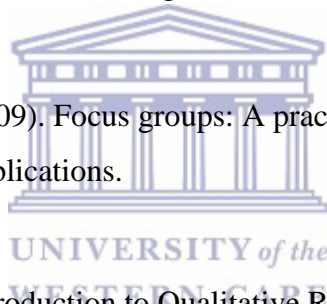
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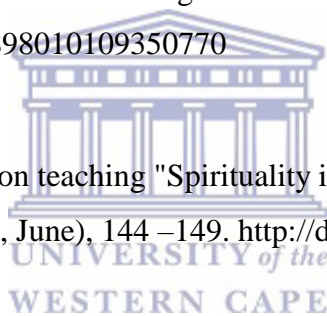
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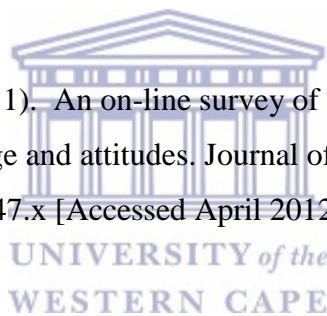
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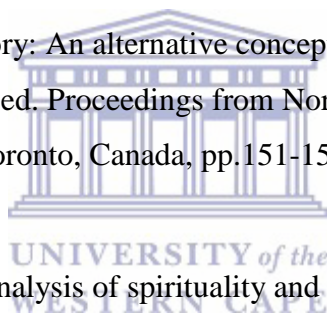
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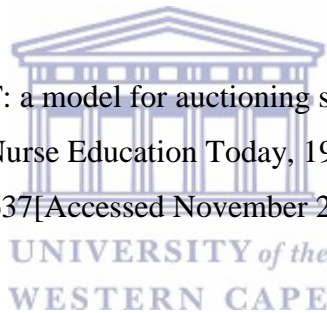
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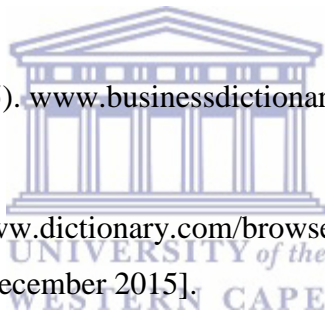
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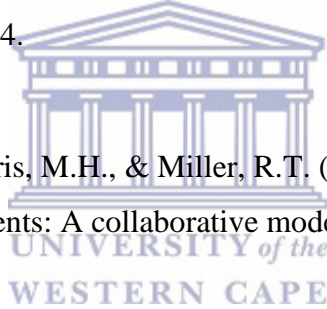
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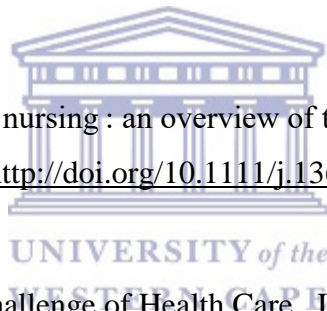
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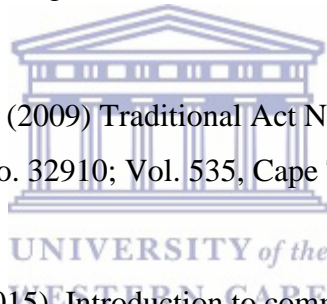
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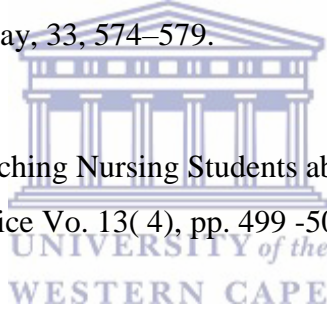
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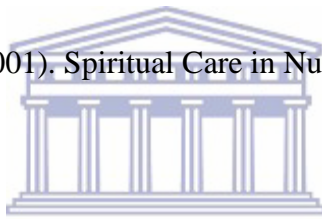
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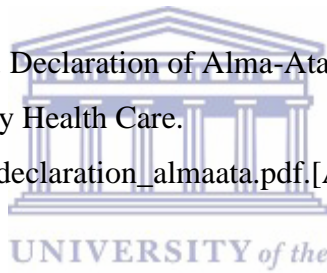
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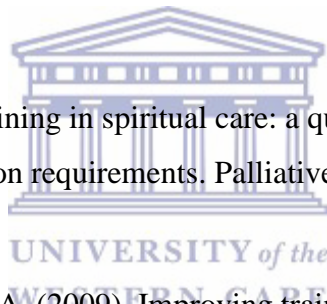
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APPENDICES

Appendix 1: Approval letter from the University Research Ethics Committee



UNIVERSITY OF THE WESTERN CAPE
OFFICE OF THE DEAN DEPARTMENT OF RESEARCH
DEVELOPMENT

Private Bag X17, Bellville 7535, South Africa
T: +27 21 959 2988/2948. F: +27 21 959 3170
E: pjosias@uwc.ac.za www.uwc.ac.za

30 May 2013

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape has approved the methodology and ethics of the following research project by: Ms N Linda (School of Nursing)

Title: A practice theory for teaching-learning of spiritual care in a nursing undergraduate programme at a higher education institution in the Western Cape.

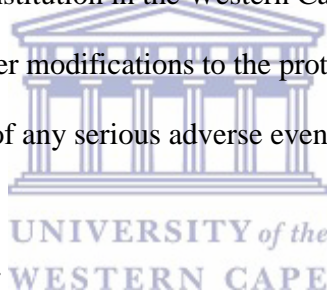
Registration no: 13/4/22

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias

Research Ethics Committee Officer
University of the Western Cape



Appendix 2: Research Project registration and Ethics Clearance Application



**UNIVERSITY of the WESTERN CAPE
DEPARTMENT OF RESEARCH DEVELOPMENT**

Form

SR1 UWC RESEARCH PROJECT REGISTRATION AND ETHICS CLEARANCE APPLICATION FORM

This application will be considered by UWC Faculty Board Research and Ethics Committees, then by the UWC Senate Research Committee, which may also consult outsiders on ethics questions, or consult the UWC ethics subcommittees, before registration of the project and clearance of the ethics. No project should proceed before project registration and ethical clearance has been granted.

A. PARTICULARS OF INDIVIDUAL APPLICANT			
NAME: LINDA Ntombizodwa Sarah Beauty TITLE: Miss			
DEPARTMENT: School of Nursing		FACULTY: Community Health Sciences (CHS)	
FIELD OF STUDY: Nursing			
ARE YOU:		Yes	No
A member of UWC academic staff?		<input checked="" type="checkbox"/>	<input type="checkbox"/>
A member of UWC support staff?		<input type="checkbox"/>	<input checked="" type="checkbox"/>
A registered UWC student?		<input checked="" type="checkbox"/>	<input type="checkbox"/>
From outside UWC, wishing to research at or with UWC?		<input type="checkbox"/>	<input checked="" type="checkbox"/>

A. PARTICULARS OF PROJECT
PROJECT NUMBER: TO BE ALLOCATED BY SENATE RESEARCH COMMITTEE:
EXPECTED COMPLETION DATE: 2014

PROJECT TITLE:

A PRACTICE THEORY FOR TEACHING-LEARNING OF SPIRITUAL CARE IN A NURSING UNDERGRADUATE PROGRAMME AT A HIGHER EDUCATION INSTITUTION IN THE WESTERN CAPE

THREE KEY WORDS DESCRIBING PROJECT:

Spiritual care in nursing, Theory generation, Practice theory.

PURPOSE OF THE PROJECT:

M-DEGREE: N/A

✓ **D-DEGREE:**

POST GRADUATE RESEARCH: N/A

B. PARTICULARS REGARDING PARTICULAR RESEARCHER

FAMILY NAME: **LINDA** INITIALS: **NSB** TITLE: **Miss**

THESIS: STUDENT RESEARCHER: **Linda NSB**

THESIS: SUPERVISOR: **Prof H KLOPPER**



C. GENERAL INFORMATION

STUDY LEAVE TO BE TAKEN DURING PROECT: **semester one in 2014**

IS IT INTENDED THAT THE OUTCOME WILL BE SUBMITTED FOR PEER REVIEWED PUBLICATION? YES NO

COMMENTS: DEPARTMENTAL CHAIRPERSON:

SIGNATURE OF THESIS STUDENT: DATE: April 2013

SIGNATURE OF THESIS SUPERVISOR: DATE: April 2013

SIGNATURE OF DEPARTMENTAL CHAIRPERSON:

DATE:

April 2013

NOTE: THESE SIGNATURES IMPLY AN UNDERTAKING *BY THE RESEARCHERS*, TO CONDUCT THE RESEARCH ETHICALLY, AND AN UNDERTAKING BY THE THESIS SUPERVISOR (WHERE APPROPRIATE), AND THE DEPARTMENTAL CHAIRPERSON, TO MAINTAIN A RESPONSIBLE OVERSIGHT OVER THE ETHICAL CONDUCT OF THE RESEARCH.

D. DESCRIPTION OF PROJECT AND RESEARCH ETHICS STATEMENT

ABSTRACT:

A PRACTICE THEORY FOR TEACHING-LEARNING OF SPIRITUAL CARE IN A NURSING UNDERGRADUATE PROGRAMME AT A HIGHER EDUCATION INSTITUTION IN THE WESTERN CAPE

Spiritual care is an aspect of holistic care and a fundamental component in nursing practice. Literature argues that nurses have a moral obligation to take an active role in meeting spiritual needs of patients. However, there seems to be a difficulty in teaching-learning and assessing nursing care skills that relates to the affective domain of nursing including spiritual skills. Studies that were done in South Africa (SA) indicate existing challenges with regards to teaching-learning and practice of spiritual care in nursing in SA. Further, these studies recommend that nursing education and training should aim at producing nurses who can holistically meet the demands of their patient's clinical problems. The aim of the study was to develop a practice theory for teaching-learning of spiritual care in nursing undergraduate programme. The study was a response to resurgence of spiritual care as an important and a vital component in health and healing.

This study adopted a qualitative approach using a theory-generation, exploratory, descriptive and contextual design to explore and describe the understanding of educators, supervisors and nursing student's opinions of spiritual care. Purposive sampling was used to select a sample of nurse educators (n=10) and clinical supervisor (n=9). Nursing students from all year levels (n=90) were invited to participate and they were accepted in the study as they availed themselves until the required number was achieved. Inclusion criteria of student nurses, nurse educators and clinical supervisors were; those individuals who were involved in the R425 programme at a university where the study was conducted and willing to participate. Any nursing student, nurse educator or clinical supervisor who was less than 6 months at the School of nursing, including those who met the inclusion criteria in principle; but who were not willing to participate were excluded from the study. A sample (n=73) from the academic document was formed. Data collection methods included in-depth interviews, focus groups interviews and document review. Tesch's method of content analysis was used to analyse the qualitative data. No particular theoretical framework was used, however, work of Dickoff, James and Wiedenbach (1968); Chinn and Kramer (2011 and Walker and Avant (2011) were used to guide the process of theory generation. Ethical clearance from the UWC Community of Health Sciences (CHS) Faculty and Senate Higher Degree Research Committees was obtained. Participants were provided with information sheet which gave them facts about the study in relation to their rights to withdraw from participation any time without giving a reason at and

this will not negatively affect me in any way. Participants were requested to give a written informed consent. Participants' real names were not used during data collection and analysis. Audio tapes and transcripts were locked up in safe place and be kept. Research documents would be destroyed five (5) years after publishing the results according to the university policy. Safety measures including use of familiar, comfortable environment, providing clarity, explanation and answers to questions as required by the informants were maintained. Staff were approached individually and invited to participate. Students were invited from their respective classes to participate and were included in the study as they presented themselves until the required number was obtained.

Trustworthiness was maintained by ensuring that credibility; conformability, dependability and transferability as observed, also by use of systematic research procedures on theory-generation process. Bracketing was applied to ensure the researcher's beliefs did not contaminate empirical essence and credibility of the study. This was also to eliminate confounding factors. Rigour was observed by framing the research process through selected theory development designs and by describing in detail strategies, process and procedures employed in the study.

Form issued by: Professor Renfrew Christie, UWC Dean of Research, February 2002.
(959 2949; 959 2948 secretary, 959 3170 fax, email: rchristie@uwc.ac.za)

*



Appendix 3: Information Sheet



THE UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2271, Fax: 27 21-959 2679

E-mail: nlinda@uwc.ac.za

INFORMATION SHEET

PROJECT TITLE: A PRACTICE THEORY FOR TEACHING-LEARNING OF SPIRITUAL CARE IN A NURSING UNDERGRADUATE PROGRAMME AT A HIGHER EDUCATION INSTITUTION IN THE WESTERN CAPE

The study intends to explore and establish what the understanding of spiritual care in nursing is among the academics, clinical supervisors and student nurses involved in the undergraduate nursing programme of the School of Nursing at the University of the Western Cape (UWC). The research study will attempt to find out how students are prepared to give holistic nursing care through incorporation of spiritual care components, spiritual nursing models or strategies to meet spiritual demands/needs of patients and clients. It is believed that this information will assist in development of a practice theory for teaching –learning of spiritual care in the nursing undergraduate nursing programme.

This research project will be conducted by Ms Ntombizodwa Sarah Beauty Linda, who is a nursing lecturer at the UWC. The researcher believes that her involvement in the undergraduate nursing programme at UWC will assist her in obtaining answers to the research questions of this study. You are invited to participate in this research project.

The purpose of this research project is to develop a practice theory for teaching-learning of spiritual care when preparing student nurses in the undergraduate programme at the school of nursing UWC. It is believed that the proposed practice theory for teaching-learning of spiritual care will improve the clinical practice of student nurses, and consequently of nurse practitioners primarily in the Western Cape and South Africa. Proactive preparation of student nurses on spiritual aspects of their nursing practice can also mould good character of good nurse qualities. So it was envisaged that such preparation may produce accountable, ethically sound and diligent nurse practitioner who is dynamic and capable of utilizing and creating nursing

knowledge when practicing. The findings of this study will provide knowledge on how spiritual care nursing is understood in the SA context. The researcher believes that preparing student nurses on spiritual aspects of nursing care may also bring meaningful practice of nursing. Your knowledge and information will afford the study findings to realize its purpose and aim is to seek effective ways to increase the caring nature of nursing and confidence of nurse practitioners through a deliberate preparation to provide holistic (spiritual) care for patients\clients.

What will I be asked to do if I agree to participate?

You will be provided with the related information about the study. Details will include the nature of participation that is expected from you. Date, time and place of the interview \ focus group (FG) discussions. You will be then asked to give consent to participate in the study if you are willing to do so. The interview session (data collection session) will take about forty-five minutes to hour and the half. Attached to this information sheet (form) are type of the questions that you will be expected to answer \ to respond to.

Would my participation in this study be kept confidential?

We will do our best to keep your personal information confidential. Confidentiality and Anonymity will be maintained by not be divulging your name in regards to your participation at any stage of the study data management. Audio tapes and transcripts will be locked up in safe place at completion of the study this would be to ensure your recorded voice is not accessed by individuals who are not research officers. Research hard copy documents will be destroyed at least 5 years after publishing the results. If we write a report or article about this research project, your identity will be protected to the maximum extent possible for example pseudo name will be used instead of your real name.

What are the risks of this research?

There are no foreseen risks physical and otherwise that might arise from participating in this research study. Because the study will involves talking and discussing about spiritual care matters which are thought to fundamental for every human being. In case you feel offended, emotional or psychological hurt during the data collection session you will be allowed to terminate your participation as you wished. A venue that you are familiar with will be used to allay your anxiety. There are no known risks associated with participating in this research project.

What are the benefits of this research?

This research is not designed to help you directly and personally, however the findings may give knowledge and understanding about the subject matter under enquiry, the study will actually help the investigator learn more about spiritual care in nursing and assist in improving the practicing of nursing. Researcher is also hoping that, in the future, other people (patients\clients) might benefit from this study through improved nursing practice.

Description of the anticipated benefits to science or society expected from the research, if any.

Study findings will enhance the effectiveness of the caring nature of nursing by increasing confidence of student nurses by preparing them to provide holistic care that acknowledges the importance of spiritual care to patients\clients. Clinical nursing practice of spiritual care by nursing students and nurse practitioners will improve consequently. Study findings will add knowledge on how spiritual care in nursing can be taught and learned. It is therefore envisaged that such preparation of both nurse educator and nursing students on spiritual matters can bring meaningful practice of nursing.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, nothing will be hold against. For example, if you do not feel comfortable with the discussion about spiritual care nursing which is the main focus for the study.

Is any assistance available if I am negatively affected by participating in this study?

In case you happen to feel negatively affected by the study you will be advised to seek support from professional care e.g. counselling if emotionally and psychologically at no cost from UWC available services. If physically affected, you may seek medical attention at your own cost.

What if I have questions?

If you have any question at any stage of the research study or any questions about the research study itself, you may contact the researcher, contact details:

Name: *Ntombizodwa Sarah Beauty LINDA*; department: *School of Nursing (faculty of Health Sciences)* at the University of the Western Cape. Contact no. Tel 021 959 3429 Reception: 021 959 2271 Fax: 021 9959 2679; email: nlinda@uwc.ac.za

Should you wish to report any problems you have experienced that is related to the study, please contact:

Prof Hester Klopper
c/o Dianne Gahiza (Secretary) contact no. Tel: 021 959 2631
CHS Faculty Dean
University of the Western Cape
Private Bag X17
Belleville
7535
Tel 021 959 2631
Fax: 021959 2755
Email: hklopper@uwc.ac.za

This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.



Appendix 4: Informed Consent



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2271, Fax: 27 21-959 2679

E-mail: nlinda@uwc.ac.za

PARTICIPANT'S INFORMED CONSENT FOR VALIDATION OF THE FINDINGS

Titled: A PRACTICE THEORY FOR TEACHING-LEARNING OF SPIRITUAL CARE IN A NURSING UNDERGRADUATE PROGRAMME AT A HIGHER EDUCATION INSTITUTION IN THE WESTERN CAPE

I _____ first name and surname _____ hereby is giving consent to participate in the process of validation of the findings of the research study as spelled out in the title above. As a nurse educator I believe that my participation will can make valuable contribution in taking the nursing profession forward in realisation of nursing explicit body of knowledge.

I know that there are no tangible or monetary benefits attached to my participation but my desire to participate in the validation session is solely influenced by the researcher's request to share relevant nursing knowledge and expertise.

Signature of the participant: _____ date: _____ time: _____

Signature of the researcher: _____ date: _____ time: _____

Appendix 5: Focus Group Binding Form



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2271, Fax: 27 21-959 2679

E-mail: nlinda@uwc.ac.za

FOCUS GROUP CONFIDENTIALITY BINDING FORM

Title of Research Project: PRACTICE THEORY FOR TEACHING-LEARNING OF SPIRITUAL CARE IN THE UNDERGRADUATE NURSING PROGRAMME AT A HIGHER EDUCATION INSTITUTION IN THE WESTERN CAPE

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone by the researchers. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits. I understand that confidentiality is dependent on participants' in the Focus Group maintaining confidentiality.

I hereby agree to uphold the confidentiality of the discussions in the focus group by not disclosing the identity of other participants or any aspects of their contributions to members outside of the group.

Participant's Name.....

Participant's Signature.....

Date.....

Appendix 6: Proposal resubmission Letter



UNIVERSITY OF THE WESTERN CAPE

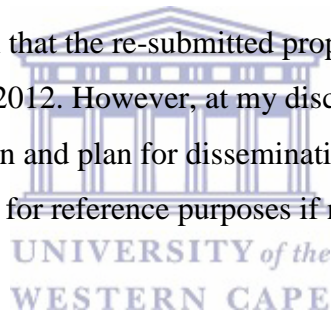
Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2271, Fax: 27 21-959 2679
E-mail: nlinda@uwc.ac.za

18 April 2013

Re: PhD Proposal resubmission: Project Title: A practice Theory for Teaching-learning of Spiritual Care in a Nursing Undergraduate Programme at a Higher Education Institution in the Western Cape

I am hereby giving an affirmation that the re-submitted proposal is copy version of the one that was submitted in November 2012. However, at my discretion as research I have updated the time lines for study completion and plan for dissemination of findings. Previous time line is also inserted in this submission for reference purposes if need be.



Sincerely yours,
NS Linda

Signature: _____

Appendix 7: Appointment Schedule for students



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
 Tel: +27 21-959 2271, Fax: 27 21-959 2679
 E-mail: nlinda@uwc.ac.za

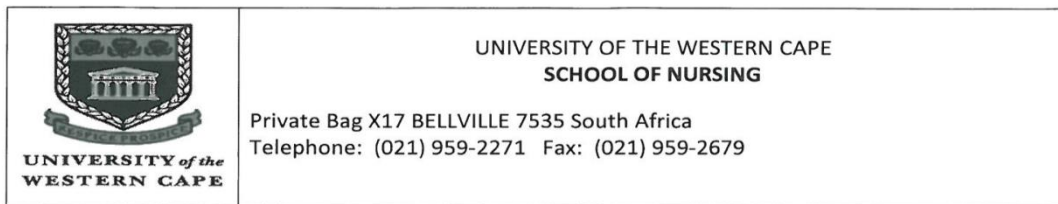
APPOINTMENT FOR PARTICIPATION

PROJECT TITLE: A PRACTICE THEORY FOR TEACHING-LEARNING OF SPIRITUAL CARE IN A NURSING UNDERGRADUATE PROGRAMME AT A HIGHER EDUCATION INSTITUTION IN THE WESTERN CAPE

No.	STUD NAME SURNAME	CONTACT DETAILS (Personal & Placement Facility email, tel. etc.)	YOUR AVAILABILITY FOR FOCUS GROUP DISCUSSION	INSTITUTION FOR YOUR CLINICAL PLACEMENT IN NOV-DEC 2012
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10				

NB: The researcher will appreciate if you can group yourself according to your clinical placements and or availability for focus group discussions. If it is not possible for you to get a group just sign your individual details and return the completed appointment form, the researcher will do matching of dates, times and venues to schedule data collection sessions.

Appendix 8: Approval letter from the School of Nursing



06 November 2012

Dear Ms N. Linda


Student number: 308346

Re: Request to conduct research at the School of Nursing

Herewith receive permission to conduct research at the School of Nursing as required for your PhD study titled: **Practice Theory for Teaching-Learning of Spiritual Care in Nursing Undergraduate programme at the University of the Western Cape**

Kind regards

Prof. Karien Jooste


.....

Acting Head of School

Appendix 10: Programme Outcomes

Programme Outcomes (POs) / Exit level outcomes with Associated Criteria

Description of the PO / ELO	Associated assessment Criteria
<p>ELO no. 1: The student can identify, analyse, formulate and solve convergent and divergent health related problems of professional, individual and societal kinds, creatively and innovatively specifically in the domain of nursing and midwifery service delivery.</p>	<p>(1). Demonstration of fundamental knowledge base of the discipline of nursing by applying the basic ethical, moral, legal and professional principles as a framework during their interaction with individuals of all age groups, their families and other multidisciplinary team members. (2) Demonstration of the ability to effectively apply knowledge from the biological sciences in solving familiar problems/ needs of individuals of all age groups in a variety of health care settings. (3). Demonstrate a sound knowledge of the scientific principles of preventive, promotive, curative knowledge of the scientific principles of preventive, promotive, curative and rehabilitative health in providing care to individuals with health needs/problems. (4). Demonstrate ability to effectively select and apply knowledge gained from Pharmacology in solving well defined medical and surgical problems of individuals of all age groups. (5). Use knowledge and experience to offer suggestions for solving health problems at a community level. (7) Demonstrate knowledge and understanding of the normal development of a person within a society and how this can influence health, illness and health care delivery</p>
<p>ELO No. 2 The student can work effectively with others as a member of a team, group, organization, community and contribute to the group outputs in tasks growing out of the field traditionally considered as social and health sciences.</p>	<p>1. Demonstrate an informed understanding of the role of the Community Health Nurse in providing preventive, promotive, curative and rehabilitative care to individuals, groups, families in community health settings. 2. Demonstrate a fundamental knowledge base of the discipline of nursing by applying the basic ethical, moral, legal and professional principles as a framework during their interaction with individuals of all age groups, their families and other multidisciplinary team members. 3. Demonstrate an ability to coherently and efficiently communicate the evidence of group interaction through professional and scientifically accepted written and /or oral reporting. 4. Demonstrate tolerance of diversity by forming partnerships with all stakeholders in the provision of nursing and midwifery care.</p>
<p>ELO no. 3 The student can manage and organize his/ her personal, academic and professional activities and life responsibly and effectively.</p>	<p>1. Develop learning contracts to identify, plan and monitor their own personal and academic development 2. Demonstrate a sound knowledge of all the principles of professional conduct using relevant legislations as a frame of reference. 3. Demonstrate a capacity for independent practice with initiative, responsibility and accountability</p>
<p>ELO No. 4 The student can collect, analyse, organize, critically evaluate and use information appropriately as required in the pursuit of both his/her studies and profession</p>	<p>1. Demonstrate efficiency in gathering, analysis synthesis and evaluation of health related information using applicable research methods. 2. Demonstrate the use of research findings in nursing and midwifery practice.</p>
<p>ELO No. 5 The student can communicate effectively using relevant and appropriate methods of</p>	<p>1. Demonstrate an ability to coherently and effectively communicate for professional and academic purposes.</p>

communications within diverse situations in the context of the health sciences and in health sciences and practice	<p>2. Demonstrate ability to communicate effectively with the client taking into consideration cultural variations that may affect communication.</p> <p>3. Demonstrate efficiency in gathering, and presenting health related information using appropriate methods and computer applications.</p>
<p>ELO No. 6 The student can use science and technology effectively and critically in the provision of a health service to individuals, families, groups and communities.</p>	<p>1. Demonstrate an ability to effectively apply scientific principles and appropriate technology to provide comprehensive care in meeting the needs of individuals, families, groups and communities of all age groups in a variety of health care settings.</p>
<p>ELO No. 7 The student can demonstrate that she/he practices within a multidisciplinary, inter-sectoral environment and understands the impact of globalisation on health care</p>	<p>1. Demonstrate a sound understanding of the comprehensive health delivery system and to appreciate the place of nursing as a practice within a wider social, cultural, and political context of health care delivery.</p> <p>2. Demonstrate scientific knowledge of the discipline of nursing by applying ethical, moral, legal and professional principles in his/her practice.</p>



Appendix 11: Exit level outcome 1

PROGRAMME OUTCOMES: EXIT LEVEL OUTCOME NO.1 WITH ASSOCIATED CRITERIA, SPECIFIC OUTCOMES AND ASSOCIATED ASSESMENT CRITERIA

Outcomes	Programme Outcomes	Associated Criteria	Specific	Associated Assessment
Baccalaureus Curationis (BCUR) (General, Psychiatry and Community Health) and Midwifery according to Government Notice R425 of 1985 (SANC).	ELO no 1: The student can identify, analyse, formulate and solve convergent and divergent health related problems of professional, individual and societal kinds, creatively and innovatively specifically in the domain of nursing and midwifery service delivery (Curriculum document 2005: 33)	Associated criteria for this ELO includes: (1). Demonstration of fundamental knowledge e base of the discipline of nursing by applying the basic ethical, moral, legal and professional principles as a framework during their interaction with individuals of all age groups, their families and other multidisciplinary team members. (2) Demonstration of fundamental knowledge e base of the discipline of nursing by applying the basic ethical, moral, legal and professional principles as a framework during their interaction with individuals of all age groups, their families and other multidisciplinary team members. (3) Demonstration of the ability to effectively apply knowledge from the biological sciences in solving familiar problems/ needs of individuals of all age groups in a variety of health care settings. (4). Demonstrate a sound knowledge of the scientific principles of preventive, promotive, curative knowledge of the scientific principles of preventive, promotive,	Specific outcomes (SO) No. 1: The learner, as a professional, practitioner, can engage in critical thinking in the domains of social and health delivery system	CRITERIA (AAC): 1.1 Analyse and reflect on the theory and practice of major disciplines in the field of general nursing, psychiatric nursing, community health nursing and midwifery. 1.2 Show potential to contribute to the development of these nursing disciplines. 1.3 Critically evaluate and utilize information from different sources to solve problems that related to general community, psychiatric midwifery fields. 1.4. Apply past and present knowledge to solve existing and potential health related problems in future general nursing, psychiatric nursing, community and midwifery context

		<p>curative and rehabilitative health in providing care to individuals with health needs/problems.</p> <p>(5). Demonstrate ability to effectively select and apply knowledge gained from Pharmacology in solving well defined medical and surgical problems of individuals of all age groups.</p> <p>(6). Use knowledge and experience to offer suggestions for solving health problems at a community level.</p> <p>(7) Demonstrate knowledge and understanding of the normal development of a person within a society and how this can influence health, illness and health care delivery (Curriculum Document 2005: 30-33].</p>		
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Appendix 12: Exit Level Outcome 2

PROGRAMME OUTCOMES: EXIT LEVEL OUTCOME NO. 2 WITH ASSOCIATED CRITERIA, SPECIFIC OUTCOMES AND ASSOCIATED ASSESMENT CRITERIA

Outcomes	Programme Outcomes	Associated Criteria	Specific	Associated Assessment
Baccalaureus Curationis (BCUR) (General, Psychiatry and Community Health) and Midwifery according to Government Notice R425 of 1985 (SANC).	ELO no 2: The student can work effectively with other as a member of a team, group, organization, community and contribute to the group outputs in tasks growing out of the field traditionally considered as Social and Health Sciences (Curriculum Document, 2005:33)	<p>1. Demonstrate an informed understanding of the role of the Community Health Nurse in providing preventive, promotive, curative and rehabilitative care to individuals, groups, families in community health settings.</p> <p>2. Demonstrate a fundamental knowledge base of the discipline of nursing by applying the basic ethical, moral, legal and professional principles as a framework during their interaction with individuals of all age groups, their families and other multidisciplinary team members.</p> <p>3. Demonstrate an ability to coherently and efficiently communicate the evidence of group interaction through professional and scientifically accepted written and /or oral reporting.</p> <p>4. Demonstrate tolerance of diversity by forming partnerships with all stakeholders in the provision of nursing and midwifery care.</p>	SO No. 2 The learner can deal with health issues in all aspects if nursing fields of health nursing, psychiatric nursing, community health and midwifery (Curriculum Document 2005:44)	<p>2.1 Identify and describe existing and potential problems in health/nursing disciplines.</p> <p>2.2 Develop and facilitate interventions to address existing and potential problems in health/ nursing disciplines.</p> <p>2.3 Formulate appropriate responses to resolve both concrete and abstract health problems</p>

Appendix 13: Exit Level Outcome 3

PROGRAMME OUTCOMES: EXIT LEVEL OUTCOME NO.3 WITH ASSOCIATED CRITERIA, SPECIFIC OUTCOMES AND ASSOCIATED ASSESMENT CRITERIA

Outcomes	Programme Outcomes	Associated Criteria	Specific	Associated Assessment
Baccalaureus Curationis (BCUR) (General, Psychiatry and Community Health) and Midwifery according to Government Notice R425 of 1985 (SANC).	ELO no 3 3. The student can manage and organize his/ her personal, academic and professional activities and life responsibly and effectively. (Curriculum Document 2005:34)	1. Develop learning contracts to identify, plan and monitor their own personal and academic development 2. Demonstrate a sound knowledge of all the principles of professional conduct using relevant legislations as a frame of reference. 3. Demonstrate a capacity for independent practice with initiative, responsibility and accountability.	SO No. 3 The learner can identify, describe and evaluate community health nursing, general nursing, psychiatric nursing, and midwifery problems and solutions related to cultural diversity in South Africa; (Curriculum Document 2005: 41)	1. Demonstrate awareness and interest in own culture and other cultures in South Africa. 2. Show awareness of the role played by culture in disease causation explore alternative strategies to address health issues in a culturally diverse society (South Africa) 3. Ability to render culturally congruent health care <i>(Need to relate spirituality and culture at the same time to show how these differ from each other yet can easily be confused)</i>

Appendix 14: Exit Level Outcome 4

PROGRAMME OUTCOMES: EXIT LEVEL NO. 4 WITH ASSOCIATED CRITERIA, SPECIFIC OUTCOMES AND ASSOCIATED ASSESMENT CRITERIA

Outcomes	Programme Outcomes	Associated Criteria	Specific	Associated Assessment
Baccalaureus Curationis (BCUR) (General, Psychiatry and Community Health) and Midwifery according to Government Notice R425 of 1985 (SANC).	ELO no 4: The student can collect, analyse, organize, critically evaluate and use information appropriately as required in the pursuit of both his/her studies and profession. (Curriculum Document 2005: 34)	1. Demonstrate efficiency in gathering, analysis synthesis and evaluation of health related information using applicable research methods. 2. Demonstrate the use of research findings in nursing and midwifery practice.	SO No. 4 The learner can identify with the ethos and dynamics of the health professions and can practice as a professional within the ethical and legal framework pertinent to the nursing profession (Curriculum Document 2005: 41)	4.1 Show awareness of aspects such as health ethics and professional practice 4.2 Use appropriate ethical codes and principles to act as advocate and role model in the health setting 4.3 Act as professional role models take responsibility and accountability within limits of own competence and relevant scope of practice according to the requirements of relevant statutory body. 4.4. Adhere to generally accepted professional norms with integrity




Appendix 15: Exit Level Outcome 5

PROGRAMME OUTCOMES: EXIT LEVEL NO.5 WITH ASSOCIATED CRITERIA, SPECIFIC OUTCOMES AND ASSOCIATED ASSESMENT CRITERIA

Outcomes	Programme Outcomes	Associated Criteria	Specific	Associated Assessment
Baccalaureus Curationis (BCUR) (General, Psychiatry and Community Health) and Midwifery according to Government Notice R425 of 1985 (SANC).	5. ELO no 5 The student can communicate effectively using relevant and appropriate methods of communications within diverse situations in the context of the health sciences and in health sciences and practice. (Curriculum Document 2005: 35)	<ol style="list-style-type: none"> 1. Demonstrate an ability to coherently and effectively communicate for professional and academic purposes. 2. Demonstrate ability to communicate effectively with the client taking into consideration cultural variations that may affect communication. 3. Demonstrate efficiency in gathering, and presenting health related information using appropriate methods and computer applications 	SO No. 5: The learner can use appropriate research/methodology activities to access and manage information in health fields (Curriculum Document 20065: 42)	<ol style="list-style-type: none"> 5.1 Interrelate with people in small and large groups and communities within health contexts 5.2 Interrelate with individuals, families, groups and communities within health contexts. 5.3 Apply knowledge / strategies to facilitate solutions to existing and potential health related problems that arise in a culturally diverse society in South Africa and Africa 5.4 Show empathy and understanding of other problems and contexts

Appendix 16: Exit Level Outcome 6

PROGRAMME OUTCOMES: ELO NO. 6 WITH ASSOCIATED CRITERIA, SPECIFIC OUTCOMES AND ASSOCIATED ASSESMENT CRITERIA

Outcomes	Programme Outcomes	Associated Criteria	Specific	Associated Assessment
Baccalaureus Curationis (BCUR) (General, Psychiatry and Community Health) and Midwifery according to Government Notice R425 of 1985 (SANC).	ELO no 6: The student can use science and technology effectively and critically in the provision of a health service to individuals, families, groups and communities (curriculum Document :35)	1. Demonstrate an ability to effectively apply scientific principles and appropriate technology to provide comprehensive care in meeting the needs of individuals, families, groups and communities of all age groups in a variety of health care settings. 	SO No. 6: The learner can use appropriate research/methodology activities to access and manage information in health fields (curriculum Document 2005:42)	<p>6.1 Collect, analyse, organise and evaluate related information and ideas from a variety of sources in various health fields and nursing disciplines.</p> <p>6.2 Identify patterns in specific fields of general, psychiatric, community and midwifery in order to generalize from specific context to more universal contexts/principles.</p> <p>6.3 Integrate information from different sources to address problems in relevant nursing.</p> <p>6.4 Use theories from a variety of fields to solve problems within the health context</p> <p>6.5 Apply the findings of the research in related health fields</p>

Appendix 17: Exit Level Outcome 7

PROGRAMME OUTCOMES: EXIT LEVEL OUTCOMES NO.7 WITH ASSOCIATED CRITERIA, SPECIFIC OUTCOMES AND ASSOCIATED ASSESMENT CRITERIA

Outcomes	Programme Outcomes	Associated Criteria	Specific	Associated Assessment
Baccalaureus Curationis (BCUR) (General, Psychiatry and Community Health) and Midwifery according to Government Notice R425 of 1985 (SANC).	ELO no.7. The student can demonstrate that she/he practices within a multidisciplinary, inter-sectoral environment and understands the impact of globalisation on health care.	<p>1. Demonstrate a sound understanding of the comprehensive health delivery system and to appreciate the place of nursing as a practice within a wider social, cultural, and political context of health care delivery.</p> <p>2. Demonstrate scientific knowledge of the discipline of nursing by applying ethical, moral, legal and professional principles in his/her practice.</p>	SO No. 7 The learner can think contextually, that is reflect on learning from individual, professional experience, nursing disciplines in relation to social, health issues and how these are influenced by political, social, cultural, technological realities influencing health locally and nationally	<p>Critical Cross Field (CCF)</p> <p>7.1 Relate learning gained from individual and professional experience in the health field to knowledge encountered in a nursing environment.</p> <p>7.2 Relate learning with regard to general nursing, psychiatric, nursing community health, nursing and midwifery from individual and professional experience and academic context, to different health related contexts using present and future scenarios</p> <p>7.3 Interpret health related issues of the past and present in relation to the future needs.</p> <p>7.4 Assimilate personal and professional experience in health problems of individuals, families, groups and communities in various health contexts.</p>

Appendix 18: List of Modules for the Bachelor of Nursing Curriculum

Table: List of Modules for the Bachelor of Nursing Curriculum as presented in the University Academic Calendar

Year level	Nursing Discipline	Numeric Code	Alpha Code	Credits	Total Reviewed
Year: 1	FUNDAMENTALS OF NURSING	Year one credits		Credits Total: 115	5
1.	Fundamentals of Nursing 111	873014	NUR111	15	X
2.	Fundamentals of Nursing 112	873015	NUR112	15	X
3.	Clinical Nursing (Lab) 111	821012	CUR111	15	X
4.	Human Biology 118	301118	HUB118	15	
5.	Human Biology 128	301128	HUB 128	15	
6.	Physics for CHS	336018	PHY118	15	
7.	Chemistry 128 (CHS)	311128	CHM128	15	
8.	Introduction to Philosophy of care 114	873011	IPC114	5	X
9.	Primary Health Care 115	873012	HDP115	5	X
Year: 2	GENERAL NURSING	Year two credits		Credits Total: 115	3
10.	General Nursing Science 211	822211	NRS211	20	X
11.	General Nursing Science 212	822212	NRS212	20	X
12.	Intro to Mental Health 214	821025	CUR214	10	X
13.	Human Biology 218	302218	HUB218	20	
14.	Human Biology 228	302228	HUB228	20	
15.	Pharmacology 204	871204	PHA204	20	
16.	Brain and Behaviour 112	861015	PSY112	7.5	
17.	Introduction to Psychology	861013	PSY111	7.5	
Year: 3	MIDWIFERY / COMMUNITY HEALTH NURSING	Year three credits		Credits Total: 125	
18.	Unit Management 334	821034	CUR334	15	X
19.	Midwifery 331	821048	CUR331	30	X
20.	Midwifery 332	821049	CUR332	15	X
21.	Community Health Nursing 324	821324	CUR324	30	X
22.	Community Health Nursing 325	821325	CUR325	15	X
23.	Child Health 324	821324	NRS 324	15	X
Duplicate module					
	Unit Management 336	821336	CUR336	15	Unit Management 336
	Midwifery 326	821326	CUR326	30	
	Midwifery 327	821327	CUR327	17	
	Community Health Nursing 311	821032	CUR311	30	
	Community Health Nursing 312	821033	CUR312	15	
	Child Health 313	821313	NRS313	15	
Year: 4	PSYCHIATRIC NURSING AND PROFESSIONAL PRACTICE	Year four credits		Credits Total: 120	4
	Psychiatric Nursing 411	821411	NRS411	30	X
	Psychiatric Nursing 412	821412	NRS412	30	X
	Research Methods 421	821421	NRS421	20	
	Professional Practice	821423	NRS423	20	X
	Gender Based Violence	821047	NRS401	20	X
		Total credits =			18

Appendix 20: Data extraction tool

Theory Categories & Sub-categories: Burkhart & Hogan, 2008	Item No	Criteria items of spirituality	Extracted spiritual elements
Category 1: Cue from the patient	1.	Personal communication (<i>may include traditional beliefs & practices</i>)	
	2.	Need for rituals	
Category 2: Decision to engage / not to engage	3.	Respect for individuality	
	4.	Assessment of spiritual concern	
	5.	Relationship with self and others	
	6.	Focused attention (Reciprocity)	
	7.	Allow patient to talk and ask questions	
	8.	Active listening	
Category 3: Spiritual Intervention	9.	Harmonious connectedness in providing care	
	10.	Responding to spiritual needs by being present, still and silence	
		Truth telling, answering questions	
Category 4: Immediate Emotional Response	11.	Kindness to others	
	12.	Positive effect in a person's health	

	13.	Learning about self through relationships	
Category 5: Searching for meaning	14.	Awareness of personal transcendence	
	15.	Personal meaning and experience of truth	
	16.	Meditation (e.g. <i>self-awareness, self-healing</i>)	
	17.	Principle of radical experience of truth	
Category 6: Formation of spiritual memory	18.	Setting of life values	
	19.	Valuing a person\ others	
	20.	Being secure in one's life	
	21.	Increase self-understanding of spirituality and decreased self-criticism	
Category 7: Nurse spiritual well-being	22.	Critical view of spirituality through a holistic focus	
	23.	Creativeness	
	24.	Prerequisite of spirituality in the nurse	
	25.	Purpose in life	

Appendix 21: Participants' request letter for member checking



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2271, Fax: 27 21-959 2679

E-mail: nlinda@uwc.ac.za

7th August 2015

Dear Colleagues,

**Re: request for your participation in validation (member checking) of the study findings:
Title Practice Theory for teaching-learning of spiritual care in the undergraduate
Nursing Programme at a Higher Education Institution in the Western Cape.**

You are requested to provide feedback on the study findings which are presented in this documentation as attachment. There are two ways to activate your participation namely: (i) face-face discussion session or (ii) texted critical comments / feedback.

How to participate?

You are kindly required to examine the findings of the study that emerged from the empirical data which are provided in a table below. The table is divided into three categories including: (i) students, (ii) nurse educators\clinical supervisors and (iii) documents data sources.

Why do you need to participate?

Your feedback on analysis of the study findings from the empirical data will assist the researcher in concluding the process of theory generating theory for teaching learning of spiritual care in the undergraduate nursing programme.

Please select a date on which you can avail your-self for plenary session from the dates provided:

17 August 2015 (Monday) @ 10h00 – 12h00 **or** afternoon @ 14h00-1600

20 August 2015 (Thursday) @ 10h00 – 12h00 **or** afternoon @ 14h00-16h00

21 August 2015 (Friday) @ 10h00 -12h00

XXX

The dates provided above are just a guide they can be changed based on your preference. Please note that only one date selected by most people that will be used for proposed discussion session. The discussion process is anticipated to last for 2hours. If you are not able to join the discussion session on preselected date you can provide your input electronically.

How to interact with the documents?

The process of verification of the study findings include application of the empirical findings on curriculum, teaching- learning and clinical practice using the nursing process approach to operationalization the model

Action Plan: Feedback about your views on the study findings and proposed guidelines to operationalize the model.

Your input is not only important but highly anticipated and welcomed.

Thank you for your positive response

Kind Regards,

Ms. NS. Linda



Appendix 22: Abstract of the paper published from the study

Title: Significance of literature when constructing a theory: A selective literature review

Date: 2014

Authors

Linda¹, N.S. (MCUR) UWC

Phetlhu², D.R. (Associate Professor) UWC

Klopper³, H.C. (Professor UWC)

Abstract

The issues around use of literature in theory construction are often a source of confusion, especially for novice researchers. The very nature of the process of theory construction remains blurred due to lack of consensus among researchers. Novice researchers are often confronted with questions of whether or not a literature review should be conducted when constructing a theory. These questions seeking to justify what a credible methodology is when constructing a theory do not only challenge novice researchers but also experienced researchers' similarly. This article explores different perspectives regarding the significance of literature review in theory construction. A selective literature review was used to access and interrogate selected arguments from published peer-reviewed work. Narrative analysis was used to analyse selected text. It is concluded that literature plays a pivotal role in theory construction, whether by active review in the case of novice researchers or being sensitised by virtue of discipline interest and prolonged exposure in experienced researchers. However, it is important not to disregard the view that it is not necessary to incorporate literature review in certain specific designs due to assumed influence on the outcome of the new theory.

Keywords: literature, theory construction, selective literature review

Corresponding Author: Linda¹, N.S.; *School of Nursing, University of the Western Cape, Faculty of Community and Health Sciences, Bellville, Tel: 021- 959 3429; Fax: 021- 959 2679 email: nlinda@uwc.ac.za*

Short running head: Significance of literature when constructing a theory

Appendix 23: Abstract of the paper published from the study

Title: Students' Voices on Spiritual Care at a Higher Education Institution in the Western Cape

Date: 2015

Authors:

Ntombizodwa S. Linda¹

Hester C. Klopper¹

Deliwe R. Phetlhu¹

Background: Nurses have a moral obligation to ensure holistic care of patients, inclusive of the spiritual dimension. However, there seems to be a void in the teaching and learning of spiritual care in nursing curricula. Despite the South African Nursing Council being in favour of holistic nursing, there are no measures in place to ensure implementation of spiritual care, hence its practice is not standardised in nursing education in South Africa. Currently, the undergraduate nursing curriculum does not provide clear direction on how spiritual care in nursing should be integrated and the reason for this is not clear. It appears that the lack of professional regulation, difficulties in definition and the personalised nature of spiritual practice are partly responsible for its practice being barely enforced and scarcely practised by students when they are in clinical placements. The aim of the study was to develop a practice theory for teaching–learning of spiritual care in the undergraduate nursing programme. *Objectives:* The study objective was to describe and explore the students' experiences of teaching–learning of spiritual care in the undergraduate nursing programme. *Methods:* A qualitative, explorative, descriptive and contextual design with purposive sampling was used. The sample consisted of undergraduate nursing students at a University in the Western Cape Province. Measures for trustworthiness were applied. *Results:* The findings indicated a need to provide support, a conducive learning environment and structure for teaching, learning and practice of spiritual care. *Conclusion:* There is a need for formal education regarding spiritual care in nursing.

The font was changed from the article font "Palatino" to "Time New Roman" to meet the institution's technical presentation font style for thesis writing.

Appendix 24: Paper presented from the study

ANNUAL NURSING EDUCATION CONFERENCE (ANEC): OLIVE CONVENTION CENTRE DURBAN;
SOUTH AFRICA

Date: Sept 2-4 2015

Title: Nurse Educators' understands of spiritual care concept in the bachelor of nursing programme at a school of nursing in the Western Cape Province, South Africa.

Authors: Linda, NS., (UWC); Klopper, HC., (UWC) & Phetlhu, DR. (UWC)

Problem Statement: Lack of formal teaching-learning of spiritual care in nursing is widely documented presenting challenges that are invariably associated with inadequate preparation with teaching skills to address spiritual matters. Despite nurse educator's acceptance of lack of confidence in facilitation of spiritual care in the undergraduate nursing, most nursing schools particularly in South Africa have not formally integrated spiritual care education. *Aim and objective:* The aim of the study was to develop a practice theory for teaching-learning of spiritual care in the undergraduate nursing programme; this was achieved by exploring and describing the understanding of nurse educators and clinical supervisors about the concept of spiritual care in the formal preparation of nurses. *Methodology:* A qualitative, explorative, descriptive and contextual research approach was applied. Data was collected through in-depth interviews with nurse educators and clinical supervisors to inform development of a practice theory for teaching-learning of spiritual care in the UG nursing programme. *Results:* Emerged themes included (i) defining spirituality (ii) Spiritual care as a missing component in the BN curriculum (iii) Challenges in teaching-learning of spiritual care. *Discussion:* Participants' urge to define the concept "spirituality" to illustrate what it meant to them was crucial for subsequent discussion on how spiritual care is taught. A unified understanding of the concept enhanced acknowledgment of the need for spiritual care subject and their preparation for facilitation as essential.

Key Term: Defining spiritual care, Spirituality, Undergraduate Nursing Programme.

Appendix 25: Paper presented from the study

Global Network conference: Australia Sydney

Date: 11 -13 Dec 2014

Title: **Voices of the Bachelor of Nursing Students in Determining Teaching and Learning of Spiritual Care in the School of Nursing at a Higher Education Institution the Western Cape; South Africa**

Authors: Linda, NSB. (UWC); Phetlhu, DR. (UWC) & Klopper, HC. (UWC)

Key Terms: *Spiritual care, Undergraduate nursing curriculum, Practice theory, Theory generation,*

Background and context: Nurses have a moral obligation to take an active role in meeting the spiritual needs of their patients. However there seems to be some difficulty in teaching and assessing spiritual care in the provision of nursing. Consequence to this lack of teaching-learning of spiritual care student hardly practice it in the clinical placements as they feel inadequately prepared to engage in patients spiritual matters in undertaking such.

Problem Statement: Currently the undergraduate nursing curriculum does not clearly and effectively provide direction on how the spiritual care in nursing should be addressed and the reason for this is not clear. Despite the South African Nursing Council in favour of holistic nursing, however there are no measures to ensure its implementation in education of nurses and standardization of its practice in South Africa. Consequent to this oversight teaching of spiritual care is hardly enforced and hardly practiced by nursing student in clinical placements.

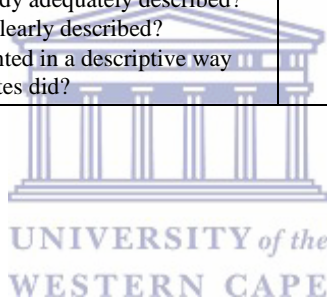
The aim of this paper is to share opinions and experiences of nursing student regarding their experience on teaching and learning of spiritual care in nursing undergraduate programme.

Methods and design: A qualitative theory generative, explorative, descriptive and contextual design was used to generate a practice theory. Data was collected through focus group interviews with student participants. *Sampling techniques:* The participants were included on receipt of a written informed consent and involvement in the R425 programme as regulated by SANC. The participants who were less than six months at the School of Nursing were excluded. *Ethical consideration and measures to ensure trustworthiness* were observed through obtaining the permission from the university Research Committes was obtained. Participants signed informed consent. *Rigour* was maintained through use of systematic research procedures according to qualitative research principles. *Findings* indicate a need for teaching, lerning and practice of spiritual care with the nursing profession.

Appendix 26: Evaluation Tool for the Research Study Method

Table 8.1: Evaluation Tool for the Nursing Research Study according to Burns & Grove (2009).

CRITIQUE PROCESS FOR QUALITATIVE RESEARCH	
CRITERIA FOR EVALUATION with Critique Guidelines	EVALUATOR COMMENTS
<p>STANDARD 1:</p> <p>DESCRIPTIVE VIVIDNESS</p> <p>a. Was the significance of the study adequately described?</p> <p>b. Was the purpose of the study clearly described?</p> <p>c. Were the interpretations presented in a descriptive way that illuminated more than the quotes did?</p>	



**STANDARD 2:
METHODOLOGICAL CONGRUENCE**

Substandard 2.1

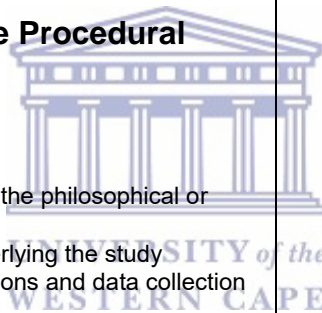
**Adequate Documentation of the
Participants**

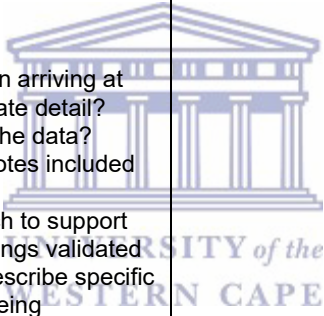
- a. Were the study participants described in detail?
- b. Was the selection of participants reasonable? Was a rationale provided for participant selection?
- c. Was the context and location of the study described with sufficient detail to determine if the findings are applicable to other settings?

Substandard 2.2


**Careful Attention to the Procedural
Approach**

- a. Did the researchers identify the philosophical or theoretical base of the study?
- b. Were the assumptions underlying the study articulated? Were the assumptions and data collection procedures congruent?
- c. Was adequate trust established with the participants? Was there an open dialogue with a conversational approach to data collection?
- d. Were research questions articulated? Did the researcher ask questions that explore participant's experiences, beliefs, values, or perceptions?
- e. Was the data collection process adequately described?
- f. Did the researcher spend sufficient time with participants gathering data? Did the researcher conduct multiple interviews?
- g. Was the approach of multiple data collectors similar?
- h. Was the method of selecting and gaining



<p>access to the study participants reasonable?</p> <p>i. Was the role of the researcher during the interview process described? Were the researcher(s) qualitative credentials and expertise described?</p> <p>Substandard 2.3</p> <p>Adherence to Ethical Standards</p> <p>a. Were participants informed of their rights?</p> <p>b. Was informed consent obtained?</p> <p>c. Were participants rights protected?</p> <p>Substandard 2.4</p> <p>Auditability</p> <p>a. Was the decision trail used in arriving at conclusions described in adequate detail? Can the findings be linked with the data?</p> <p>b. Were enough participant quotes included to support the findings?</p> <p>c. Were the data sufficiently rich to support the conclusions? Were the findings validated by data? Did the participants describe specific examples of the phenomenon being investigated?</p>	
<p>STANDARD 3: ANALYTICAL AND INTERPRETATIVE PRECISENESS</p> <p>a. Do the categories, themes, or findings present a whole picture? Did the findings yield a meaningful picture of the phenomenon under study?</p> <p>b. Were the findings returned to participants or experts in the area?</p> <p>c. Did two or more researchers participate in data analysis? How were disagreements about data analysis handled?</p>	

<p>STANDARD 4: PHILOSOPHICAL OR THEORETICAL CONNECTEDNESS</p> <p>a. Was a clear connection made between the data and nursing practice? b. Did the researcher identify the philosophical or theoretical basis for the study? Were citations provided for the philosophical or theoretical approach used? c. Was the philosophical or theoretical basis of the study consistent with the study assumptions, data collection process, and analysis and interpretative methods used? Were citations provided for the philosophical or theoretical approach used?</p>	
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<p>STANDARD 5: HEURISTIC RELEVANCE</p> <p>Substandard 5.1 Intuitive Recognition</p> <p>a. Can the reader recognize the phenomenon described in the study? b. Are the findings consistent with common meanings or experiences?</p> <p>Substandard 5.2 Relationship to the Existing Body of Knowledge</p> <p>a. Did the researcher adequately examine the existing body of knowledge? b. Did the researcher compare and contrast the findings with those of other studies? c. Did the researcher describe the lacunae or omissions in current understandings that would account for unique findings?</p> <p>Substandard 5.3 Applicability to Nursing Practice,</p>	
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<p>Research, or Education</p> <p>a. Are the findings relevant to nursing practice, research, or education?</p> <p>b. Did the reader learn more than had been previously reported in the literature?</p> <p>c. Do the findings have implications for related cases?</p> <p>d. Are suggestions for further study identified?</p>	
<p>SUMMARY COMMENTS</p>	

NB: The use of the selected tool for evaluation was described and the research for its selection explained in relation to the standards criteria of the tool.

