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Article

Development and Psychometric Evaluation of a Spiritual Care Simulation and Companion Performance Checklist for a Veteran Using a Standardized Patient

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KEYWORDS

nursing education;
simulation;
spiritual care;
standardized patient;
veteran

Abstract

Background: Spiritual care is a professional mandate in nursing. Patients want and benefit from spiritual care, but nurses report lack of education and uncertainty on how to integrate spiritual care into practice. Simulation can evaluate nurses' ability to provide spiritual care but must be evidence-based and requires psychometric evaluation.

Method: A spiritual care simulation for a veteran and performance checklist were created based on literature review and were psychometrically evaluated. Forty RNs participated in the simulation and completed the Spiritual Care Inventory. The participants, the standardized patient and independent observer completed the performance checklist.

Results: Findings supported content, face, construct and predictive validity as well as interrater reliability.

Conclusions: Simulation can be used to teach spiritual care.

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Spiritual care is a professional mandate in nursing (American Nurses Association, 2010). Patients want and benefit from spiritual care, but nurses report being unsure how to integrate spiritual care in practice (Gallison, Xu, Jurgens, & Boyle, 2013; Pearce, Coan, Herndon, Koenig, &

Abernethy, 2012; Rushton, 2014). Spiritual care incorporates both holistic and cultural/religious care required in the *Nursing Scope and Standards of Practice* (2010) by American Nurses Association (2010). Spiritual care education is also included in four provisions of *The Essentials of Baccalaureate Education for Professional Nursing Practice* (American Association of Colleges of Nursing, 2008). In order for nurses to provide spiritual care, it must be taught in nursing education and supported in practice.

Research suggests that nurses are uncertain about providing spiritual care because of lack of practice guidelines, education in nursing school, and training in practice (Rushton, 2014). Nurses are concerned that spiritual care may be viewed as preaching and are unsure how to provide spiritual care, particularly if the patient has a different faith tradition than their own (Gallison et al., 2013). Institutional barriers are also a concern, including inadequate time, lack of privacy, and lack of organizational support to address spiritual concerns (Gallison et al., 2013; Rushton, 2014).

Patients want spiritual care from their health care providers, particularly those with chronic illness and at end of life, and are more satisfied when they receive spiritual care (Pearce et al., 2012). Research indicates that veterans want spiritual care to cope with military experiences and chronic health issues (Bonner et al., 2013; Chang et al., 2012). There are approximately 23 million veterans in the United States and Puerto Rico, with about eight million veterans receiving care through the Veterans Health Administration (Anthony, Carter, Freundl, Nelson, & Wadlington, 2012, p. e145). It is essential that nurses in both civilian and Veteran Administration (VA) health systems understand how to tend to the unique spiritual needs of veterans.

Simulation is an educational technique that provides an opportunity to assess whether nurses can address the spiritual care needs of their patients. The challenge in using simulation is to first define what is Spiritual Care in Nursing Practice (SCiNP) and operationalize that definition in a simulation and performance checklist (Kerns & Dhingra, 2012). Because spiritual care is relationship based and requires the nurse's caring presence with a patient, it is best to use a live

person as the patient (Burkhart & Hogan, 2008; Watson, 2008). Previous studies have successfully used simulation with standardized patients (SPs), faculty, and students to play patient and family roles in spiritual care end-of-life and mother/baby scenarios (Costello, Atinaja-Faller, & Hedberg, 2012; Fink, Linnard-Palmer, Ganley, Catolico, & Phillips, 2014). Use of SPs has been successful in addressing the relationship-based dimension of spiritual care.

More research is needed to develop and psychometrically evaluate a spiritual care simulation and companion performance checklist. Therefore, this study used a literature review, content validity, and the International Nursing Association for Clinical Simulation and Learning (INACSL) Standards of Best Practice: SimulationSM to develop and evaluate a spiritual care simulation and companion performance checklist for a veteran at risk for spiritual distress (Herdman & Kamitsuru, 2014; www.nursingsimulation.org).

Theoretical Framework

The SCiNP theory (Burkhart & Hogan, 2008) considers spiritual care as an intentional process when a nurse recognizes patient's verbal, nonverbal, and situational cues for spiritual need, intentionally decides to engage with the patient, and provides spiritual interventions designed to promote connectedness to self, others, and/or a higher power to facilitate patient's search for meaning and purpose in life. The spiritual encounter also affects the nurse, leading to an emotional response after encounter, requiring self-reflection and meaning making to facilitate the nurse's own spiritual well-being. The ability of the nurse to find meaning and purpose in providing spiritual care will affect their willingness to engage in future spiritual encounters with patients (Burkhart & Hogan, 2008).

The SCiNP theory guided the development of the simulation and checklist in that the simulation script included patient cues for needing spiritual care, and the companion Spiritual Care Cue and Intervention Checklist (SCCL) listed the nursing spiritual care interventions in response to the patient cues. The SCiNP theory defines human spirituality as the search and reflection of meaning and purpose in life through connections with self, others, arts/music, nature, and/or higher power (Burkhart & Hogan, 2008; Herdman & Kamitsuru, 2014). This search includes one's values, beliefs, mission, and facilitates meaning that transcends the moment toward a future with greater meaning, which may or may not involve a deity (Burkhart & Schmidt, 2012; Frame, 2003).

Study

The study was conducted in three phases. Phase 1 consisted of a literature review to identify patient cues and nursing interventions and the development of a simulation script and

Key Points

- Veterans have unique spiritual care needs when hospitalized.
- Development and psychometric evaluation of an evidence-based spiritual care and companion performance check list requires a methodical process.
- It is possible to teach spiritual care using simulation with a standardized patient.

the SCCL based on that review. Both were evaluated by content experts and refined based on the expert feedback. In phase II, the simulation was developed and pilot tested. In phase III, the simulation and checklist was implemented with a sample of 40 RNs to examine psychometric properties (i.e., interrater reliability and construct and predictive validity).

Phase I: Development of Simulation Script and Checklist

A literature review was conducted using Cumulative Index to Nursing and Allied Health Literature, PubMed, Scopus, PsycINFO, and ERIC databases from 2002 to 2016. These databases were searched using variations on the terms: spirituality, spiritual care, simulation, and veterans. In addition to research, the VA Web site (www.va.gov) was searched for documents related to spiritual care.

The literature review supported seven central concepts related to patient cues and nursing interventions for spiritual care: anxiety, physical suffering, coping with fears, the presence of meaningful objects, connection to veteran culture, connection with family/friends, and connection with higher power/faith rituals. The literature also indicated examples of patient cues and nursing interventions that exemplified each central concept, as shown in [Table 1](#). Drafts of the simulation script and performance checklist were developed based on this literature review. Two expert nurse educators at the VA reviewed the draft list of cues and interventions and provided additional clarity to ground the examples of the central concepts in veteran care.

Simulation Scenario

The clinical simulation scenario was an individual mini-case—focused assessment scenario designed to last ten minutes ([Gordon, 2012](#)). The central event involved a Vietnam era veteran patient at risk for spiritual distress who was one-day postcolectomy, diagnosed with colon cancer, and anxiously awaiting the prognosis and treatment plan from the surgeon, who was delayed for eight hours. The patient was a 64-year-old male, African American, baptist, with a new onset of colon cancer who also had several chronic health conditions, including chronic obstructive pulmonary disease, diabetes, and posttraumatic stress disorder, which is consistent with typical demographics and medical conditions of a Vietnam veteran ([Centers for Disease Control and Prevention, 2016](#); [RAND Corporation, 2015](#)). He had a family history of colon cancer (brother and father both of whom died from the disease). He is married and has a daughter and a grandchild who live out of the town. He is a retired marine who is active with veteran groups (www.rollingthunder1.com). The patient's nasogastric tube was discontinued that morning, and his pain is well managed with oral medication. A VA nurse education

expert reviewed the simulation-focused assessment and script scenario for face validity, and a VA pharmacist confirmed the accuracy and appropriateness of the medication list.

Content Validity

Content experts rated each patient cue in the script and related nursing interventions checklist using the content validity index method ([Polit, Beck, & Owen, 2007](#)). That is, experts were selected based on their clinical expertise with veterans and spiritual care and/or scholarly research in spiritual care, as described in [Table 2](#) ([Grant & Davis, 1997](#)). Different content experts were purposely chosen in each round to best address the further refinement required. During each round of evaluation, content experts rated script and checklist items on a 4-point Likert scale (1 = does not reflect and 4 = completely reflects) as they related to each respective spiritual care central concept. The script and SCCL were iteratively revised until 100% scale item content validity index/average was achieved. Five rounds were conducted to finalize the script ([Appendix A](#)) and SCCL ([Appendix B](#)), as described in [Table 2](#).

Phase II: Developing the Simulation

The simulation was developed following the INACSL Standards of Best Practice: SimulationSM, which included the objectives, prebriefing, SP training, and debriefing scripts (www.nursingsimulation.org). The simulation and checklist were piloted tested with student nurses and practicing RNs to ensure face validity, flow, timing, equipment, and data collection procedures. The simulation was conducted by an RN researcher who had 32 years of clinical experience, two masters' degrees in nursing and spirituality, five years' educational experience with simulation, and completion of University of Washington simulation education modules (collaborate.uw.edu). Approval was obtained by a Midwest VA Health System and the university institutional review boards to conduct the study.

Learning Objectives

RN participants were told to perform an initial nursing assessment of the veteran (played by a simulated standardized patient) who was postoperative day 2 S/P colectomy (diagnosed with colon cancer). The overall learning objective was to recognize the patient's spiritual care cues and perform spiritual care interventions.

Prebriefing

Participants were oriented to the simulation environment from the control room, and all questions were answered (five minutes). Participants had ten minutes to review a

Table 1 Spiritual Care Cue Script and Intervention(s) Checklist Development Summary

Central Concepts (Based on the Literature)	Patient Cue(s) for at Risk for Spiritual Distress as Operationalized in Simulation Script	Nursing Spiritual Care Intervention(s)
Anxiety: a feeling of apprehension caused by anticipation of danger (Herdman & Kamitsuru, 2014, p. 323)	<p><i>Situational cues for anxiety:</i> Colon cancer diagnosis</p> <p><i>Verbal cues</i> (Herdman & Kamitsuru, 2014):</p> <ul style="list-style-type: none"> • Verbalizes having a bad morning • Surgeon delayed telling him his test results • Asks nurse if he/she knows test results • Hopes results are not bad <p><i>Nonverbal cues</i> (Herdman & Kamitsuru, 2014):</p> <ul style="list-style-type: none"> • Tapping hands on tray table anxiously • Wringing hands • Wipes tears out of eyes 	<ul style="list-style-type: none"> • Pauses (Deal & Grassley, 2012) • Makes eye contact (Deal & Grassley, 2012) • Listens to patient (Wallace et al., 2008) • Provides a comforting touch (Deal & Grassley, 2012) • May state a supportive statement (Wallace et al., 2008)
Physical suffering: an individual's experience of threat to self and is a meaning given to events such as pain or loss (Kahn & Steeves, 1986, p. 623)	<p><i>Verbal cues</i> (Smyth & Allen, 2011):</p> <ul style="list-style-type: none"> • Verbalizing he had a terrible night; did not sleep <p><i>Nonverbal cues</i> (Taylor, Park, & Pfeiffer, 2014):</p> <ul style="list-style-type: none"> • Blank stare and withdrawal 	<ul style="list-style-type: none"> • Provides comfort measures (Burkhart & Hogan, 2008) • Stops tasks (Deal & Grassley, 2012) • Makes eye contact (Deal & Grassley, 2012) • Listens to patient (Wallace et al., 2008) • Provides a comforting touch (Deal & Grassley, 2012) • May state a supportive statement (Wallace et al., 2008) • Encourages to talk about fears (Wallace et al., 2008) • Stops tasks, eye contact (Deal & Grassley, 2012; Giske & Cone, 2012) • Listens to patient (Wallace et al., 2008) • Observes sleep trends (Smyth & Allen, 2011) • Offers patient music/headset (Ahmadi, 2013)
Fears: response to perceived threat that is consciously recognized as a danger (Herdman & Kamitsuru, 2014, p. 336)	<p><i>Verbal cues</i> (Herdman & Kamitsuru, 2014):</p> <ul style="list-style-type: none"> • Fear of test results, family history of colon cancer • Wants to go home (Smyth & Allen, 2011) • Poor sleep since Vietnam • Music helps in coping/sleep (Ahmadi, 2013) <p><i>Nonverbal cues:</i></p> <ul style="list-style-type: none"> • Yawning • Headset for his music on nightstand 	<ul style="list-style-type: none"> • Pauses, makes eye contact (Deal & Grassley, 2012; Giske & Cone, 2012) • Listens to patient (Wallace et al., 2008) • Provides a comforting touch (Deal & Grassley, 2012) • Helps him put blanket on bed. Recognize importance of brother's blanket (Burkhart & Hogan, 2008; Wallace et al., 2008) • Asks about/recognizes importance of the blanket (Deal & Grassley, 2012; Wallace et al., 2008) • Recognizes his marine status/asks about/recognizes the importance of service, trip (Chang et al., 2012) • Thanks them for their service • Pauses, makes eye contact (Deal & Grassley, 2012) • Listens (Wallace et al., 2008) • Provides comforting touch (Deal & Grassley, 2012)
Meaningful object: patient behaviors indicating a search for meaning and connection to others through meaningful objects (Burkhart & Hogan, 2008)	<p><i>Verbal cues:</i></p> <ul style="list-style-type: none"> • States that he is cold, requests blanket that his deceased brother gave him. He wishes his brother was with him (Wallace et al., 2008) <p><i>Nonverbal cue:</i></p> <ul style="list-style-type: none"> • Blanket his brother gave him on chair (Wallace et al., 2008) 	<ul style="list-style-type: none"> • Pauses, makes eye contact (Deal & Grassley, 2012; Giske & Cone, 2012) • Listens to patient (Wallace et al., 2008) • Provides a comforting touch (Deal & Grassley, 2012) • Helps him put blanket on bed. Recognize importance of brother's blanket (Burkhart & Hogan, 2008; Wallace et al., 2008) • Asks about/recognizes importance of the blanket (Deal & Grassley, 2012; Wallace et al., 2008) • Recognizes his marine status/asks about/recognizes the importance of service, trip (Chang et al., 2012) • Thanks them for their service • Pauses, makes eye contact (Deal & Grassley, 2012) • Listens (Wallace et al., 2008) • Provides comforting touch (Deal & Grassley, 2012)
Veteran culture: patient behaviors indicating a veteran status because of past active military service or indicating a present connection to veteran groups (Veterans Authority, 2017)	<p><i>Environmental cues</i> (Burkhart & Hogan, 2008; Chang et al., 2012):</p> <ul style="list-style-type: none"> • Marine/Vietnam hat at bedside • Picture of Veteran friends at bedside <p><i>Verbal cues:</i></p> <ul style="list-style-type: none"> • Asks for Vietnam hat 	<ul style="list-style-type: none"> • Pauses, makes eye contact (Deal & Grassley, 2012) • Listens (Wallace et al., 2008) • Provides comforting touch (Deal & Grassley, 2012)

(continued on next page)

Table 1 (continued)

Central Concepts (Based on the Literature)	Patient Cue(s) for at Risk for Spiritual Distress as Operationalized in Simulation Script	Nursing Spiritual Care Intervention(s)
Family/social support: patient behaviors of indicating a need for family or social support. Social support is helpful, protective, mutual relationships that enhance one's sense of comfort (Langford, Bowsher, Maloney, & Lillis, 1997)	<ul style="list-style-type: none"> • Talks about being a marine in Vietnam • States lost friends in war • States brother was shot in Vietnam and survived • Looking forward to planned motorcycle trip with veteran group (Burkhart & Hogan, 2008; Chang et al., 2012) <p><i>Environmental cues:</i></p> <ul style="list-style-type: none"> • Picture of family on nightstand • Cell phone on bedside table <p><i>Verbal cues</i> (Chang et al., 2012; Deal & Grassley, 2012):</p> <ul style="list-style-type: none"> • Married, concern about wife not at hospital yet • Asks nurse if she/he could call wife • Has dog, daughter. Does not want to worry daughter <p><i>Nonverbal cues</i> (Smyth & Allen, 2011):</p> <ul style="list-style-type: none"> • Crosses arms when talks about his daughter; smiles when talks about veteran friends 	<ul style="list-style-type: none"> • Invites conversation related to service or trip plans (Burkhart & Hogan, 2008; Chang et al., 2012) • Pauses, makes eye contact (Deal & Grassley, 2012) • Sits in chair (Deal & Grassley, 2012) • Listens (Wallace et al., 2008) • Provides a comforting touch (Deal & Grassley, 2012) • Recognizes importance of pets (Smyth & Allen, 2011) • Offers to call family or friend (Chang et al., 2012) • Encourages him to reach out to family/friends (Chang et al., 2012)
Higher power/faith rituals: patient behaviors indicating a need to participate in rites and rituals associated with a faith tradition (Burkhart & Hogan, 2008)	<p><i>Environmental cues</i> (Smyth & Allen, 2011):</p> <ul style="list-style-type: none"> • Bible at bedside <p><i>Verbal cues:</i></p> <ul style="list-style-type: none"> • Uses religious words • Accepts offer for chaplain (The Joint Commission [TJC], 2014). • States importance of scripture and church community support and prayer (Deal & Grassley, 2012; Wallace et al., 2008) <p><i>Nonverbal cues</i> (Smyth & Allen, 2011):</p> <ul style="list-style-type: none"> • Opens hands and makes sign of cross when referring to God 	<ul style="list-style-type: none"> • Pauses, makes eye contact (Deal & Grassley, 2012) • Sits in chair (Giske & Cone, 2012) • Listens (Wallace et al., 2008) • Provides comforting touch (Deal & Grassley, 2012) • Acknowledges fears (Wallace et al., 2008) • Offers to call the chaplain (TJC, 2014) • Suggests calling home pastor (Deal & Grassley, 2012; TJC, 2014) • Prays with patient (Taylor et al., 2014) • Supports use of faith rituals, as appropriate (Deal & Grassley, 2012)

Table 2 Spiritual Care Cue Script and Intervention Checklist Content Validity Summary

Review Elements	Content Validity				Final Tool
	Review 1	Review 2	Review 3	Review 4	Review 5
Reviewers	3 VA experts 2 RNs 1 Chaplain	3 VA RN experts	5 RN experts 2 VA 3 Academics	Same experts as round 3	4/5 RNs from reviews 3 & 4
Total items	35 items	Revised items from 35 to 22 items	Revised items from 22 to 21 items	Revised items from 21 to 19 items	12-item tool
Number of patient cues	7	7	7	7	7
Number of spiritual care interventions	28	15	14	12	12
S-I-CVI/Ave	0.46	0.77	0.88	1.0	1.0

Note. S-I-CVI/Ave = scale item content validity index/average; VA = Veteran Administration.

standard focused assessment describing the patient history, diagnosis, current vital signs, medications, and situation ([Appendix A](#)) (www.nursingsimulation.org).

Standardized Patient

The veteran was played consistently by the same male professional actor who was trained as an SP, with ten years of SP experience. The SP participated in three training workshops (totaling 14.5 hours), which included reviewing the script, colon cancer patient information, veteran spiritual needs, debriefing procedures, and SCCL completion.

Equipment

To enhance fidelity, the INACSL Standards of Best Practice: SimulationSM were used in the simulation design (www.nursingsimulation.org). The simulation laboratory located on the VA campus is a well-lit enclosed room, which included a bed, nightstand, two chairs, and tray table to resemble an inpatient hospital room. Props used for the scenario included family pictures, bible, music headset, and brother's blanket, in addition to typical medical supplies ([Appendix A](#)). The control room was adjacent to the simulation laboratory with a one-way mirror and portable speaker system, which allowed for visualization and communication between the observer and the RN and simulated patient. Only two researchers were in the control room to reduce noise. There was adequate space in the simulation laboratory for debriefing. A checklist and photo of the environment were used to ensure consistent room setup ([Appendix A](#)).

Debriefing

The Plus-Delta debriefing method provided the best method to meet the learning objectives of recognizing spiritual patient cues and providing nursing interventions (www.nursingsimulation.org). The RN participant and the SP completed the SCCL and a Plus-Delta form to write

down what went well and what could be improved before verbal debriefing. The facilitator used a script to guide the debriefing process ([Appendix C](#)). Debriefing began by asking the participant for an initial emotional response. Both the participant and SP described what went well in the simulation sequentially and then both described what could be improved.

Pilot Testing

Eight pilot simulations were conducted. Participants included five RNs and three VA capstone student nurses during two days. Each participant was asked scripted questions to evaluate flow and timing of the prebriefing, simulation, and debriefing. Findings indicated acceptable flow and timing and a positive evaluation. The RNs stated that the script and SCCL sufficiently represented and measured spiritual care for a veteran ([Polit & Beck, 2008](#)).

Phase III: Psychometric Evaluation of Final Simulation and Checklist

In phase III, the simulation was conducted with 40 RN participants to measure the interrater congruence of the SCCL and whether the simulation increased the participants' perceived ability to provide spiritual care, as intended ([Kerns & Dhingra, 2012](#); [Polit & Beck, 2008](#)).

Sample

A convenience sample of RNs employed at a Midwest VA health care facility was recruited for this study using an initial broadcast e-mail, presentations at 14 unit-level staff meetings, and one shared governance meeting. To be included as a participant, an RN had to provide direct care for veterans with chronic conditions and had to hold at least 0.5 full-time equivalent. Participants with a personal relationship with the researchers or SP were excluded. It

took one month to recruit 40 participants, which exceeded the G-Power estimated sample size of 39 participants required at 0.95 power for the Spiritual Care Inventory (SCI) (Burkhart & Schmidt, 2012).

Variables and Instrumentation

Performance of spiritual care interventions was measured using the SCCL as performed or not performed, as described in phase 1. Perceived ability to provide spiritual care was measured using the SCI, which is a 17-item instrument that measures perceived ability to provide spiritual interventions (four items), engage in meaning making activities (ten items), and faith rituals (three items) after spiritual encounter (Burkhart, Schmidt, & Hogan, 2011). Each item is measured on a 5-point Likert scale, where 1 is strongly disagree and 5 is strongly agree. The tool was developed based on the grounded theory study by Burkhart and Hogan (2008) with published psychometric support (Burkhart et al., 2011). For this study, internal consistency remained high for the overall tool SCI (alpha = 0.94) and each subscale (spiritual care interventions [alpha = 0.89], meaning making [alpha = 0.93], and faith rituals [alpha = 0.88]). The simulation was designed to increase spiritual care interventions and meaning making subscales but was not expected to affect the faith rituals subscale.

Data Collection

Each RN participant was scheduled for approximately one hour in the simulation laboratory. Data collection occurred in five steps. The participant completed the consent, demographic survey, and pre-SCI instrument; orientation to the simulation environment; and completed the prebrief (30 minutes). Each participant experienced the simulation with the SP, whereas the independent observer (IO) watched the simulation through a two-way mirror and completed the SCCL (ten minutes). After the simulation, the RN participant and SP independently completed the SCCL and a Plus-Delta form (five minutes). The IO, who was the RN researcher, then facilitated the debriefing session with the RN participant and SP (ten minutes). After debriefing, the RN participant completed the post-SCI instrument.

Analysis

Congruence of RN-, SP-, and IO-perceived performance of spiritual care interventions was measured between two pairs of raters (RN-SP and RN-IO) using Cohen’s kappa (Cohen, 1960) and between three raters (RN-SP-IO) using Fleiss kappa (Fleiss, 1971). Landis and Koch (1977) benchmarks for kappa to interpret the strength of rater agreement are as follows: <0.0 poor; 0.0 to 0.20 slight; 0.21 to 0.40 fair; 0.41 to 0.60 moderate; 0.61 to 0.80

substantial; and 0.81 to 1.0 almost perfect (p. 165). For simulation, the kappa benchmark was 0.7 to 1.0 (Kerns & Dhingra, 2012, p. 82). However, kappa could not be calculated when there was a perfect or near-perfect agreement. Therefore, percent match was also calculated to provide additional evaluation of interrater reliability (Cicchetti & Feinstein, 1990; McHugh, 2012). Construct validity is supported when RN participants, SP and IO, reach this benchmark, as all agree that the central concepts from phase I of the study exist (Polit & Beck, 2008). Predictive validity was evaluated using dependent paired *t* test of the SCI prescore and postscore.

Results

The final sample included 40 RNs, as shown in Table 3. Participant’s age was on average 52.6 (SD = 8.77, range = 27-65), female, and Caucasian. Participants were employed on average nine years at the VA and practiced nursing on average 25 years.

Congruence among Raters

Interrater reliability between RN-SP-IO, RN-SP, and RN-IO is shown in Table 4. Three nursing interventions consistently met benchmarks, indicating strong interrater reliability and construct validity: anxiety (100% match), physical suffering (97%-100% match), and chaplain referral (82%-92% match; Fleiss, 0.761; and Cohen’s kappa, 0.745-0.847). One intervention, *noticing or offering the bible*, only met benchmark between the RN and

Table 3 Demographics

Participant Demographics	n (%)
Gender	
Female	37 (92.5)
Male	3 (7.5)
Ethnicity	
African American	1 (2.5)
Asian	13 (32.5)
Caucasian	21 (52.5)
Hispanic	5 (12.5)
Religion	
Catholic	24 (60)
Noncatholic Christian	13 (32.5)
None	3 (7.5)
Highest level education	
Associate or diploma degree	5 (12.5)
Bachelor’s degree	22 (55)
Master’s degree	13 (32.5)
Current specialty area at VA	
Outpatient	19 (47.5)
Inpatient/operating room	21 (52.5)

Table 4 RN–SP–IO, RN–SP, and RN–IO Interrater Congruence

Central Concepts	RN–SP–IO		RN–SP		RN–IO	
	n (Raw %)	Kappa (<i>p</i>)	n (Raw %)	Kappa (<i>p</i>)	n (Raw %)	Kappa (<i>p</i>)
Anxiety	39 (100%)*	No kappa	39 (100%)*	No kappa	39 (100%)*	No kappa
Physical suffering	38 (97%)*	−0.009 (.925)	38 (97%)*	No kappa	38 (100%)*	No kappa
Chaplain	39 (82%)	0.761 (<.001)†	39 (87%)	0.745 (<.001)†	39 (92%)	0.847 (<.001)†
Bible	33 (76%)	0.676 (<.001)	33 (79%)	0.585 (<.001)	33 (91%)	0.816 (<.001)†
Social support	36 (69%)	0.591 (<.001)	37 (81%)	0.628 (<.001)	37 (76%)	0.504 (.002)
Religion	38 (76%)	0.41 (<.001)	38 (79%)	0.269 (.015)	38 (84%)	0.533 (<.001)
Music	38 (53%)	0.367 (<.001)	38 (61%)	0.252 (.082)	38 (79%)	0.559 (<.001)
Veteran culture (past)	38 (53%)	0.348 (<.001)	38 (66%)	0.258 (.106)	38 (61%)	0.219 (.162)
Meaningful object	37 (57%)	0.123 (.197)	37 (68%)	0.136 (.233)	37 (73%)	0.337 (.025)
Family support	38 (61%)	0.090 (.334)	38 (66%)	0.089 (.185)	38 (66%)	0.151 (.249)
Veteran culture (present)	39 (31%)	0.076 (.409)	39 (67%)	0.235 (.141)	39 (46%)	0.113 (.238)
Fears	37 (59%)	0.024 (.799)	37 (68%)	0.224 (.11)	37 (84%)	No kappa

Note. IO = independent observer; SP = standardized patient.

The variation in sample size is due to missing data.

* Items with no kappa that meet threshold.

† Meets kappa threshold 0.7 to 1.0 (Kerns & Dhingra, 2012; Landis & Koch, 1977) and is statistically significant (provided in bold).

IO (91% match; kappa, 0.816; $p < .001$) but did not meet benchmark between RN and the SP. This suggests that two nurses agreed that this care was provided, but the RN participant and SP disagreed. The remaining eight nursing interventions did not meet benchmarks for interrater reliability. This indicates that the RN, SP, and IO perceive this care differently in the same simulation.

Pre–Post SCI

Findings indicated a statistically significant increase in SCI total score ($p < .001$), spiritual intervention subscale ($p = .004$), and meaning making subscale ($p < .001$) after participating in the simulation experience (prebriefing, simulation, and debriefing). As expected, there was no statistically significant change in the faith rituals subscale ($p = .181$).

Discussion

This research described a methodical process to develop a theoretically grounded and evidence-based spiritual care simulation and performance checklist. Each step toward creating the simulation was psychometrically tested. The process began with a scoping literature review of the central concepts of spiritual care. These concepts were translated into a script and performance checklist, which was validated using content experts and practicing RNs. The script and checklist was integrated into a simulation with an SP. This step was psychometrically supported through SP training and pilot testing. Each step was scripted and consistently followed. Finally, the full simulation (i.e., prebriefing, simulation with performance checklist, and debriefing) was evaluated using a sample of practicing RN

participants. This final psychometric evaluation of the simulation supported construct validity of three spiritual care interventions (addressing anxiety, physical suffering, and chaplain referral) and predictive validity in that the simulation demonstrated its intended effect by increasing the participant's perceived ability to provide spiritual care.

The simulation further developed an understanding of SCiNP. This research supported that spiritual care interventions consistently address anxiety, physical suffering, and chaplain referral, with some recognition of promoting religious practices. Interventions that help the patient find meaning and purpose in life (i.e., supporting veteran culture, coping using music, recognizing meaningful objects, supporting family connection, and addressing patient fears) were not consistently perceived. This may indicate that interventions the RN performed may not be perceived or received by the patient, and/or the patient may experience spiritual interventions that the RN did not remember was performed or did not perform. This is consistent with the literature in that differences in human perception of interpersonal relationships and human connection may require finer judgments that may not be captured in this performance checklist (McHugh, 2012; Wasson, Parsi, McCarthy, Siddall, & Kuczewski, 2015).

The strength of the SCCL is that it raised the RN participant awareness of spiritual interventions that were later discussed during the debriefing. Both the SCCL and Plus-Delta were used in the debriefing process to further explore the patient cues and spiritual interventions performed/not performed. This provided the opportunity to explore the central concepts of spiritual care in a reflective face-to-face format. Consistent with the theory, debriefing provided an opportunity to express their emotional response and was a time to search for meaning experienced in the simulation, which could lead to an

increase in the ability to provide spiritual care. This effect was further supported by a statistically significant increase in the SCI intervention and meaning making subscales after simulation.

Limitations

Several limitations were identified in this study. The sample included RNs who only worked at one VA site and may not represent all VA RNs or all RNs. Also, the SP went off script during four simulations. Specifically, the SP requested to read his bible, rather than waiting for the nurse to notice the bible. These measurements on the SCCL were deleted from the analysis. This was consistently discussed with the SP after each error. This limitation is common in that SPs want to help students during the simulation, although they know that they must stay on script (Jarosinski & Webster, 2016).

For several checklist items, kappa could not be calculated. The kappa statistic requires that the data (performed and not performed) be symmetrically distributed. Extreme agreement or disagreement causes an imbalance in the kappa calculation, which leads to an unrealistic agreement estimate (Cicchetti & Feinstein, 1990). Therefore, percent agreement is the more meaningful indicator. However, it is important to critically evaluate this statistic, as percent agreement includes agreement because of random chance (Cicchetti & Feinstein, 1990; McHugh, 2012).

Conclusion

This study provides a methodical process for developing and psychometrically evaluating a spiritual care simulation in each phase of its development. In its final form, the simulation has the capability to increase the provision of spiritual care. The simulation also deeply affected RN participants. Many described being fully immersed in the simulation, feeling that the SP was real and, as a result, experienced a strong emotional response. Many participants did not want to leave the patient at the conclusion of the simulation and expressed relief when they saw the SP during the debriefing. This simulation not only supported education in providing spiritual care, particularly for the veteran population, but also supported the importance of the reflective dimension of debriefing to support nurses' spiritual care meaning making.

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Appendix A

Focused Assessment

RN Participant Objectives

Perform an initial nursing assessment of simulated standardized patient postoperative day 2 status post colectomy (diagnosed with colon cancer). The nurse is beginning a 0730 to 1600 shift, and this is her and/or his first morning encounter with this patient. The standardized patient will be in a hospital gown and sweatpants lying in the bed with a saline lock in left forearm.

Name: John Bell MR# 000123; *DOB:* 12/17/1952; *Allergies:* No known allergies; *Code status:* Full code; *Marital status:* M; *Religion:* Baptist; and *Race:* African American.

Military Service: Vietnam—Marine; *Employment:* Retired.

Past medical Hx: PTSD, HTN, COPD, Type 2 DM; *Alcohol use:* Social; *Tobacco:* Quit 20 years ago; *Height:* 5' 8" *Weight:* 155 lbs; *Family Hx:* Father/brother died of colon cancer.

Emergency contact: Hollie Bell; *Relationship:* Spouse.

Phone: 708-222-2222 (home); 708-222-2223 (cell)

Second contact: Rochelle Jones; *Relationship:* Daughter.

Phone: 272-333-3333 (home); 272-333-2333 (cell)

Scenario

The patient presents to your medical—surgical unit postoperative day 2 after a colectomy for colon cancer. Mr. Bell knows he has cancer. Pathology reports to determine prognosis and treatment are pending. The patient has hypoactive bowel sounds, complaining of mild incisional pain (last received two 5/325 mg Norco tablets 45 minutes ago for a pain rating of 5/10); otherwise without complications. Nasogastric tube and Foley catheter discontinued this morning at 0600. IV saline lock patient in left forearm. Abdominal dressing is dry. Incision approximated and glued with steri-strips. Incentive Spirometer is at the bedside. *Diet:* Clear liquid, advance as tolerated. *Morse rating:* 45. His wife of 40 years plans to arrive later this morning.

Orders

Saline lock; vital signs every four hours; dry abdominal dressing to surgical site—change daily and prn; D/C oxygen; notify health care provider for SBP <100, HR >120, temperature >100.5, and SPO₂ <94%. Call health care provider if no void six hours after Foley catheter discontinued. Activity ordered is up as tolerated with one assist. Accucheck four times a day, before meals and at bedtime.

Medications:

- Lisinopril 10 mg by mouth daily
- Symbicort 160/4.5 two puffs by mouth twice a day
- Albuterol inhaler (90 mcg) two puffs every four hours as needed
- Metformin 500 mg by mouth twice a day
- Prazosin 1 mg by mouth at bedtime
- Norco 5/325 mg one to two tablets by mouth every four to six hours as needed for pain when tolerates oral intake
- Hydromorphone hydrochloride 1 mg IV push every four to six hours as needed for severe pain (>6) or pain not relieved by Norco
- Docusate sodium 50 mg/sennosides 8.6 mg by mouth twice a day as needed for constipation

Instructions/Door Sign

Vital signs were recorded 30 minutes ago: T—98.9; R—20; P—84; B/P—138/80; and SPO₂—95%. Accucheck at 0700 was 110. The resident just informed the patient that the surgeon has back—to—back surgeries today and will not be able to discuss the patient's pathology reports until 1600 or after. The patient was expecting the results of his pathology report this morning. The RN—patient encounter will last ten minutes.

In Preparation for the Clinical Simulation Experience.

- SP to be in hospital gown and wearing own sweat pants
- ID wristband

- Saline lock left forearm
- Abdominal dressing with steri strips
- Raise patient's head of bed up 30°
- Place an extra pillow on the chair
- Place on the bedside table a bible, cell phone with earbuds (music), and Vietnam veteran hat
- Place on bedside tray an incentive spirometer, half eaten clear liquid tray (120 mL tea, 60 mL apple juice)
- Prepare room (water pitcher/cups/gloves/phone/bedside table/garbage can/menu/box tissues/urinal/soap/toothbrush/towel)
- Wall clock/or clock visible to SP
- Place patient's own blanket (from brother) on chair/shoes on floor
- Phone in room (instructions next to phone to call operator for all pages)
- Two chairs in room
- Patient information board similar to patient room
- Family picture/Rolling Thunder[®] picture at bedside
- Laboratory coat

Simulation Script With Verbal Responses From the Patient, RN, Wife, or Chaplain

Begin Situational Verbal and Nonverbal Cues for Anxiety

(RN enters the patient's room and introduces herself/himself):

Mr. Bell: "Hello."

(The following script will begin after the nurse begins the assessment. The intention is that the nurse is focused on the physical care and Mr. Bell will raise concerns while the nurse is performing the physical assessment.)

Mr. Bell: "This is a bad morning. They just told me that the doctor isn't coming until this afternoon to talk with me about the tests. I thought he was coming to see me this morning."

Mr. Bell: "Do you know the results of my test?"

(If RN says she/he does not know the test results and/or the doctor will discuss results).

Mr. Bell: "I hope the results aren't bad!" (tapping his hands on tray table anxiously)

(If RN demonstrates caring presence and listening related to test results. For example, pauses, sits in chair, makes eye contact, listens to patient, and/or provides a comforting touch. May state supportive statement).

Mr. Bell: "Waiting is awful!" (Moving feet)

(If RN states something nontherapeutic such as "Don't worry, you will be fine," Mr. Bell is quiet, looks away, and continues to tap his hands.)

Begin Behavioral Cues for Physical Suffering

Mr. Bell: "I had a terrible night last night and didn't sleep at all. This pillow is like a rock." (agitation)

(If RN attempts to provide comfort measures, such as fluffs pillow, gives own pillow, offers to get him more clear liquids, or offers to help him up to chair)

Mr. Bell: "Well that doesn't feel right either. Can you just give me my pillow from home?"

(If RN gives patient own pillow)

Mr. Bell: "That's better."

(If RN offers to get patient up to chair patient states "No. Maybe later.")

Mr. Bell: "I'm so hungry. I haven't eaten in days!"

(If RN asks about the clear liquid breakfast tray)

Mr. Bell: "It was okay."

(If RN asks what he means by "okay")

Mr. Bell: "Well I don't like jello and the broth was cold when I got it. I just want to eat regular food."

(If RN demonstrates caring presence and listening related to physical suffering. For example, stopped the physical assessment or tasks, pauses, sits in chair, makes eye contact, listens to patient's concerns, and/or provides a comforting touch. May state supportive statement.)

Mr. Bell: "Colon cancer is awful!"

(If RN continues assessment, ignores complaints or brushes off patient concerns, offers false reassurance such as, "You'll be fine.")

Mr. Bell: Blank stare and withdrawal

Situational Verbal and Nonverbal Cues for Insomnia and Fear

Mr. Bell: "Oh, I'm so tired. I heard noises out in the hall all night. I keep worrying about my test results." (Patient yawning)

Mr. Bell: “I have to listen to music to fall asleep. I do not sleep well since Vietnam and now this waiting is making it worse.”

(If RN offers to call physician to get him medicine for insomnia)

Mr. Bell: “No, I already take something every night.”

(If RN encourages patient to talk about his fears, e.g., asking more about his fears about test results, having cancer, father/brother cancer experience)

Mr. Bell: “I’m really afraid the results are bad. I do not want to have that awful chemo. My dad and brother had colon cancer. They were so sick. They lost so much weight. They were throwing up all the time and were in so much pain. I hope that does not happen to me.”

(If RN tells patient not to worry, Mr. Bell becomes quiet and withdrawn)

(If RN demonstrates importance of music. For example, stopped the physical assessment or tasks, makes eye contact, and listens to patient, and/or demonstrates recognition for the importance of music to help patient sleep. May state, “Sounds like you have difficulty sleeping. Does music help you sleep in the hospital? Would you like to listen to your music now?” and/or explores type of music he enjoys.)

Mr. Bell: “I like Motown, Old School songs.”

Physical Environmental Cues (Meaningful Object)

Mr. Bell: “I’m cold. Can I have my blanket?”

(If RN provides hospital blanket)

Mr. Bell: “I want my blanket over there. It was my brothers. He wanted me to have the blanket.”

(If RN recognizes the importance of the blanket and/or brother. May state supportive statement. For example, “It seems that the blanket from your brother is meaningful to you.”)

Mr. Bell: “My brother died from colon cancer. He loved this blanket. Yea, he loved this blanket. I wish he were here. He’d be making me laugh.”

Veteran Culture Environmental Cues

Mr. Bell: “I cannot reach my hat. Can you get it for me?” (Vietnam Vet Marine hat) (If RN gives patient his hat and asks about the importance of the hat)

Mr. Bell: “I went to Vietnam when I was 18 years old.”

Mr. Bell: “I lost a lot of friends there. My brother Jimmy got shot there. He was in the Army. He survived that, but it was a bad time.”

(If RN demonstrates caring presence and listening related to past veteran experiences. For example, pauses, sits in chair, makes eye contact, listens to patient, and/or provides a comforting touch. May state supportive statement. For example, “It sounds like you lost a lot of friends. That must be hard for you.” May explore importance of the hat and/or thank him for his service.)

Mr. Bell: “Yeah. I have a big motorcycle trip this summer that I’ve been looking forward to. I hope I can still go.”

(If RN recognizes Veteran picture on bedside table or deliberately asked patient questions about the importance of current Veteran supportive connections such as the Rolling Thunder® group and/or his hope to participate in the Memorial Day parade/motorcycle ride)

Mr. Bell: “It’s a motorcycle trip in D.C. I just got a new trike for me and my wife. We are supposed to ride in a Memorial Day parade with the Rolling Thunder® group. We ride to the Vietnam Memorial Wall. I do not want to miss it.”

Verbal Cues for Social Support/Connections With Family/Friends—Nonverbal With Family Picture/Rolling Thunder® Picture on Bedside Table

Mr. Bell: “I’m worried about my wife. She is usually here usually here by now. I hope she did not get lost.” (either driving or in the hospital)

(If RN responds that wife is not here yet)

Mr. Bell: “I’m usually the driver. We are always together. It’s just me and my wife and dog. I just want to go home and chill out.”

(If RN demonstrates caring presence and listening related to family supports. For example, pauses, makes eye contact, listens to patient, and/or provides a comforting touch. May state supportive statement. For example, “It seems like you really miss home. Tell me more about it.”)

(If RN suggests Mr. Bell call his wife and/or Mr. Bell asks RN to call his wife and/or Mr. Bell asks RN for his cell phone)

Hollie Bell (Wife): “I’ll be there as soon as I can. Please tell him I am on my way.”

(If RN recognizes family picture on bedside table and/or promotes connection with family/friend. Asks him if he wants her/him to call his wife, another family member, or friend)

Mr. Bell: “That’s my daughter, Rochelle. I wish she did not live out of town.” (crosses arms).

Verbal/Nonverbal Cues for Connection With Higher Power/Faith Rituals

Mr. Bell: “I’m afraid of the test results. It’s in God’s hands.” (opens hands)

(If RN discusses the tests and states the doctor will be there that afternoon)

Mr. Bell: "I hope my wife is with me when the doctor tells me the results."

(If RN demonstrates caring presence and listening related to religion. For example, pauses, makes eye contact, listens to patient, and/or provides comforting touch. May states supportive statement: "It seems like your faith is a source of strength for you.")

(Mr. Bell response if RN offers to call chaplain. Calls chaplain if patient requests.)

Mr. Bell: "Yes, I would like to see a chaplain."

Chaplain: "I will be there as soon as I can."

(Mr. Bell response if RN asks about his pastor/church)

Mr. Bell: "My pastor knows I'm here. He'll visit me. My wife has everyone from church praying for me."

(If RN recognizes Bible on the bedside table and/or asks patient if he wants his Bible and/or asks patient if he has a favorite verse)

Mr. Bell: "Yes, Psalm 139?" (puts hands in prayer)

(If RN asks if he wants her/him to read the verse)

Mr. Bell: "Sure."

(If RN initiates reading the verse stop simulation immediately after)

At the end of the ten-minute simulation scenario announce the simulation is over. Instruct the RN to step out of the room to complete tools.

Appendix B

Spiritual Care Cue and Intervention Checklist

Cue(s)	Intervention(s)	Performed	Not Performed
1. Situational verbal and nonverbal cues for <i>anxiety</i>	a. <i>Demonstrates caring presence and listening related to test results</i> For example, pauses, sits in chair, makes eye contact, listens to patient, and/or provides a comforting touch. May state supportive statement		
2. Behavioral cues for <i>physical suffering</i>	a. <i>Demonstrates caring presence and listening related to physical suffering</i> For example, stopped the physical assessment or tasks, pauses, sits in chair, makes eye contact, listens to patient's concerns, and/or provides a comforting touch. May state supportive statement		
3. Situational verbal and nonverbal cues for <i>insomnia and fear</i>	a. <i>Encourages patient to talk about his fears</i> (e.g., asking more about his fears about test results, having cancer, father/brother cancer experience) b. <i>Demonstrates importance of music</i> For example, stopped the physical assessment or tasks, makes eye contact, and listens to patient, and/or demonstrates recognition for the importance of music to help patient sleep. May state, "Sounds like you have difficulty sleeping. Does the music help you sleep in the hospital? Would you like to listen to your music now?" and/or explores what type of music he enjoys		
4. Physical environmental cues/ <i>meaningful object</i>	a. <i>Recognition of the importance of the blanket and/or brother.</i> May state supportive statement. For example, "It seems that the blanket from your brother is meaningful to you."		
5. <i>Veteran culture</i> environmental cues	a. <i>Demonstrates caring presence and listening related to past veteran experiences</i> For example, pauses, sits in chair, makes eye contact, listens to patient, and/or provides a comforting touch. May state supportive statement related to veteran culture: "It sounds like you lost a lot of friends. That must be hard for you." May explore importance of the hat, and/or thanks him for his service b. <i>Recognition of veteran picture on bedside table or deliberately asked patient questions</i> about the importance of current veteran supportive connections such as the Rolling Thunder [®] group and/or his hope to participate in the Memorial Day parade/motorcycle ride		
6. Verbal & nonverbal cues for <i>social support/connections with family/friends</i>	a. <i>Demonstrates caring presence and listening related to family supports</i> For example, pauses, makes eye contact, sits in chair, listens to patient, and/or provides a comforting touch. May state supportive statement. For example, "It seems like you really miss home. Tell me more about it?" b. <i>Recognition of family picture on bedside table and/or promotes connection with family.</i> Asks him if he wants her to call his wife, another family member, or friend		
7. Verbal & nonverbal cues for <i>connection with higher power/faith rituals</i>	a. <i>Demonstrates caring presence and listening related to religion.</i> For example, pauses, sits in chair, makes eye contact, listens to patient, and/or provides a comforting touch. May state supportive statement: "It seems like your faith is a source of strength for you." b. <i>Offers to call chaplain.</i> Calls chaplain if patient requests c. <i>Recognition of/offers the Bible on bedside table.</i> May read verse		

Appendix C

Debriefing Script:

Thank you for participating in the simulation. We will take about ten minutes to debrief the simulation.

Participant: Give me a one word description of your emotions now.

Let us share the evaluation forms:

- What went well for you providing holistic care during the simulation? Start with the nurse, then SP.
- Would you do anything different? Start with nurse, then SP.