Spiritual and Cultural Assessments in Nursing

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Spiritual and cultural assessments have become necessities within nursing care. As the country and the world becomes more and more diverse, assessing for an individual's values and beliefs allows for nursing to care for a patient in the manner in which the patient wants to be cared. Understanding a person's culture and spirituality is key to being able to connect with the patient and develop a relationship that will allow for the best possible patient outcome that is patient-centered. This paper will focus on what has influenced the need for spiritual and cultural assessments within routine nursing care, personal beliefs and reflection about the integration of culture and spirituality, approaches to use during assessment, two critiques along with recommendations on spiritual assessment tools, and strategies to help guide the use of these tools in health assessments so that spirituality and culture are addressed properly.

Importance of Cultural and Spiritual Assessments

Various reasons apply to why there has been a growing importance placed on spirituality and cultural care within the healthcare setting. The United States itself has always been considered a melting pot because of the multitude of immigrants into the country, mixing in different cultures, ethnicities, religions, and other factors that now define humans. While it is not as prominent as it once was, immigration still occurs on a small scale, and individuals will always hold onto their heritage. Because of that, it is more important than ever to be open to the beliefs and ways of life that others have.

Furthermore, the world on a whole has evolved, and individuals' views have changed. As Power (2006) explains, postmodernism has changed the view people have of spirituality as it is no longer connected strictly to an institutional religion. Cultural and spiritual diversity has been awakened as globally, there is more awareness of these diversities, sparked by

the migration of people are they are able to travel and live in various parts of the world (Power, 2006). Each of us need to be empowered by having the knowledge in how to not only address spiritual and cultural concerns, but also how to show patients that this is just as important to the care provided and their overall health.

Spirituality

However, the question arises then as to where culture and spirituality fit in the world of nursing on an everyday basis. Nursing is taught to be a discipline that is practice-based with the focus being on an individual (Veloza-Gomez, Guevara-Armenta, & Mesa-Rodriguez, 2016). Veloza-Gomez et al. (2016) continue stating that when spirituality is incorporated, the care is patient-centered and allows for being able to address the physical, psychological, and spiritual needs of that person by providing holistic care.

Patient-centered care has been identified as one of the competencies needed to achieve the Quality and Safety Education for Nurses (QSEN, 2012). As part of the knowledge factor of that competency, transition and continuity specifically, requires, an analysis of the diverse cultural, ethnic, spiritual and social background function as sources of patient, family, and community values (QSEN, 2012). Lastly, nurses also need to be able to incorporate knowledge of psychological, spiritual, social, developmental and physiological models of pain and suffering (QSEN, 2012). The development of spiritual assessment tools allowed for this as the tools look to treat the patient beyond just symptoms and to instead include both the psychosocial and spiritual aspects in assessing and caring for patients within health care (Cadge & Bandini, 2015).

Culture

Culture is equally as important as in today's world, as nurses encounter many patients with differing cultural backgrounds. Because of this, intercultural caring, defined by Hemberg

and Vilander (2017) as caring work that occurs between nurses and patients who have different cultural backgrounds, has become a part of the nursing world. Within cultural backgrounds, people also have traditions and values, which must be considered by nursing (Hemberg & Vilander, 2017). Doing so demonstrates to patients that the nurse is treating them with dignity by applying their cultural needs to their care (Hemberg & Vilander, 2017). More importantly, when that dignity is experienced by the patient, Hemberg and Vilander (2017) add that the patient will feel as if the nurse sees him and is respecting him as a human because of allowing him to participate in the type of care that he wants based off of cultural needs.

Personal Beliefs on Incorporating Spirituality and Cultural Assessments

A question I frequently ask myself in nursing is that if this were my family member, how would I want them cared for and am I caring for them in that way? Every nurse is faced with a difficult patient or situation and turning to that question can help provide guidance through the situation. The same applies for me to spirituality and culture. While I may not believe one way or have values that are different from a patient, I certainly will not try to apply my way to their care as I would not want that done to myself or my family.

As a result, spirituality and cultural assessments of patients are important in nursing, because they help nurses see patients for who they are, what they believe in, and how it is best to provide care for them. It is the responsibility of the nurse to assess these areas so that the patient's needs culturally and spiritually are considered, especially when it comes to caring for that person (Hemberg & Vilander, 2017). If these areas are not assessed, nursing is unaware as to how to carry out care that is patient-centered. The more that is known about a patient, the better a plan of care can be developed and carried out in a manner that the patient wants. Additionally, a caring relationship will grow between patient and nurse because if they

are each able to express to one another how they differ in their cultures, each will be more knowledgeable and thus, more respectful (Hemberg & Vilander, 2017).

Approaching Spiritual and Cultural Assessment in Nursing

Like how most assessments and cares in nursing are approached, timing is crucial, and a patient must be willing and able to participate, and within the right mindset to do so. While a person's values, beliefs, and spirituality may be helpful in guiding a patient through a difficult time, such as having uncontrolled pain, tearfulness, anger, or are withdrawn, that time is not appropriate to carry out an initial assessment. Instead, the nurse should make the spiritual and cultural assessments part of the other assessments made, as it can be incorporated into those.

As Puchalski, Menehan, and Moore (2008) suggest, a spiritual assessment should be made during an initial visit, if possible, may it be a clinic visit, home visit, at the bedside, or in another nursing facility or setting. Doing so will make it relevant to both the healthcare professional and the patient as it shows the patient that spirituality is important to the provider and gives the patient the opportunity to express his needs (Puchalski et al., 2008). Furthermore, as Puchalski et al. (2008) point out, when done in a manner that is not persuasive or judgmental, it will build rapport with the person. Lastly, and most importantly, these assessments should guide conversations with patients and not merely be checklist of a task to complete (Puchalski et al., 2008).

Spirituality Assessment Tools in Nursing

Within healthcare and nursing, spirituality has also evolved. Specifically, the origins of spiritual assessment tools can be identified as starting in the 1960s and 1970s through chaplaincy and counseling by pastors (Cadge & Bandini, 2015). From there, it grew into being a part of healthcare through medicine itself and nursing and social work, leading to the

development of spiritual assessment tools so that others, not just chaplains, could be involved with patients in discussing spirituality too (Cadge & Bandini, 2015).

In looking at the various tools to assess spirituality, many have been developed over the years. According to Cadge & Bandini (2015), the first one for physicians, the Spiritual Profile Assessment (SPA), was designed in the 1980s by a physician. This further sparked work on designing and applying spiritual assessment tools within healthcare and nursing. In 2003, even more attention was put onto the importance of assessing spirituality as it was brought up in an interview with an associate director of the Joint Commission, whose use of the words spiritual assessment called for further development and inclusion of these assessments within healthcare (Cadge & Bandini, 2015). Now, in the current decade, over 40 tools to assess spirituality are available within the United States, created by physicians, nurses, chaplains, and social workers to be used by healthcare professionals (Cadge & Bandini, 2015). Two of the tools specific to spirituality, the FICA Spiritual History Tool and the HOPE Model will be explored further.

FICA Spiritual History Tool Background

Spiritual assessment tools were developed over the years for various reasons and by various individuals. Some were for research, with others being for use within the clinical setting, which was the intent of the FICA Spiritual History Tool (FICA), created in 1996 by Dr. Christina Puchalski with three other physicians (Borneman & Puchalski, 2010). As Borneman & Puchalski (2010) describe, it was created as a way for healthcare providers to ask open ended questions during the collection of a medical history that would allow for the obtainment of the patient's spiritual beliefs as well.

The tool includes four domains, specific to each of the letters within the FICA acronym. The first, or letter F, represents the presence of faith, which includes the beliefs or

meanings of an individual, while the I signifies the importance of spirituality within a person's life, including the influence of his beliefs and values on the decisions the person makes about his health care (Borneman & Puchalski, 2010). Next, as Borneman & Puchalski (2010) explain, the C stands for the spiritual community of the individual, while the A focuses on what interventions can address the spiritual needs.

Performing and Using the FICA

Within each of the domains, various questions may be asked to assess that area. The first few will help to open the conversation. Within the F, several questions suggested by Puchalski et al. (2008) include whether or not an individual views himself as spiritual or religious, if the person has any spiritual beliefs that help one cope with stress, and if the answers to those questions are no, to continue by asking what does give the individual's life meaning.

Addressing the next part, the I, will help the provider identify what beliefs the person has that will likely influence health care decisions and what resources the person has spiritually that can help during times of difficulty (Puchalski et al., 2008). The community, or C, domain allows the provider to explore any connections the patient has to others that may be providing support as well as guidance to the person, and this can include people specifically or whole communities, such as groups found within places of worship (Puchalski et al., 2008). Puchalski et al. (2008) suggests asking the individual whether he is part of a religious or spiritual community, if it is supporting if he is, and if there is a specific group or people that the person views as really important or feels a profound sense of love for.

Finally, the A category allows the provider to bring it all together, exploring how the information may be used and identifying whether or not recommendations should be made to the patient for spiritual support resources (Puchalski et al., 2008). Questions for this area are ones

that the provider asks themselves based off the data collected from the assessment and can include whether or not a referral should be made to a spiritual counselor or chaplain, whether or not to recommend a spiritual resource such as meditation, or to encourage the patient to reach out to a spiritual community (Puchalski et al., 2008). While no action may be required at that specific time, Puchalski et al. (2008) adds that it may be of benefit in the future, when the person is facing a crisis and needs to pull from that support system identified.

Strengths and Weaknesses of the FICA

One of the strengths of the using the FICA is its feasibility as it can be quickly and easily integrated into a social history with a patient. The acronyms also make it simple to remember each area to assess, especially with only four areas of focus. It also allows for the inclusion of any type of spirituality, as it fits if the individual has a relationship with a god or if it is instead one with family, community, nature, or art (Puchalski et al., 2008). Additionally, the person doing the assessment does not need to have the same beliefs and still be comfortable performing the assessment because it allows for exploring and learning what the patient feels about their own spirituality and not spirituality or religion as a whole (Puchalski et al., 2008). Lastly, the information collected during a FICA assessment can be used at that time or prove to be beneficial at another time when the person needs spiritual support. Having done the FICA prior will allow a provider to quickly identify what support the person would like and has present in his life, so it can be included during that time of need and within the plan of care (Puchalski et al., 2008).

A weakness already suggested with the FICA is how it can turn into a checklist that a healthcare professional needs to complete instead of a tool to integrate within the assessment. The questions listed are similar to others most nurses and healthcare providers are

required to ask during the admission process or a clinic visit, which can turn it into an impersonal interaction. The questions also may be too specific for some patients or too intrusive as, while the questions are simple, they are also straight to the point, which may offend some individuals. As a study on the evaluation of the FICA tool found, the providers that were interviewed indicated that the FICA was like a survey, being too prescribed and categorical and also did not allow any opportunity to inquire about specific needs, limiting spontaneity (Vermandere et al., 2012).

Background of The HOPE Model of Spiritual History-Taking

Similar to the FICA tool the HOPE Model is similar in make-up as it is also based off an acronym, in this case, HOPE. It was developed by medical doctors Anandarajah and Hight (2001) as a teaching tool to help students, residents, and physicians in the medical field so that they could better integrate an assessment of one's spirituality into a patient's medical assessment. As Anandarajah and Hight (2001) explain, this model used an approach of open-ended questions to delve deeper into the spiritual resources and concerns of patients with a minimization initially on spirituality or religion.

Each letter of the word HOPE guides the spiritual assessment. The first letter, H, stands for hope overall, specifically, the basic sources a patient has for spirituality, or simply stated, what gives a person hope (Anandarajah & Hight, 2001). The next part, represented by O, focuses on organized religion, while P pertains to personal spirituality and practices the person finds helpful (Anandarajah & Hight, 2001). Completing the word, letter E, indicates the effects that a patient's beliefs and spirituality have care medically as well as end-of-life care (Anandarajah & Hight, 2001).

Performing and Using the HOPE Model

Closely related to the style of the FICA tool, the HOPE Model also uses questions within each category to make the spiritual assessment. Questions to help assess the person's sources of hope can include specifically asking a person what he views as sources of hope, comfort, peace, and strength, asking what the person holds on to during difficult moments, or asking what keeps the individual going each and every day (Anandarajah & Hight, 2001). If the answers to the questions asked are yes, Anandarajah & Hight (2001) suggest going to the next section, organized religion. If, instead, no answers are given, it is important to try to find out if there has been hope and what changed it (Anandarajah & Hight, 2001).

Moving on to the O, Anandarajah & Hight (2001) recommend asking questions about whether or not the person is part of an organized religion, how important it is to the person, and what part of it is helpful or not. Questions that are suggested for P, personal spirituality and practices, include if the patient has personal beliefs of his own, separate from organized religion, and if so, what along with whether or not the person believes in a god and what type of relationship he has with that god if he does (Anandarajah & Hight, 2001). Other questions that may be helpful in the section according to Anandarajah & Hight (2001) are what specific aspects of the person's spirituality are most helpful to him. To address the final letter, E, questions to ask can be whether or not being ill has affected being able to participate in spiritual or religious activities and if there are any resources that may be of benefit that a medical professional could provide (Anandarajah & Hight, 2001). It is also important in this portion to find out whether or not the person has specific practices or restrictions in regard to medical care based on religion or spirituality (Anandarajah & Hight, 2001).

By completing this assessment, a provider may determine that no further interventions are needed, or ways were discovered in how the person's spirituality may be incorporated into the plan of care (Anandarajah & Hight, 2001). Some possibilities Anandarajah & Hight (2001) recommend include prayer, meditation, or the use of music. A person's spirituality practices may also be added to a treatment plan as well as within adjuvant care based on what is discovered in this spiritual assessment (Anandarajah & Hight, 2001).

Strengths and Weaknesses of the HOPE Model

Acronyms again make this model easy to use as the letters help one remember each area to assess. The HOPE Model also has better flow as the conversation is not so restricted to specific questions but instead can be a range of questions. This tool also begins using an approach that may be more appealing as it allows for a discussion about hopes and belief and does not focus immediately on spirituality or religion. It allows for the patient to express what is most important and how that provides comfort and support. In the same sense, it allows for a wider discussion of topics during the assessment, which could provide more useful information to the person completing it.

There are also weaknesses to this model. While it does start out as being less restrictive, moving into the 'OPE' portion could cause offense to many people. Not every person follows an organized religion or believes in a specific god. If this is not accepted well within the community the person lives in, the person may not be as forthcoming with details or even want to discontinue the conversation. The assessment tool may also be too short to identify all aspects of someone's spirituality.

The FICA Tool Versus the HOPE Model

As discussed in describing the HOPE Model, the two spiritual assessment tools are very similar. They are both known as spiritual history assessment tools and contain acronyms that help remember and guide what areas to assess. Both are short assessments that can be intertwined into other assessments health care providers may do with patients. The two were also both developed by physicians for use within healthcare. They also both start out in being broad without a direct focus immediately on religion as each look to discover what a person believes in first, though each could actually both be offensive in nature to a person as well. The information collected using each tool can also be used either immediately or at another time. Both also allow for the incorporation of beliefs and values into the care a patient receives.

In contrast, the FICA has more specific questions that guide the assessment, making the HOPE Model the one to use for a more natural flowing conversation instead of the FICA one which comes off more as a checklist or survey. However, the HOPE Model shifts to a very religious point of view. Providers may not be comfortable asking such questions as they may feel that if they do not have the same beliefs or are knowledgeable in religion that they may offend the patient. Positively, the HOPE Model does allow for better incorporation into all aspects of an individual's medical care versus the FICA tool.

Cultural Assessment Tools in Nursing

Assessing a person's cultural background is as important as spirituality. Oftentimes, the two go hand in hand as a culture includes having certain beliefs or religious values that everyone within that culture follow. A culture may also follow certain norms and not understanding those can lead to issues with carrying out medical care, such as if the entire family was not part of a decision when in that culture, it is to be carried out in that manner. As Albougami, Pounds, and

Alotaibi (2016) write, nurses need to be adaptable, especially in cultural diversity as it can have profound implications on the care and quality of care provided to patients. Additionally, to provide the best care, complete holistic assessments need to be carried out by nursing, including culturally assessing individuals (Albougami et al., 2016).

The evolution of cultural assessment tools came as countries became more and more diverse. The original interest and research by theorist Leininger, who experienced cultural shock brought an area to nursing known as transcultural nursing in the mid 50s along with the Sunrise Model as a cultural assessment tool (Albougami et al., 2016). Many other methods were developed after this, along with an emphasis being placed on cultural competence (Higginbottom, Richter, Mogale, Ortiz, Young, & Mollel, 2011). Two models that will be reviewed include the Sunrise Model and the Assessment, Communication, Cultural negotiation and compromise, Establishing respect and rapport, Sensitivity, Safety (ACCESS) model.

Background of the Sunrise Model

As mentioned, the Sunrise Model was at the forefront of transcultural nursing. Developed by Leininger in 1955, it is still one of the most popular models focusing on various factors and concepts (Higginbottom et al., 2011). Furthermore, it connects the theory concepts to clinical practice using an approach that identifies values, beliefs, behaviors, and customs of cultures while also taking into consideration aspects such as religion, finances, social norms, technology, education, legality, politics, and philosophy (Albougami et al., 2016). Most importantly, it helps those in health care overcome stereotyping patients (Albougami et al., 2016).

Three concepts allow for incorporating the needs of a patient into achieving desired clinical outcomes and include culture care maintenance and prevention, culture care negotiation

and accommodation, and culture care restructuring and repatterning (Albougami et al., 2016). In cultural preservation, the nurse seeks to provide support of practices specific to the patient's culture, such as the use of acupuncture to reduce anxiety (Albougami et al., 2016). Secondly, cultural negotiation, as explained by Albougami et al. (2016), is the nurse supporting both the patient and family in allowing cultural activities or practices as long as no threats from those are posed to them or anyone in that setting. Lastly, restructuring involves the nurse helping change an aspect of a culture for a person, if permission granted, in the care in which an activity is harmful to the person's health or well-being (Albougami et al., 2016). All three of these are beneficial and useful to both the nurse and the patient in achieving goals related holistically to the health of the patient (Albougami et al., 2016).

Strengths and Weaknesses of the Sunrise Model

A major strength of the Sunrise model is that it incorporates activities from a person's culture into the care of the patient. This helps show the patient that if a nurse or other provider understands and allows such practice, that they also understand the person and his culture. Likely, this will make for a positive, therapeutic relationship among the patient and care team. Secondly, as Albougami et al. (2016) found, it helps to remove stereotypical thoughts. Finally, this model is very concise and if the activity is possible and safe, the concepts are easy to incorporate into a care plan.

With that said, one weakness that can be recognized in this model is that it does seem to focus only on activities. While those are very important to individuals and cultures, it is important too to understand the person entirely, which this does not achieve. The model is not diverse enough in what to assess for culturally in a patient. It also does not allow a respect of differing cultures among the patient and nurse to occur, as without fully learning about one

culture constricts the relationship that would form if a more in-depth assessment were completed. This restricts becoming more culturally competent too because more is not being learned.

Background of the ACCESS Model

The second model, the ACCESS Model, was created in 1999 to provide nurses a framework that would help them deliver transcultural care (Narayanasamy, 2002). As Narayanasamy (2002) writes, this model is centered on taking action so that the care planned and implemented for patients may be culturally congruent, sensitive, and compassionate. Each of the letters within the word access identifies an area that must be considered in transcultural nursing, assessment, communication, cultural negotiation and compromise, establishing respect and rapport, sensitivity, and safety (Narayanasamy, 2002).

To explore each component further, the assessment one focuses on completing a comprehensive look at the person's lifestyle, benefits of health, and health practices in terms of their culture (Narayanasamy, 2002). This helps the nurse obtain a better understanding of those areas and how they will influence the care plans and interventions carried out for the patient. The second, communication, is to help health care providers understand how verbal and non-verbal actions can have different meanings in different cultures (Narayanasamy, 2002). Narayanasamy (2002) provides an example in how Asians view direct eye contact as disrespectful. Care should also be given to language as barriers within this may prolong treatment or cause an incorrect treatment (Narayanasamy, 2002).

Moving on to cultural negotiation and compromise and for this to occur, it is crucial that nursing becomes more aware of other cultures, and like with spirituality, no one needs to be an expert, some recognition of differences needs to exist (Narayanasamy, 2002). According to

Narayanasamy (2002), this will help aim nursing interventions towards the patients' values and demonstrate sensitivity. Being aware of other cultures helps a nurse show patients that she understands differences, which will establish respect and rapport. This will build trust between the nurse and patient, allowing for a therapeutic relationship and mutual respect by each of the other's values and beliefs (Narayanasamy, 2002).

The sensitivity portion of the ASSESS model looks to deliver care that diverse culturally and is sensitive to the needs of that culture (Narayanasamy, 2002). Lastly, patients must feel a sense of culturally safety. To achieve this, the environment must not be made to feel foreign to the patient, and the patient equally must not be made to feel as if their needs are not being met or are being ignored altogether (Narayanasamy, 2002). This will contribute further to the trust patients develop in nurses as well as in forming a therapeutic relationship, which is one of the key uses of this model overall (Narayanasamy, 2002).

Strengths and Weaknesses of the ACCESS Model

Similarly, to the two spirituality tools, the acronym of this model allows the user to remember the components of it quickly, allowing it to be easily applied in practice. The components all relate to one another, which allows each portion to build off of the other. In a study on the use of this model in practice, one of the findings was that the tool helped nurses understand and deliver culturally sensitive care to a wide range of cultures (Narayanasamy, 2002). It was also demonstrated in that study that this model encouraged positive relationships with patients, as patients felt valued and recognized (Narayanasamy, 2002).

A weakness of the model is that it is built on a strong notion that a nurse or other user will be culturally competent. While cultural competency is being recognized as an essential need in health care, not all persons yet have accomplished having it, making this tool of little use to

them. Another downfall of this model is that it is very simple and may not allow for enough information about patients to be gathered culturally, missing key components in caring for culturally diverse patients.

Sunrise Model Versus the ACCESS Model

In comparing these two models, both are relatively easy to use. Both also ensure that the patient is understood as his own practices will be included in his care and also demonstrates to the patient that his culture is important. The two can also be adjusted as necessary to how each needs to be used for each patient. Lastly, they both ensure that priority is given to trying to make the patient comfortable in his environment and to be understood culturally.

In contrast, the ACCESS model allows for a much deeper exploration of the patient's culture, which will allow for a better, more therapeutic relationship to be formed between the patient and nurse. The ACCESS model also requires a nurse to be much more culturally competent. The Sunrise model allows for learning about a culture to occur from a patient telling the nurse about it, but it does not require any prior competency in culture to be present.

Spiritual Assessment Tool Recommendations

In considering both the FICA and the HOPE model for assessing spirituality, an important factor to look at when selecting to use one over the other would be if there is prior knowledge to how a patient may answer. While both of these tools are effective to discuss spirituality with patients, if little is known about the population or norms of the community one practices in, the FICA tool may be the better option. An example is that in the south central part of the state of North Dakota, the population is rich in elderly, strong-willed individuals who hold onto both their German heritage and Christianity tightly. Knowing this, it would be best to use the HOPE model to assess their spirituality as this method delves deeper into the spirituality one

knows is present within that community. In contrast, a nurse who practices in a large medical facility within a metropolis may instead want to use the FICA tool, as this would be less probing at a specific religion, which I feel the HOPE model does.

However, the two tools together may be the best option. For instance, if little to nothing is known about the person or how he may respond to the assessment, it would be best to start using the methods of the FICA tool. If it is quickly determined that the person is very spiritual or has specific religion followings and needs, the assessor can switch to using the HOPE model, as that tool would allow for a better assessment of the individual who has a much more complex spiritual following and beliefs.

Along with that argument, I would suggest that the best way for a nurse to assess a patient's spirituality, is to be comfortable with their own beliefs as well as others and also to have some knowledge of what others may believe, including the various religions that exist. Like having cultural competency, it is equally important to have spiritual competency. This will especially be of importance as the world continues to become more and more diverse and as individuals become more comfortable in having and sharing their own belief systems.

Cultural Assessment Tool Recommendations

In researching the tools used for cultural assessments, it was interesting to learn that a model first developed in 1955 remains popular yet today. Recommendations for the Sunrise model would be to update it to fit today's diverse world. The tool has a strong base of beginning an assessment, but it fails to build upon expanding the knowledge of both the patient and the nurse of one another's culture.

As Albougami et al. (2016) argues, the model does not go beyond the culture of the patient, failing to see the differences that there may be within that culture for others in that same

group or community. It also highlights the inequalities that may exist between patient and nurse more, which may not prove conducive to building a trusting relationship between the two, hindering the care the patient receives (Albougami et al., 2016). While it is an easy tool to use, it is too simple to complete a full cultural assessment necessary to providing patient-centered care.

My personal preference would be to use the ACCESS model since it allows for a deeper exploration of the cultural needs of the patient, while allowing the patient and nurse to relate to one another even if it is through differences. This allows a more therapeutic relationship to form. This model is also preferred because of the necessary cultural competence that is required of the nurse. Healthcare providers need to be making an effort and taking the time to educate themselves and be culturally competent. The need for that element is missed when using the Sunrise model, as that model instead focuses on being culturally congruent (Albougami et al., 2016).

In Comparison to the Heritage Assessment

Jarvis (2016) explains that the Heritage Assessment tool helps to identify if a traditional heritage is present within a patient, which includes exploring cultural beliefs and the practices of the family, extended family, and ethnoreligious community. While this assessment addresses cultural beliefs and religion, it is restrictive in how it does so. The Heritage Assessment tool does not allow for an expansion on spirituality as it is very focused on religion. If this is completed with an individual, he may feel as if the assessor is only interested in religious components, and if the person does not have those beliefs, that it does not matter.

While the assessment does touch on culture, it, like the Sunrise model, limits an in-depth discussion about culture. There is a focus on how the person applies his culture to himself, but not the other components of it that may exist in others of the same culture. Lastly, there is a

strong influence made by the assessment that family needs to be a component. Like with religion, if a person is no longer connected to his family or considers others family, he may not address these questions, leading to an inaccurate assessment.

Instructing Others on Cultural and Spiritual Assessments

A major theme throughout this paper is that nursing needs to have an understanding of and be competent in spirituality and culture. To best achieve this, it is important that individuals first understand their own culture and spirituality, and identify their own beliefs and values, which fits into Bloom's affective domain to learning. In reviewing my own experiences in education, I feel there was certainly more emphasis placed on becoming culturally competent verses becoming comfortable talking about spirituality with patients. Literature shows that while assessing spirituality in patients is a key part of nursing and patient care, it is oftentimes not addressed fully in nursing education (Williams, Voss, Vahle, & Capp, 2016). My vision as a future nurse educator would be to ensure that students are competent both culturally and spiritually and have an awareness of their own spirituality and cultural background.

In earning one of my undergraduate degrees, I had the opportunity to take a religion course and anthropology class, both of which expanded my knowledge greatly. As a current mentor and future educator, I encourage future nurses to take similar ones if at all possible during their own education. While I do not feel that a specific course on these subjects should be a requirement, it certainly should be suggested and shared with students about the importance of the classes in their future profession. Discovery of other cultures, religions, and practices of others by students meets the cognitive domain of Bloom's Revised Taxonomy of Learning.

Students can then build on that knowledge in clinical experiences. Applying it and then learning how to assess it and provide care related to it in real life situations are essential for

students to fully grasp the concepts and to be comfortable in using it in their own future practice (Williams et al., 2016). Furthermore, this will utilize the psychomotor domain of Bloom's Revised Taxonomy of Learning.

When thinking back to my own clinical experiences, I realized that I explored both culture and spirituality for assignments and on my own with patients, but how to perform these types of assessments with patients was not taught in the clinical setting. I would ensure that this is incorporated into the curriculum of clinical experience. Williams et al. (2016) discusses how spiritual assessments as well as interventions should be made part of the studies of nursing students and should also be modeled by instructors.

Lastly, demonstration of some of different assessment tools for both culture and spirituality would be done either in the classroom or as part of clinical experience. Assessing spirituality and culture is difficult for even experienced providers at times, so it is imperative that exposure to tools to do so occurs early in a nursing students' curriculum so that they may use them throughout their education and experiences (Williams et al., 2016). By providing them options with a variety tools they can use to assess patients, they will be able to better understand which of the tools or methods will help them to address spiritual and cultural needs in patients and also become more at ease in assessing both.

Final Reflections

Until undertaking this paper, I was unaware as how little I personally knew and was taught on spiritual and cultural assessments within nursing. While I am culturally competent and include spirituality and culture awareness in my practice, I learned new tools to assess these areas that I was unaware of prior. In the area I practice nursing, it is also quite common to discuss spirituality and offer chaplaincy service or other support to patients, so I also learned that

this is not the care for everyone and that some may be quite uncomfortable in bringing this up with patients. Thus, it is important that I include these important components to holistic care in those I mentor and teach.

As I was working on this paper, I encountered an opportunity to teach the students I have in clinical setting this semester about spirituality. A patient was being prepared to go to surgery, and various checklists and tasks needed to be completed yet before she could be taken to the operating room. The primary nurse seemed flustered, and even though I was present there with my student to help, the nurse still seemed to feel as if she was not going to accomplish everything she needed to. In the midst of it all, a priest from one of the local churches stopped by to offer communion and prayer. Before he was barely in the room, I knew I had to step in to ensure that he was invited in to do so and not made to feel as if there was no time for it. More importantly, I wanted to be sure that the patient had the opportunity to pray with him before her surgery. After my student and I witnessed this, I used the example later in post clinical to demonstrate the importance of knowing the spiritual needs of patients and to ensure that those needs are met. I strongly believe that if I had not been present in that moment, the patient's nurse would have likely dismissed the priest without much thought, which I discussed with my students.

Lastly, this reinforced to me the huge need there is to provide better education to our future nurses so that they are able to assess their patients both spiritually and culturally to ensure care really is patient-centered and that the proper resources are brought in to meet the needs identified in those assessments. The research done for this paper has allowed me to obtain a better grasp on the material and recognize the need to continue to educate myself in these areas as one can never know enough about the various cultures and spiritual practices individuals have.

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