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Perceptions of Spiritual Care in Nursing

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PERCEPTIONS OF SPIRITUAL CARE IN NURSING

by

Charlotte S. Connerton

Dissertation

Submitted to the Faculty of

Olivet Nazarene University

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in Partial Fulfillment of the Requirements for

the Degree of

Doctor of Education

in

Ethical Leadership

May 2016

PERCEPTIONS OF
SPIRITUAL CARE IN NURSING

by

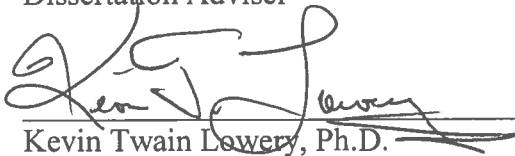
Charlotte S. Connerton

Dissertation



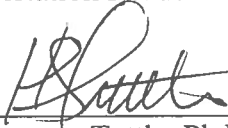
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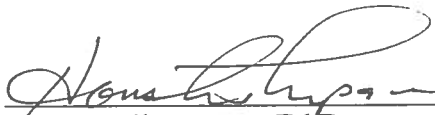
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ABSTRACT

Nurses are challenged to delivery holistic care to their patients by the accreditation agencies. Holistic care includes care for the mind, body, and the spirit. The purpose of the study was to explore the perceptions of spirituality and spiritual care of practicing Registered Nurses (RNs) in a faith based and non-faith based hospital in the Midwest in order to increase self-awareness among practicing RNs. The research was guided by three questions: 1. What differences exist in the perceptions of spirituality among practicing RNs in a faith based and non-faith based hospital? 2. What differences exist in the perceptions of spiritual care among practicing RNs in a faith based and non-faith based hospital? 3. What relationship exists between the RNs who practice religion and do not practice religion and the perception of meeting the spiritual needs of the patient? A convenience sample of for the faith-based hospital was $n = 209$ and for the non-faith based hospital was $n = 206$. Data was analyzed using the Mann-Whitney U and a Chi-Square. The results demonstrated that there was a significant difference in spirituality and spiritual care in a faith based and non-faith based hospital. The results did not demonstrate a relationship between RNs' who practice religion and do not practice religion and the perception of meeting the spiritual needs of the patient.

Keywords: spirituality, spiritual care,

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CHAPTER I

INTRODUCTION

Holistic care of the patient includes care of the mind, the body, and the spirit. Spiritual care in nursing addresses the spiritual needs of patients. Spirituality is a functional health care pattern. Spirituality is a value and belief system. Spirituality and spiritual care are beginning to be defined in the nursing literature. According to the American Nurses Association (2008), “an individual’s lifestyle, value system and religious beliefs should be considered in planning health care with and for each patient” (p. 147). According to Narayanasamy (1999), spirituality is rooted in awareness; presents to all individuals; derived from a transcendent God, ultimate reality, or whatever the individual values as supreme; and can evoke strong feelings. These feelings may be faith, hope, love, and acceptance. Spirituality encompasses the patient’s whole being during states of well-being and illness. Wright (1998) stated “spirituality is an integral part of being human” (p. 81). According to the American Nurses Association and Health Ministry Association [ANA & HMA] (2012) spiritual care involves any type of intervention which addresses the whole person’s state of being. Spiritual care should involve assessment, nursing diagnosis, planning, implementation, and evaluation of outcomes.

The Joint Commission on Accreditation of Healthcare Organizations does not tell organizations what to include in a spiritual assessment. However, The Joint Commission (2008) provided the following questions directed to the patient or his/her family:

- Who or what provides the patient with strength and hope?
- Does the patient use prayer in their life?
- How does the patient express their spirituality?
- How would the patient describe their philosophy of life?
- What type of spiritual/religious support does the patient desire?
- What is the name of the patient's clergy, ministers, chaplains, pastor, rabbi?
- What does suffering mean to the patient?
- What does dying mean to the patient?
- What are the patient's spiritual goals?
- Is there a role of church/synagogue in the patient's life?
- How does your faith help the patient cope with illness?
- How does the patient keep going day after day?
- What helps the patient get through this health care experience?
- How has illness affected the patient and his/her family? (para 1)

The intent of spiritual care in nursing is to assess and respond to the spiritual needs of each individual patient. The patient's spiritual needs will be based on his or her spirituality. The patient may express this need or the need may be implied. The nurse must be astute enough to pick up on the need whether it is stated or implied. The nursing literature has published several spiritual assessment tools. The *Stolls's Guidelines for Spiritual Assessment*, *Dossey's Spiritual Assessment Tool*, and the *HOPE Model of Spiritual-History-Taking*, the *FICA tool*, and *Jarel Spiritual Well-being scale* (Hickman, 2006; McEwen, 2005). One assessment tool called *BELIEF* which addresses beliefs and values can be used with pediatric patients (McEvoy, 2003). The tools used reflective

questions to assess and evaluate spiritual issues relating to the patient's concept of God or deity, sources of strength and hope, meaning and purpose, interconnectedness, and religious practices (Hickman; McEwen). Once an assessment is completed the nurse can incorporate the identified needs of the patient into a plan of care to help the patient's spiritual needs be met.

O'Brien (1999) identified seven nursing diagnosis related to alterations in spiritual integrity. The diagnoses were spiritual pain, spiritual alienation, spiritual anxiety, spiritual guilt, spiritual anger, spiritual loss and spiritual despair. The North American Nursing Diagnosis Association International (2014) has also identified readiness for enhanced spiritual well-being and spiritual distress. A nurse could use one of these nursing diagnoses to plan and implement spiritual care for and with his or her patient.

Implementing holistic, patient centered care is a required component of nursing education for baccalaureate prepared nurses as described by the American Association of Colleges of Nursing (2008) and specifically delineated in Essential VIII Professionalism and Professional Values and IX Baccalaureate Generalist Nursing Practice. Essential VIII rationale stated that Baccalaureate graduates should be able to recognize the impact of attitudes, values, and expectations on the care of all patients especially vulnerable populations (American Association of Colleges of Nursing). Essential IX rationale stated that baccalaureate graduates should be prepared to implement holistic, patient centered care (American Association of Colleges of Nursing).

Registered Nurses (RNs) from all educational levels might also follow the guidelines established by the National League for Nursing (2013a, 2013b, 2013c, 2013d) and specifically delineated in competencies of Professional Identity and Human Flourishing.

The rationale for the competence of Professional Identity, the nurses' role from associate degree to doctorate of nursing practice should be implemented in ways to deliver evidence-based care to diverse populations and promote positive changes in people, systems, or policy. The rationale for the competence of Human Flourishing, the nurse should be prepared to advocate for patients in ways to promote their self-determination, integrity, and ongoing growth as human beings. In addition, the nurse should promote progress toward fulfillment, being a leader or change agent in the specialty area of practice, and promote human flourishing within the organizational culture.

Cronewett et al. (2007) identified patient-centered care as one of the quality and safety education measures utilized when educating nurses. Registered Nurses practicing patient-centered care will look at patients as partners and will incorporate the patients' preferences, values, and needs into the plan of care. Understanding holistic care brings the patient's individual cultural and religious beliefs into the plan of care. Holistic care is crucial to the quality of care provided to all patients. The National Council of State Boards of Nursing (2012) included detailed test content mastery involving religious and spiritual influences on health.

Taylor (2008) conducted a study of spiritual care in nursing with a panel of nine experts to identify the most appropriate therapeutic interventions which nurses can provide. Taylor identified seventeen therapeutic interventions. "Helping a patient have quiet time or space was relevant in highly intensive, busy, and noisy environments where healthcare delivery is typically performed" (p. 157). Sharing spiritual materials such as tapes or readings requires too much attention for those patients in an acute setting. Taylor

recommended that further studies need to be conducted to promote informed practice and enlightened health policy.

Prior to the 1990s, nursing research was sparse on spiritual issues (McEwen, 2005). Since that time there have been clusters of research on frequencies and characteristics of spiritual care provided by nurses, spiritual care in education, descriptions of spiritual needs or spiritual care to specific aggregates, and research on discrete concepts (McEwen). McEwen recommended that nurse leaders, scholars, managers, and educators work toward equipping nurses to provide spiritual care through enhancing education, research, and application to practice.

Statement of the Problem

According to Hood, Olson, and Allen (2013), “despite mandates to provide spiritual care, confusion persists among nurses about spirituality, spiritual needs, and related roles” (p. 1198). It is suspected that this issue is due to lack of self-awareness, educational preparation, or confidence in identifying a need for spiritual care (Abbas & Dein, 2011; Narayanasamy, 1993). Registered Nurses need to examine the relevance of spirituality and spiritual care and provide this type of care to their patients. Therefore, Registered Nurses were asked to examine their understanding of spirituality and spiritual care in order to determine their delivery of spiritual care.

Incentive to conduct this study came from the individual’s lived experience of receiving and providing spiritual care during the death of a loved one. There was a scarcity of research on comparison of Registered Nurses who have received specialized instruction on spiritual care and those who have not received specialized instruction on spiritual care. The purpose of the study was to explore the perceptions of spirituality and

spiritual care of practicing Registered Nurses (RNs) in a faith based and non-faith based hospital in the Midwest in order to increase self-awareness among practicing RNs.

Background

Animism and primitive medicine demonstrated that women were the ones who cared for children and those people affected by disease (Narayanasamy, 1999).

Narayanasamy reported that their care was based on animism and superstition along with the support of the medicine men or physician-priest. As far back as ancient Egypt (5000 – 1500 BC) hieroglyphics depict that mental and physical illness were inseparable and understood in religious terms (Hickman, 2006). Interventions such as laying on of hands and use of pulse were used. Hinduism used herbs, water, incantations, dancing, and amulets to cure illness (Hickman). China treated disease with acupuncture and medicine (Hickman). Judaism and health were tied together in which the body is God's masterpiece and people were to take care of it and seek healing (Hickman).

Deaconesses, early nurses, in the first century ministered to those in need of healing (Hickman, 2006). These nurses put into practice the Corporal Works of Mercy which are to feed the hungry, to give water to the thirsty, to visit the imprisoned, to shelter the homeless, to care for the sick, and to bury the dead (Narayanasamy, 1999). This practice continued until about 1500 -1700 AD when the reformation began with the split of the Western Christian Church and the Protestant Church (Hickman). The Roman Catholics continued to have nursing orders to heal the sick in hospitals and communities while the Protestants closed the monasteries, hospitals, and suppressed religious orders caring for the sick (Hickman). In the 1820s, Germany saw a rebirth of the nursing orders. Nursing was introduced in the Western Hemisphere based on the foundations of the

mother countries. Florence Nightingale was considered the founder of modern professional nursing. Nightingale received her training in Kaiserswerth, Germany. Nightingale believed that an individual must harmonize oneself with the divine sources of all existence (Hickman). Nursing was considered a calling and nurses had received very little education training. In 1853, Nightingale visited hospitals in France to inspect hospitals, religious institutions, and observe surgeries (Hickman). Nightingale shortly after was able to utilize what she had observed during the Crimean War. It was after the Crimean War experience that she established the first school of nursing.

It was not until after the Civil War in America that nurses begin to establish nurse training schools. The difference between Nightingale's school of nursing and America's school of nursing was based on funding of the training. Nightingale's school was privately funded. America's school of nursing was funded by hospitals and not financially independent. With the move of nursing care being moved from the home into the hospital the delivery of nursing care became highly regimented and task oriented with little attention being given to the spiritual and psychosocial needs of the patient (Hickman, 2006).

During the 1950s nursing curricula was divested of spiritual content and replaced with content about major world religions (Hickman, 2006). Theorist such as Henderson, Peplau, Levine, Travelbee and Watson all addressed spiritual needs as a component of nursing (Hickman; Narayanasamy, 1999). The 1980s and 1990s brought about an intense interest in holistic health. Holistic health is care for the mind, the body, and the spirit. According to McSherry and Draper (1997), teaching concepts and interventions related to spiritual care is fairly new to nursing education.

According to Wright (1998), the ethical principles of beneficence, nonmaleficence, autonomy, and advocacy were also applicable to spiritual care. Beneficence is the duty to do good, a nurse can accomplish this by including the patient's religious, cultural, and spiritual needs into the plan of care. Wright believed that withholding spiritual care can be a violation of nonmaleficence. Autonomy requires nurses to assess patient's spiritual needs to assist the patient with self-determination of care. Nurses can perform advocacy by assisting patients to meet their spiritual needs.

According to Wright (1998), the nurse has a professional, ethical and legal responsibility to the patient to provide spiritual care. Spirituality is interdependent and interrelated to all components of the human dimension (Wright). In order to provide holistic care the nurse must be able to meet the spiritual needs of the patient. Ledger (2005) implied it is the nurse's duty to assess spiritual needs of each patient, identify the need, and help the patient meet this need without frightening the patient. Not all nurses will feel confident enough to assess and meet the patient's spiritual need (Narayanasamy, 1993). The nurse must recognize that this as a limitation and refer the patient to a nurse who feels confident addressing spiritual care or an appropriate person such as clergy or a rabbi who can assist the patient to meet their spiritual needs.

Govier (2000) proposed the five Rs of spirituality to build a systematic approach to assess spiritual care in nursing. The five Rs included reason, reflection, religion, relationships, and restoration. Once the nurse has completed the assessment he or she can use the nursing process to meet the patient's spiritual needs.

Campinha-Bachote (2002) developed a model for cultural competent care. The principles for the model of cultural competent care were applied to the topic of spiritual

care. Nurses can develop and obtain competence with spiritual care. Competence of spiritual care must begin with the nurse wanting to be engaged in the process of becoming knowledgeable about spiritual care and in the delivery of spiritual care. Self-awareness is the first step. The self-assessment would identify how the nurse defined spirituality and spiritual care, in addition to an examination of values, biases, and prejudices. Those nurses who are not spiritually aware may try to impose their spiritual beliefs on their patients (Campinha-Bachote). The second step would be spiritual knowledge. Once spirituality and spiritual care have been defined by self, he or she could start to examine how others such as the patient or other nurses defined spirituality and spiritual care. Step three would be carrying out a spiritual assessment with the patient to determine if there is a spiritual need. Step four would be incorporating the patient's spirituality into his or her plan of care. Step five would be exploring more than one patient's spirituality and spiritual needs. The building of his or her knowledge base can then be achieved by adding other's additional practices and beliefs into the plan of care where appropriate for each individual patient. If the nurse was to follow all of the steps for the development of spiritual care competency he or she would be able to identify his or her spiritual care practices in order to meet the spiritual care needs of their patients.

Taylor (2008) conducted an exercise to determine content validity of spiritual care in nursing. The panelist of nine doctoral prepared nurses with publications on spirituality concurred that activities involved with assessment and listening, supporting spiritual practices, making referrals, and communicating with colleagues regarding patient spirituality were considered spiritual care therapeutics. Even among the panelist of

experts there were disagreements of what spiritual care in nursing entailed. This would be recommendations for further studies of spiritual care in nursing.

McEwen (2005) cited three categories of barriers to spiritual nursing care: personal or individual; knowledge; and environmental, institutional, or situational. Among the list were viewing spiritual needs as being private, concerns of own spirituality, uncomfortableness of dealing with the conditions which lead to spiritual distress, lack of knowledge of others' beliefs, lack of time, and environment being nonconductive to talking about spiritual needs. The barriers need to be taken into consideration when studying about spiritual care in nursing.

Research Questions

1. What differences exist in the perceptions of spirituality among practicing RNs in a faith based and non-faith based hospital?
2. What differences exist in the perceptions of spiritual care among practicing RNs in a faith based and non-faith based hospital?
3. What relationship exists between the RNs who practice religion and do not practice religion and the perception of meeting the spiritual needs of the patient?

Description of the Terms

Faith based hospital. "A hospital affiliated with, supported by, or based on a religion or religious group: faith-based charities" (Random House, 2015)

Registered Nurse. "Is a nurse who has graduated from a state-approved school of nursing, passed the professional nurse licensure examination (NCLEX-RN), and has been granted a license to practice within a given state" (Venes, 2013).

Specialized instruction. According to the Church Health Center (2013), specialized instruction is the completion of an educational course or content on spiritual beliefs and practices of faith communities.

Spiritual Care. According to the ANA and HMA (2012) spiritual care involves any type of intervention which addresses the whole person's state of being.

Spirituality. According to Narayanasamy (1999), spirituality is rooted in awareness; presents to all individuals; derived from a transcendent God, ultimate reality, or whatever the individual values as supreme, and can evoke strong feelings. These feelings may be faith, hope, love, and acceptance.

Significance of the Study

Nurses are challenged to delivery holistic care to their patients by the accreditation agencies. Holistic care includes care for the mind, body, and the spirit. The purpose of the study was to explore the perceptions of spirituality and spiritual care of practicing Registered Nurses (RNs) in a faith based and non-faith based hospital in the Midwest in order to increase self-awareness among practicing RNs. The findings from this study determined the spiritual care practices of practicing RNs in a faith based and non-faith based hospital. The information obtained from this study will serve to stimulate further research and discussion on spiritual care in nursing.

Process to Accomplish

Purpose

The purpose of the study was to explore the perceptions of spirituality and spiritual care of practicing Registered Nurses (RNs) in a faith based and non-faith based hospital in the Midwest in order to increase self-awareness among practicing RNs.

Population and Sample

The target population studied was practicing Registered Nurses (RNs) from two hospitals in the Midwest. One hospital was a faith-based hospital and the other hospital was a non-faith based hospital. All practicing RNs were invited to participate in a study on Spiritual Care in Nursing. The educational level of the RNs was an associate degree, diploma certificate, Baccalaureate, Master, or Doctorate. The population of practicing RNs at the faith-based hospital was $N = 1554$. The population of non-practicing RNs at the non-faith based hospital was $N = 760$.

A convenience sample from the targeted population of practicing RNs was drawn from the two Midwest Hospitals. All RNs were invited to participate in the study. The sample was determined by those who complete the survey. The participants were invited by a flyer, through various meetings, personal conversation with the nurse managers and nurses, and electronic invitation. The larger the sample size the less margin error can be expected. If the sample size is $n = 240$ the margin of error is 5%, $n = 200$ the margin of error is 5.74%, or $n = 100$ the margin of error will be 9% (Raosoft, 2004). The learner will met with the nurse employee who will serve as the data collector to pass out packets with detailed instruction sheets for data collection, survey tools and collection envelopes for informed consents and completed survey tools.

Methodology

This was a quantitative and descriptive research study using the characteristics of a survey with the use of a scale. Leedy and Ormrod (2013) described quantitative research as involving the measurement of one or more variables. Leedy and Ormrod defined survey research as asking questions about their opinions, attitudes, and

characteristics of one or more groups. According to Robson (2011), “there are measurement scales where the function is not to test but to gain some insight into what people feel or believe about something” (p. 303). Leedy and Ormrod indicated that rating scales facilitate evaluation and quantification of complex phenomena. Three different questionnaires were reviewed and were appropriate for the study of spiritual care in nursing. The learner contacted each of the primary authors to ask for permission to utilize the instrument and permission was granted (See Appendix A).

Measures

Burkhart, Schmidt, and Hogan (2011) developed and tested the *Burkhart Spiritual Care Inventory (BSCI)*. The *BSCI* determines the delivery of spiritual care to patients and the impact that care has on the nurses’ spirituality. A convenience sample $n = 298$, $n = 248$ nurses at the hospital and $n = 50$ graduate student nurses in study one. The *BSCI* was initially a 48 item questionnaire. Study two was streamlined down to 18 item questionnaire; $n = 78$, $n = 30$ staff nurses and $n = 48$ graduate student nurses. The *BSCI* was analyzed using exploratory factor analysis of spiritual care interventions, meaning making, and faith rituals with internal consistency measures for the subscales above 0.8 in study one and above 0.87 in study two (Burkhart et. al).

Chan (2009) developed a tool to examine nurses’ attitudes and factors associated with providing spiritual care. The instrument was tested for internal reliability by test and re-test with Registered Nurses, $n = 10$. The results were $\alpha = 0.83$ for nurses’ perceptions, $\alpha = 0.82$ for nurses’ practices, and $\alpha = 0.84$ for overall spiritual care. Validity was established by confirmatory factor analyses. The target population was all nurses with an identified hospital. The questionnaire was distributed, $n = 178$, the completed

questionnaires was $n = 110$. The results were $\alpha = 0.83$ for nurses' perceptions and $\alpha = 0.82$ for nurses' practices. The correlation $r^2 = 0.15$ between perception and practices of spiritual care.

The *Spirituality and Spiritual Care Rating Scale (SSCRS)* by McSherry, Draper, and Kendrick (2002a) assessed the areas of spirituality and spiritual care along with how the individual felt about delivery of care. McSherry, Draper, and Kendrick (2002b) conducted a study where the authors developed a rating scale to assess spirituality and spiritual care of qualified nurses. The original scale was structured around nine fundamental areas pertaining to spirituality. The *SSCRS* was initially a 23-item scale. The instrument was piloted with 70 nurses, six statements were found to be problematic to the participants. The statements were removed from the scale before it was administered to over 500 participants. The internal consistency reliability of Cronbach's alpha coefficient was 0.64. The development of the *SSCRS* has since been utilized to gain a deeper understanding of spirituality and spiritual care. The *SSCRS* was modified with a Likert scale for the research process to quantify the results. Review of the literature revealed that the *SSCRS* has been used to assess the nursing populations (McSherry & Jamieson, 2011). No studies have been conducted to compare the perceptions of Registered Nurses who work in a faith based and non-faith based hospital related to spirituality and spiritual care. No studies have been done to do a comparative analysis the practicing RN who practice religion and do not practice religion and the perception of meeting the spiritual need of the patient. The learner determined that the *Spirituality and Spiritual Care Rating Scale* was the most appropriate for the study being proposed.

Procedures

The learner approached two Midwest Hospitals, one faith based and one non-faith based hospital to obtain permission to conduct research within the guidelines of the Institutional Review Boards. The learner complied with the policies and procedures concerning human subjects at the facilities which included additional training. The learner had to have a hospital representative within each hospital who was an employee. Data collection was done by the learner and the hospital representative with the cooperation of hospitals and the practicing RNs. All participants provided voluntary and informed consent.

Data collection was done by the researcher and the hospital representative with the cooperation of hospitals and the practicing RNs. All participants provided voluntary and informed consent. Two forms of data collection were utilized. Data collection was conducted through a paper method and an online method through a software program called Qualtrics. The researcher designed a flyer and letter to invite participants to join the study.

Paper survey tools were color coded to discriminate which hospital was faith-based and which was non-faith based. The faith-based hospital was on pink paper. The non-faith based hospital was on blue paper. The researcher met a hospital representative to explain the data collection process. The hospital representative met with the managers, provided detailed instruction sheets for distribution of the survey tool, posted the flyers, and provided packets of surveys with attached informed consents and collection envelopes to be distributed on the unit. The flyer was placed on units at the participating hospitals for 30 days. The surveys were available for a 30 day time period to the

practicing RNs. The researcher returned to collect the data packets at agreed upon times with the agencies which were established at the beginning of the study. An incentive of two \$25 gift cards from Wal-Mart was offered for each hospital. The names of participants obtained from the informed consent were placed in a hat and two names were drawn from the hat for each hospital at the completion of data collection. The gift cards and thank you notes were given to the nurse managers of the participating units at both agencies. A generalized comment was placed on the acknowledgement page thanking the nurse managers for assistance with study.

Online data collection was conducted with the assistance of the hospital representative and the technology department. A letter was designed inviting participants to join the study. The letter was emailed to all of the practicing Registered Nurses (RNs) or placed on the hospital web page for employees inviting them to participate. The first page of the survey obtained informed consent. If the participant answered yes, the survey continued to be conducted. If the participant answered no, the participant was logged out of the survey. The surveys were available for a 30 day time period to the practicing RNs. Reminder notices were sent out at 10 days and 20 days in the study. An incentive of two \$25 gift cards from Wal-Mart was offered for each hospital. The departments who participated were placed in a drawing and two departments were drawn out to receive the \$25 gift cards. The gift cards were to be used at the discretion of the departments who received the incentive for nursing employees. Thank you notes were given to the departments who participated.

Research Question One

1. What differences exist in the perceptions of spirituality among practicing RNs in a faith based and non-faith based hospital?

In order to answer this question the participants completed the selected statements on the *SSCRS*:

I believe spirituality is about finding meaning in the good and bad events of life. I believe nurses can provide spiritual care by enabling a patient to find meaning and purpose in their illness. I believe spirituality has to do with the way one conducts one's life here and now. I believe spirituality is a unifying force which enables one to be at peace with oneself and the world. (McSherry et al., 2002b, pp. 732-733) [See Appendix B]

The independent variable was the hospital. The dependent variable was Spirituality. A Likert scale of 1 strongly disagree, 2 disagree, 3 uncertain, 4 agree, and 5 strongly agree were used on each item. Descriptive statistics were used to analyze the data. A Mann-Whitney U was utilized to determine if there was a difference between the perceptions of spirituality among practicing RNs in a faith based and non-faith based hospital.

Research Question Two

2. What differences exist in the perceptions of spiritual care among practicing RNs in a faith based and non-faith based hospital?

In order to answer this question the practicing RNs completed the following questions on the *SSCRS*:

I believe nurses can provide spiritual care by arranging a visit by the hospital Chaplain or the patient's own religious leader if requested. I believe nurses can

provide spiritual care by showing kindness, concerns, and cheerfulness when giving care. I believe nurses can provide spiritual care by spending time with a patient giving support and assurance especially in time of need. I believe nurses can provide spiritual care by listening and allowing patients' time to discuss and explore their fears, anxieties, and troubles. I believe nurses can provide spiritual care by having respect for privacy, dignity, and religious and cultural belief of a patient. (McSherry et al., 2002b, pp. 732-733) [See Appendix B]

Registered Nurses rated the questions on a five point Likert Scale. The response options were as follows: 1 strongly disagree, 2 disagree, 3 uncertain, 4 agree, and 5 strongly agree. A variable for spiritual care was computed from these rankings. A Mann-Whitney U was utilized to determine if there was a difference between the perceptions of spiritual care among practicing Registered Nurses in a faith based and non-faith based hospital.

Research Question Three

3. What relationship exists between the RNs who practice religion and do not practice religion and the perception of meeting the spiritual needs of the patient?

In order to answer question three two questions were taken from Part A and two questions were taken from Part C. Part A questions: "Are you practicing your religion? How frequently do you practice your religion?" (McSherry et al., 2002a, pp. 6-7) [See Appendix B] Part C questions: "As a regular part of your nursing practice do you feel that you are usually able to meet your patient's spiritual needs? How often do you address the spiritual needs of your patients in practice?" (McSherry et al.) [See Appendix B] A Chi-Square was utilized to determine if there was a difference between Registered Nurses who practice religion and do not practice

religion and perception of meeting the spiritual needs of the patients. The second questions in both parts will be analyzed using frequencies.

Demographic variables

Demographic variables such as gender, age, educational preparation, lessons on spiritual care or faith based nursing during nursing school, years of experience as a Registered Nurse, years part-time or full time, specialty area, years of experience as a RN in the specialty area, and training courses since becoming a licensed RN were described.

Summary

The purpose of the study was to explore the perceptions of spirituality and spiritual care of practicing Registered Nurses (RNs) in a faith based and non-faith based hospital in the Midwest in order to increase self-awareness among practicing RNs. All practicing RNs were invited to participate at both facilities. The sample was the participants who signed the informed consents and returned the questionnaire. The questionnaire consisted of three sections: Section I was demographic data, Section II was the *Spirituality and Spiritual Care Rating Scale*, and Section III ask questions on how nurses felt about providing spiritual care and who should be responsible for that care. The *SSCRS* was a 17-item Likert scale asking about spirituality and spiritual care. Participants rated items from 1 strongly disagree to 5 strongly agree. Descriptive statistics were used to analyze the data. The compiled variable of spirituality and spiritual care were analyzed with the Mann-Whitney U. A Chi-Square was analyzed to determine if a relationship exists between the practicing RNs who practice religion and do not practice religion and the perception of meeting the spiritual needs of the patient. Those questions which asked for explanation generated qualitative results. The qualitative results were coded, analyzed

for themes, and placed in categories. Three research questions were asked to determine the differences in perceptions of the practicing RNs spirituality and spiritual care, and if a relationship exists between the practicing RNs religion and the perception of meeting the spiritual care needs of the patient. In the following chapter, the available literature and prior research on spirituality and spiritual care were summarized.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

According to the American Nurses Association (2008), “an individual’s lifestyle, value system and religious beliefs should be considered in planning health care with and for each patient” (p. 147). Holistic care involves care of the mind, body, and spirit. According to Soeken and Carson (1987), “these parts cannot be separated, but rather function as an integrated unit with the whole person more than the sum of the parts” (p. 603). Nurses who provide holistic care will incorporate spiritual care into their practices. The researcher has explored the concepts of spirituality and spiritual care. This chapter provided a discussion on historical aspects, spirituality, spiritual care, barriers, benefits, educational preparation, nurses’ and student nurses’ perceptions and patient’s perceptions of spiritual care.

Historical Aspects

Animism and primitive medicine demonstrated that women were the ones who cared for children and those people affected by disease (Narayanasamy, 1999). Narayanasamy reported that their care was based on animism and superstition along with the support of the medicine men or physician-priest. As far back as ancient Egypt (5000 –

1500 BC) hieroglyphics depicted that mental and physical illness were inseparable and understood in religious terms (Hickman, 2006). Interventions such as laying on of hands and use of pulse were used. Hinduism used herbs, water, incantations, dancing, and amulets to cure illness (Hickman). China treated disease with acupuncture and medicine (Hickman). Judaism looked to the body as God's masterpiece and people took care of it and sought healing (Hickman).

Deaconesses, early nurses, in the first century ministered to those in need of healing (Hickman, 2006). These nurses put into practice the Corporal Works of Mercy which are to feed the hungry, to give water to the thirsty, to visit the imprisoned, to shelter the homeless, to care for the sick, and to bury the dead (Narayanasamy, 1999). This practice continued until about 1500 -1700 AD when the reformation began with the split of the Catholic Church and the Protestant Church (Hickman). The Roman Catholics continued to have nursing orders to heal the sick in hospitals and communities while the Protestants closed the monasteries, hospitals, and suppressed religious orders caring for the sick (Hickman). In the 1820s, Germany saw a rebirth of the nursing orders. Nursing was introduced in the Western Hemisphere based on the foundations of the mother countries.

Florence Nightingale was considered the founder of modern professional nursing. Nightingale received her training in Kaiserswerth, Germany. Nightingale believed that an individual must harmonize oneself with the divine sources of all existence (Hickman, 2006). Nursing was considered a calling and nurses had received very little education training. In 1853, Nightingale visited hospitals in France to inspect hospitals, religious institutions, and observe surgeries (Hickman). Nightingale shortly after was able to

utilize what she had observed during the Crimean War. It was after the Crimean War experience that she established the first school of nursing. It was not until after the Civil War in America that nurses begin to establish nurse training schools. The difference between Nightingale's school of nursing and America's school of nursing was based on funding of the training. Nightingale's school was privately funded. America's school of nursing was funded by hospitals and not financially independent. Delivery of nursing care became highly regimented and task oriented with little attention being given to the spiritual and psychosocial needs of the patient when care was moved from the home into the hospital realm (Hickman).

During the 1950s nursing curricula was divested of spiritual content and replaced with content about major world religions (Hickman, 2006). Theorist such as Henderson, Peplau, Levine, Travelbee and Watson all addressed spiritual needs as a component of nursing (Hickman; Narayanasamy, 1999). The 1980s and 1990s brought about an intense interest in holistic health. Holistic health is care for the mind, the body, and the spirit. According to McSherry and Draper (1997), teaching concepts and interventions related to spiritual care were fairly new to nursing education. Clarke (2009) reported that nursing had taken spirituality away from the true source of religion. Clarke believed that nurses must refer back to religion and theology to determine how spirituality and spiritual care can meet the spiritual needs of the patient.

According to Wright (1998), the ethical principles of beneficence, nonmaleficence, autonomy, and advocacy were also applicable to spiritual care. Beneficence is the duty to do good, a nurse can accomplish this by including the patient's religious, cultural, and spiritual needs into the plan of care. Wright believed that

withholding spiritual care can be a violation of nonmaleficence. Autonomy requires nurses to assess patient's spiritual needs to assist the patient with self-determination of care. Nurses can perform advocacy by assisting patients to meet their spiritual needs.

According to Wright (1998), the nurse has a professional, ethical and legal responsibility to the patient to provide spiritual care. In order to provide holistic care the nurse must be able to meet the spiritual needs of the patient. Ledger (2005) implied it is the nurse's duty to assess spiritual needs of each patient, identify the need, and help the patient meet this need without frightening the patient. Not all nurses will feel confident enough to assess and meet the patient's spiritual need (Narayanasamy, 1993). The nurse must recognize that this is a limitation and refer the patient to a nurse who feels confident addressing spiritual care or an appropriate person such as clergy or a rabbi who can assist the patient to meet their spiritual needs.

Campinha-Bachote (2002) developed a model for cultural competent care. The principles for the model of cultural competent care were applied to the topic of spiritual care. Nurses can develop and obtain competence with spiritual care. Competence of spiritual care must begin with the nurse wanting to be engaged in the process of becoming knowledgeable about spiritual care and in the delivery of spiritual care. Self-awareness is the first step. The self-assessment would identify how the nurse defined spirituality and spiritual care, in addition to an examination of values, biases, and prejudices. Spiritual awareness reduces the risk of imposing the nurse's spiritual beliefs on the patient. The second step would be spiritual knowledge. Once spirituality and spiritual care have been defined by self, he or she could start to examine how others such as the patient or other nurses defined spirituality and spiritual care. Step three would be

carrying out a spiritual assessment with the patient to determine if there is a spiritual need. Step four would be incorporation of the patient's spirituality into his or her plan of care. Step five would be exploring more than one patient's spirituality and spiritual needs. The building of his or her knowledge base can then be achieved by adding other's additional practices and beliefs into the plan of care where appropriate for each individual patient. If the nurse followed all of the steps for the development of spiritual care competency, he or she would be able to identify his or her spiritual care practices in order to meet the spiritual care needs of the patients.

Spirituality

According to Soeken and Carson (1987), "the spiritual dimension of a person is broader than institutionalized religion, although for some persons spirituality is expressed and developed through formal religious activities such as prayer and worship services" (p. 603). Clifford and Gruca (1987) referred to spirituality as a complex area of human experience. "The root meaning of the term is related to its Latin origin breath" (Clifford & Gruca, p. 331). "The etymological derivation of spirituality contains a metaphor: Spirituality is as fundamental to humans as the act of breathing" (Clifford & Gruca, p. 331). Spirituality was interdependent and interrelated to all components of the human dimension (Wright, 1998). According to Narayanasamy (1999), spirituality is rooted in awareness; presents to all individuals; derived from a transcendent God, ultimate reality, or whatever the individual values as supreme, and can evoke strong feelings. These feelings may be faith, hope, love, and acceptance.

Coyle (2001) used a concept indicator to analyze spirituality in the literature. Three approaches were identified: transcendence, value guidance, and structural-

behaviorist. The transcendence was divided into transpersonal and intrapersonal. Transpersonal is a connectedness to a God/higher power/conscious universe. The transpersonal truth was connected to the sacred. Intrapersonal was the potentialities of self (p. 591). Transpersonal included the concept of rules when looking at faith. Contemplation of inner resources is the source of connectedness for intrapersonal. The truth of the intrapersonal was connected to self, others, and the divine. Faith was broken out into meaning and purpose which included hope, motivation, enabling, guidance, meaningful relationships, and self-identity. Value guidance was similar with all being connected to values/principles, ideals, and beliefs. The meaning and purpose was also the same for both. The structural-behaviorist approach had the similar attributes of religious commitment which was associated with the community of faith with church attendance, religious affiliation, prayer, and networks/social support in religious community. “Meaning and purpose is therefore a dimension of spirituality, which unifies all three approaches and which specific benefits to health” (p. 594). The benefit of a positive frame of mind encouraged healthy behavior.

Greasley, Chiu, and Gartland (2001) conducted a study related to the concept of spiritual care in mental health nursing. The concept of spirituality involved the notion of God, religion, metaphysical beliefs, and meaning and purpose within all focus groups. Interpersonal values identified by users and carers were the importance of love, caring, and compassion. Personal well-being was defined differently from the view point of users and carers versus mental health professionals. Users and carers associated spirituality with inner peace, emotional well-being, hope, personal crisis, and depression. Mental health professionals associated spirituality with self-fulfillment, opportunity to achieve

and being productive. Mental health professionals identified that spiritual needs were being addressed in the context of religious affiliation. All focus groups reported that cultural, religious, and spiritual beliefs affect how people respond to health and illness. Identifying and addressing spiritual needs required a personal, trusting relationship between patients and nurses.

Pesut (2002) conducted a mixed method study using the *Spiritual Well-Being Scale (SWBS)* and three opened-questions with nursing students. Triangulation was used to determine the nursing students' description of spirituality. The sample, $n = 35$, $n = 18$, was first year students and fourth year students respectively. The decrease in the sample size was attributed to attrition. The data from the *SWBS* were analyzed with Statistical Package for the Social Sciences (SPSS). Content analysis was performed with the open-ended questions and themes were identified. The spiritual well-being $mean = 108.7$ of first year students and $mean = 105.2$ of fourth year students indicated a high level of spiritual well-being. Existential well-being had a $mean$ of 52.7 and 50 for first and fourth year students respectively. Students reported feeling uncertain of the future and that life was full of conflict and unhappiness. Practical teachings on conflict management and personal and career planning may have been needed to increase the results for existential well-being. Themes identified to describe spirituality were relationship with a higher being, reason for living, journey of growth, and community.

Wright (2002) conducted phenomenological research into an inquiry of the essence of spiritual care. The sample, $n = 16$, was spiritual care stakeholders. Interviews were conducted with open-ended questions on spirituality and spiritual care. The interviews lasted from 31 to 90 minutes. Interviews were transcribed, coded and

categorized to identify themes. “Spirituality transcends the here and now by reaching both beyond and within the self, and has the capacity to search for meaning by addressing the big questions of life and death” (p. 127). Illness and the prospect of death can bring on a spiritual crisis. It is believed that when one is in spiritual crisis it can be a time of personal growth.

McEvoy (2003) defined culture as a particular set of beliefs of a given group of people in a given time. Emblem (1992) found that spirituality was explained as an individual’s personal beliefs, transcendent experiences, and principles. Spirituality was seen as subsystem of culture. Religion was described as an organized system of beliefs or a practice of worship and can be seen as a subsystem of spirituality (McEvoy). Nurses should talk with the patient and family to determine which cultural, spiritual, or religious practices are important to their well-being.

Sorajjakool and Lambertson (2004) defined spirituality as the search for the sacred. The sacred may be God, Allah, life force, energy, or a place set aside for spiritual significance (Sorajjakool & Lambertson). Spirituality can be involved in the coping process through a stable resource or burden, as an intervention, as a coping response, or as an outcome (Sorajjakool & Lambertson). It is believed that when one is in spiritual crisis it can be a time of personal growth.

McSherry, Cash, and Ross (2004) used a qualitative research design involving grounded theory to gain a deeper insight into the meaning of spirituality. The sample, $n = 53$, included nurses, patients, and representatives from four major world religions. A questionnaire was completed by participants prior to interviews. All interviews were recorded, transcribed, coded, and themes were identified. The findings demonstrated a

statistically significant difference between the language, interpretation, and understanding of the concept of spirituality among the sample. One nurse's definition, "I think it's different for every person, to me spirituality is what makes me feel what makes me!" (p. 937) Patient responded, "I have not a clue. I don't know what it means. To me it is just religion" (p. 938). A Muslim responded, "Will first of all spirituality exists within everyone whether you believe in God or not. To me personally it would be overall, look at the patient overall and address their needs to the way that they would see it" (p. 939). A Sikh responded, "Sikh religion is secretion of spirituality. Spirituality is the main thing in Sikh religion" (p. 939). A Hindu responded, "Yes spirituality is pertaining to religion and its principles" (p. 939). A Buddhist responded, "I was gonna say it's not a term we use in Buddhism as such! It's a hard word to define actually (laughing) it's just a difficult word to define" (p. 939). Factors which may account for the differences were professional education, age, gender, religious practices, and cultural influences.

McSherry (2006) conducted a qualitative study using grounded theory to advance spirituality and spiritual care. The sample, $n = 53$, participants were nurses, chaplains, social workers, occupational therapist, physiotherapist, patients, and the public. Information was collected by semi-structured interviews. Transcripts were coded and themes were identified. The principal components identified were individuality, inclusivity, integrated, inter-professional, intra-professional, innate, and institution. Individual described the personal nature of spirituality which is shaped by culture, socialization, life experiences, religious beliefs, and institutions. A spiritual need may or may not be directly expressed. Inclusively referred to all the stakeholders involved in the delivery of care to the patient. Spiritual care cannot be separated from the physical and

material. If it is separated, it may lead to fragmentation of care. Inter-professional is working with other professionals. Intra-professional is working within the same professional group. Innate is the possession of conscious or unconscious awareness of spirituality. Resources must be made available by institution and organizations to meet the patient's spiritual needs. All components must be addressed to meet the spiritual needs of the patients.

Lowry (2012) conducted a qualitative descriptive study of spirituality guided by the *Neuman System Model*. Using the *Neuman System Model*, patients should be given the opportunity to explain what spirituality means to them. The sample, $n = 40$, was elderly volunteers in East Tennessee. The sample was divided into focus groups of three to five participants each. Each focus group took part in an hour long meeting which was tape recorded.

Questions were: What does spirituality mean to you? How do you express your spirituality? What other words do you associate with spirituality? In what situations does your spirituality help you cope? How does your spirituality affect your health or feelings of well-being? What do you expect healthcare professionals to do for you related to your spiritual needs? Do you think that healthcare professionals should be taught how to meet spiritual needs of persons? (Lowry, p. 358)

Descriptive and interpretative methods were used to analyze the data. The identified findings were: Spirituality was defined as an individual, conscious, committed connection to God. God gives unfailing love, comfort, and support (Lowry). Spirituality helped volunteers to cope.

Govier (2000) proposed the five Rs of spirituality to build a systematic approach to assess spiritual care in nursing. The five Rs included reason, reflection, religion, relationships, and restoration. Once the nurse has completed the assessment he or she can use the nursing process to meet the patient's spiritual needs.

A variety of definitions and meanings have previously been published on spirituality. Spirituality is connected with religion and derived from a transcendent God or higher being (Coyle, 2001; Emblem, 1992; Govier, 2000; Greasley et al., 2001; Lowry, 2012; McEvoy, 2003; Narayanasamy, 1999; Pesut, 2002; Soeken & Carson, 1987; Wright, 2002). Greasley et al. related spirituality with the concept of well-being and finding mean and purpose. Sorajjakool and Lamberton (2004) defined spirituality as the search for the sacred. At the present time there is not one universal definition on spirituality. Spirituality can be seen as individualized for each person. The study being conducted explored what differences exist in the perceptions of spirituality among practicing RNs in a faith based and non-faith based hospital? Participants were asked about their religious affiliation, practice of their religion, and if spirituality was obtained outside of a religious affiliation.

Spiritual Care

Chronic illness can result in an imbalance or disharmony of mind, body, and spirit (Soeken & Carson, 1987). The imbalance or disharmony can be treated with holistic care, which will address physical, social, mental, and spiritual aspect of care. According to Piles (1990), spiritual care must go beyond honoring dietary regulations and other special requests of a religious nature. Health care providers can show spiritual care by providing kindness, respect, and listening to the individual. Spiritual care can affirm the value of the

individual by addressing spirituality and maintaining health and well-being (Lowry, 2012).

Soeken and Carson (1987) identified emotions as an aspect of alerting the nurse to a spiritual need. "Pain, low self-esteem, feelings of isolation, powerlessness, hopelessness, and anger are all possible consequences of chronicity- impact on one's ability to affirm life to the fullest" (p. 606). The nurse providing spiritual care around pain can explore with the patient the meaning of suffering and the patients' beliefs about God. Does the patient feel that this is a punishment from God and refuse treatment for the pain? When one experiences low self-esteem, the patient may see himself or herself as out of step with the rest of the world (Soeken & Carson). The love of oneself is connected with the love of God and can provide support and sustenance (Soeken & Carson). Isolation can be the drawing away from one's self, family, friends, environment, and God. Chronic illness takes a toll and can decrease the person's independence and religious practices (Soeken & Carson). Providing activities related to religious practices or referral can be a form of spiritual care. Powerlessness or feelings of having no control can cause the patient to feel a loss of empowerment by God (Soeken & Carson). Spiritual care would be involving the patient in the plan of care and giving the patient some control by encouraging spiritual practices such as prayer, quiet meditation, scriptural readings, and communion. Hope allows the patient to look to the future by setting goals, taking actions, and being involved with others (Soeken & Carson). Anger is common to chronic illness (Soeken & Carson). The patient may feel anger toward God, others, and self (Soeken & Carson). The nurse can provide spiritual care by encouraging the patient to overcome the anger, receive and accept forgiveness, and also forgive others. Spiritual

care is multi-dimensional and needs to be holistic to cover all aspects of the mind, body, and the spirit.

Stiles (1994) conducted a phenomenological study that described the meaning of spiritual relationships between hospice nurses and families. The sample included ($n = 11$) hospice nurses and ($n = 12$) families in bereavement. All of the nurses were women ranging in age 30 to 69 years. “Six nurses had associate degrees or diplomas and four had bachelor of science in nursing degrees” (p. 19). Families consisted of a patient, spouse, and/or children who had been in hospice two weeks to one month. Data were analyzed using Husserlian phenomenology and an ethnographic computer program. Themes identified were nurses’ ways of being, knowing, receiving and giving, and welcoming a stranger. Shared experiences were availability of the nurse, sitting with the patient and family, truth telling, humor, pain control, explaining, teaching, reassuring, preparing, personal growth, entrusting love one with the nurse, and helping patients die with dignity (Stiles). Nurses shared their knowledge of the dying process and their knowledge of the transcendence. Stiles reported that nurses and family spiritual relationships were for the most part in unity. These findings support the proposed research by demonstrating the impact which spirituality and spiritual care can have on patient perceptions. The presence of the nurse was felt by the family in the time the nurse spent at the bedside of the dying loved one (Stiles). Surviving family members were encouraged by the nursing care provided and lead them to want to volunteer on the hospice unit in the future. The nurse-patient spirituality relationship was enriched and could be used to develop a definition of a spiritual relationship. A spiritual relationship was defined as a relationship between the patient, the nurse, and God or ultimate

power to assist the patient meet a spiritual need. Spiritual care could be delivered to meet the need. A variety of interventions could be provided such as prayer, mediation, grief-facilitation, scriptural readings and so forth.

Harrington (1995) conducted a qualitative research study in Australia with a sample ($n = 20$) of Registered Nurses (RN). An inclusion criterion was RNs with two years' work experience. Interviews were conducted and taped over a one to two hour time period. Four interview questions were asked:

Describe briefly what you understand by the term spirituality. Please indicate how you would give spiritual care to your client/patient? Do you normally want to be asked before you give spiritual care to your client or is it part of the normal care you give? Do you believe you have had adequate preparation for you to assess spiritual needs and offer spiritual care? (Harrington, pp. 8-10)

Collected data were first, hand coded then an ethnography computer was used to identify elements. The four elements identified were: the nurse, practice setting, educational preparation, and spiritual care. The nurses' beliefs and values influenced the spiritual care implemented. One RN reported, "I don't prioritise it in my life then I don't prioritise it in my patient's life (Harrington, p. 11). "Respondents felt strongly that spirituality is a private matter and that they should intrude in this domain" (Harrington, p. 11). Spiritual care was delivered in the form of listening, exploring issues, praying, and tender loving care (Harrington).

Hicks (1999) proposed that spiritual nursing care with the elderly was divided into four phases: achieve a state of personal comfort, assess resident's spirituality, provide spiritual intervention, and evaluate spiritual outcomes. The state of personal comfort was

self-awareness. Spiritual assessment can be accomplished through questioning and observation of social isolation, depression, questioning the meaning of existence, attendance at spiritual services, and display of religious items. Spiritual interventions can be offered in one of three ways: silent witnessing, a liaison role, and active listening (Hicks). Evaluation should be conducted to see if the spiritual intervention was effective.

Pesut (2002) identified themes to provide spiritual care were building relationships and characteristics of the nurse such as kindness, compassion, and an attitude of service. Pesut research demonstrated students' spiritual health along with developing an understanding of spiritual nursing care can help students to meet the spiritual needs of their patients.

Gordon and Mitchell (2004) developed a competency model for assessment and delivery of spiritual care. The four level model could be used by all staff, volunteers, and multidisciplinary team members who have contact with patients, families, and carers. Level one referred to those staff and volunteers who had casual contact and sought to encourage basic skills of awareness, relationships and communication, and ability to refer. Level two referred to staff and volunteers who have duties requiring contact, built upon level one requirements, and identified personal training needs. Level three referred to multidisciplinary teams, built on levels one and two, and moved into assessment, development of a plan of care, and documentation. Level four referred to those employees that involved management and facilitation to meet the spiritual and religious needs of patients, families, and careers.

Training and reflective practice was conducted over a four-month time period with each session lasting one hour and scheduled six weeks apart. The training was

conducted by a hospital chaplain with fourth level competence. The study included 24 participants, $n = 24$. Three findings were obtained from the study: good practices were affirmed, limits and personal skills were identified, and additional training and developmental needs were identified. Participants also expressed that development of spiritual and religious care were seen as important, profile of spiritual care was raised, and the pilot study increased discussion of the competencies for spiritual and religious care (Gordon & Mitchell, 2004). The research study, perceptions of spiritual care in nursing, being proposed would ask the participants to explore perceptions of their practices in the delivery of spiritual care that would include all levels of the competency model.

Sorajjakool and Lambertson (2004) believed that providing spiritual care was a privilege to strengthen the link between the patient and his or her resources. The nurse must recognize that each patient is at a different stage of spiritual growth and presents with individual spiritual needs. "These needs include physical, emotional, and/or spiritual areas of life (Sorajjakool & Lambertson, p. 98). Sorajjakool and Lambertson identified twelve pieces to take into consideration when providing spiritual care: know thyself, create a safe atmosphere, be aware of your surroundings, identify with the patient's humanness, let the patient be your teacher, ask well-chosen questions, mirror what you hear, reevaluate a patient's spiritual status, anyone can pray, be a person of hope, tackle the hard questions prior to the visit, and network.

Sawatzky and Pesut (2005) described the role of nurse as being a presence available to the patient as he or she searches for meaning. Sawatzky and Pesut proposed that nurses must begin to incorporate three elements into spiritual care: religious

background, scientific process, and a dialogue of existential influences. The religious perspective is important to the patient's spiritual well-being looking at his or her faith traditions (Sawatzky & Pesut). The scientific process allowed the nurse to think in a systematic way to address spiritual needs. The dialogue of existential influences has been what nursing has considered the psychosocial care in previous years (Sawatzky & Pesut). The key expressions of spiritual care were love, hope, and compassion addressing the most basic and universal needs of the patient (Sawatzky & Pesut). The attributes of spiritual care in nursing were intuitive, interpersonal, altruistic, and integrative (Sawatzky & Pesut). Intuition is a way of knowing beyond logic. Intuition is similar to sensing what the patient needs is something other than what is being provided physically to assist with healing (Sawatzky & Pesut). Interpersonal is the therapeutic use of self in the nurse-patient relationship. The nurse can use therapeutic communication skills such as active listening, reflection of feelings, restating, paraphrasing, silence, etc. to engage the patient in the plan of care which could include spiritual care. Altruism would be placing the needs of the patient before the nurse. The nurse can be empathetic, compassionate, kind, and caring in providing spiritual care. Integrative would be combining intuition, interpersonal, and altruistic attributes all toward achieving the best outcomes possible for the patient including the spiritual domain. Spiritual care is a concept that can be learned by developing therapeutic communication skills, offering of self, and placing the patients' needs first to help with healing of the mind, body, and spirit of the patient.

Cavandish et al (2006) identified complimentary therapies, presence, meditation, touch, active listening, humor, prayer, and referral as spiritual care activities. Hubbell, Woodard, Barksdale-Brown, and Parker (2006) conducted a descriptive study to explore

how rural Nurse Practitioners (NPs) in North Carolina integrated spiritual care into their practices. The sample ($n = 65$) was mailed a demographic sheet and the *Nurse Practitioner Spiritual Care Perspective Survey (NPSCPS)* questionnaire. The tool was tested with the Cronbach's alpha coefficient and descriptive statistics were used for the demographic data. The qualitative answers to the questions were compiled and themes were identified. Education preparation ranged from Doctorate to associate or diploma degree. Eighteen participants had no training related to spiritual care while 24 had spiritual care integrated into their basic education (Hubbell et al.). Seventy-seven ($n = 50$) of the NPs held Master's degrees. Seventy-three percent ($n = 47$) did not routinely provide spiritual care to their patients. Only 19% ($n = 12$) of the NPs actively participated in spiritual care. Fifty four percent ($n = 35$) of Nurse Practitioners incorporated care by referral to pastoral care, 46% ($n = 29$) with encouraging patients to pray, and 39% ($n = 25$) by talking with patients about spiritual or religious topics. Common themes identified were holistic care, active practices, respect for differences, hands off, religiosity, awareness of patients' beliefs, higher power, and life events to give meaning to spiritual care (Hubbell et al.)

According to Delgado (2007), the literature for meeting the spiritual needs of the patient can be classified into three target areas: communication, facilitation of religious or spiritual activities, and referral. Communication was aimed at the aiding the process of connecting to others or a supreme being (Delgado). Interventions included listening, building trust, and being a presence. Prayer, meditation, and arranging ritual needs such as dietary accommodation and administration of the sacraments were interventions focused on the facilitation of the religious or spiritual aspect. Referral would be achieved

through contacting the clergy or making information available concerning resources. Since 2000 literature on meeting the spiritual needs has declined and there has been a shift in the focus of spiritual care. Communication has expanded to include active listening, presence, actively exploring the patient's spirituality, comforting with words and physical contact, reminiscing, supporting, and demonstrating respect (Delgado). Therapeutic communication skills were important in all aspects of spiritual care. Effectively communicating with the patient builds a trusting relationship between the patient and the nurse.

Van Dover and Pfeiffer (2007) conducted a grounded theory study to explain the process Parish Nurses (PNs) use to provide spiritual care to parishioners in Christian churches. The sample included ($n = 10$) PNs who were recruited from the mid-west and southwest USA. Inclusion criteria were training from a formal parish nursing program and one year minimum experience working with a Christian congregation. Interviews were taped recorded and transcriptions were written verbatim. Constant comparison analysis was used to analyze the data collected. The questions were:

Would you please tell me about a time when you gave spiritual care to someone in your parish nurse practice? How long had you known the person and why were you caring for this person? (Van Dover & Pfeiffer, p. 215)

Fifty episodes of care were described. The theory which emerged was *Bringing God Near*. Parish Nurses come close to people who need spiritual care, bringing something of value (Van Dover & Pfeiffer). Parish nurses convey the love and power of Jesus to the parishioners to assist with wholeness during moments of elation, joy, distress or suffering. The five phases used were a trust in God, forming relationships with patients

and families, opening to God, activating or nurturing faith, and recognizing spiritual renewal and growth. Van Dover and Pfeiffer's findings supported the relationship of educational preparation and the practice of spiritual care.

Taylor (2008) conducted an exercise to determine content validity of spiritual care in nursing. The panelist of nine doctoral prepared nurses with publications on spirituality concurred that activities involved with assessment and listening, supporting spiritual practices, making referrals, and communicating with colleagues regarding patient spirituality were considered spiritual care therapeutics (Taylor). Even among the panelist of experts there were disagreements of what spiritual care in nursing entailed. "One panelist thought "Helping a patient have quiet time or space" was relevant only in highly intensive, busy, and noisy environments where health care is typically performed" (Taylor, p. 157). Another panelist thought spiritual care should only be related to the current health problem. Therapeutics such as giving a knowing look, actively listening to patients, using non-procedural touch, and story using could also be considered psychosocial care (Taylor). Guided spiritual imagery or dream therapy can be harmful if provided by the nurse (Taylor). One panelist described what therapeutics would be provided versus what could be provided by the training of the nurse (Taylor). The following therapeutics were agreed upon by all nine: talking about a spiritual concern, arranging a visit by the clergy, reading a nurturing scripture passage, discussion of meaning of the spirituality as it related to the illness, and how one spiritually copes with his or her illness (Taylor). Twenty four other topics were listed with scores ranging from one to eight on being in agreement of what therapeutics were appropriate for the delivery of spiritual care. The demonstration of disagreement among nine published experts on

spirituality indicates that further studies of spirituality and spiritual care need to be conducted.

Deal (2010) conducted a phenomenological study to explore nurses' experience of giving spiritual care. The sample ($n = 4$) nurses were interviewed and audio taped using unstructured interviewing techniques asking open-ended questions related to spiritual care. The interview opened with the statement talk to me about spiritual care. The interviews lasted one hour. Data were analyzed using Colaizzi's phenomenological method. The themes identified were spiritual care is patient centered, importance of spiritual care, simplicity of giving care, patients do not expect spiritual care but welcome it, and spiritual caregivers are diverse (Deal). Limitations of the study were the interviews were too long and the questions did not always describe the essence of spirituality. It was recommended that spiritual care should be initiated by the patient. Spiritual care is important because it offers comfort and peace to the patient.

Chronic illness could bring about a spiritual crisis. "Pain, low self-esteem, feelings of isolation, powerlessness, hopelessness, and anger are all possible consequences of chronicity – impact on one's ability to affirm life to the fullest" (Soeken & Carson, 1987, p. 606). These symptoms can alert the nurse to a need to conduct a spiritual assessment. Once a spiritual assessment is conducted and a need determined the nurse can determine if he or she will enter into a spiritual relationship with the patient to meet the need. Shared experiences were availability of the nurse, sitting with the patient and family, truth telling, humor, pain control, explaining, teaching, reassuring, preparing, personal growth, entrusting love one with the nurse, and helping patients die with dignity were components of a spiritual relationship (Stiles, 1994). Delivery of spiritual care can

increase the depth of the nurse-patient relationship. The nurse has been granted a privilege and opportunity that can help the nurse understand what gives the patient hope, meaning or the ability to cope during times of illness. Presence in the form of listening, exploring issues, praying, and showing compassion, kindness, and caring were all forms of spiritual care (Cavendish et al., 2006; Deal, 2010; Delgado, 2007; Gordon & Mitchell, 2004; Harrington, 1995; Hicks, 1999; Hubbell et al., 2006; Pesut, 2002; Sorajjakool & Lamberton, 2004; Stiles; Taylor, 2008; Van Dover & Pfeiffer, 2007). The study explored the spiritual care practices of RNs in a faith based and a non-faith based hospital.

Barriers to Spiritual Care

Piles (1990) conducted a study of practicing Registered Nurses (RNs) within the United States from four regions: North Atlantic, Midwest, Southern, and Western. The sample size was $n = 176$. Multiple regression analysis was utilized on the findings to report that the variables of ability, education, and opinion nearly accounted for two-thirds of the determinants for perceived practice of spiritual care. Sixty-five point nine percent of the respondents ($n = 122$) felt inadequately prepared to perform spiritual care. The highest barrier to spiritual care was lack of time at 87.1% ($n = 153$).

Harrington (1995) identified that perceived barriers to spiritual care were pluralism, fear, spiritual unawareness, confusion, and failure to heal. Hospice RNs ($n = 7$ out of 10) reported the setting makes a difference in delivery of spiritual care. Educational preparation for spiritual care was lacking. Individual RNs sought courses which would be relevant to learn spiritual care.

Vance (2001) conducted a descriptive correlational assessment through a survey to determine how acute care registered nurses (RNs) influence spiritual care delivery and

to identify barriers to spiritual care. The mail survey was distributed randomly ($n = 425$) with a response rate of 40.7% ($n = 173$) to nurses in acute care areas. The top three barriers identified are insufficient time, insufficient education, and belief that spiritual matters were private to the individual.

Wright (2002) and Sawatzky and Pesut (2005) identified difficulties with definitions of spirituality and spiritual care provision of services, delivery of care, personal challenges, and lack of confidence. The hope for the future of spirituality and spiritual care needed improvement through human touch, assessment, more research and resources, training for the recognition of the spiritual needs, and more accessible chaplains (Wright). Spirituality was the transcendence or going beyond the inner self and religion. Spiritual care should be non-judgmental care that affirms the value of the individual. Provision of services were inhibited by absence of generally accepted definition of spiritual care, time of patient stay, the relationship between care and the church, cultural differences, lack of the ability to measure the care provided (Wright). Spiritual care should be freely given and not constrained by time which interferes with a secular, task-oriented organization focused on outcomes (Wright). Better record keeping and information management could produce greater efficiency to monitor and document spiritual care outcomes. The proposed study explored the Registered Nurses' (RNs) perceptions of training provided and who the RNs recommend providing the training.

McEwen (2005) cited three categories of barriers to spiritual nursing care: personal or individual; knowledge; and environmental, institutional, or situational. Among the list are viewing spiritual needs as being private, concerns of own spirituality, uncomfortableness of dealing with the conditions which lead to spiritual distress, lack of

knowledge of others' beliefs, lack of time, and environment being nonconductive to talking about spiritual needs (McEwen). The barriers need to be taken into consideration when studying about spiritual care in nursing.

Cavandish et al., (2006) identified high tech care focus on physiological aspects, nursing shortages, heavy workloads, and comfort of discussing spirituality as barriers of spiritual care. For nurses to be perceived as a spiritual care provider, nurses need to have the awareness of patients' spiritual needs, the intent to provide spiritual care, and the appropriate spiritual care interventions (Cavandish et. al). Baldacchino, (2006) conducted a study with Maltese nurses to discover competencies of spiritual care with nurses. The Maltese nurses associated spiritual care with religiosity and for the most part felt incompetent to deliver spiritual care. Maltese nurses relied on the chaplains to deliver spiritual care. Nurses considered the incompetence was related to lack of educational preparation. In addition, identified factors which inhibit delivery of spiritual care are time, work overload, lack of privacy, nurses' perception that it is the sole domain of chaplain, lack of nursing expertise, and a religious conflict. Nurses felt inhibitions could be overcome by education; coordination, communication, and collaboration with interdisciplinary team; and provision of privacy.

Koenig (2007) the co-director of Duke's Center for the Study of Religion/Spirituality and Health believed that health care professional-patient boundaries were not threatened when spiritual assessments and support were provided to patients. Koenig identified personal resistance, fears, and unjustified concerns about delving into spiritual issues as barriers. Koenig's review of the literature demonstrated lack of knowledge, lack of training, lack of time, concerns about projecting beliefs onto patients

and uncertainty on how to address spiritual issues raised by patients as barriers to spiritual care. Koenig (2004) recommended receiving education, receiving training, recognizing the importance of spirituality to the patient, and time management as activities that help overcome barriers to spiritual care. In addition, Koenig (2007) believed that barriers could be overcome by exposing health care providers to research and providing training. Personal discomfort can be overcome by the nurse developing spiritual competence. Self-awareness is an integral part of the process.

Daaleman, Usher, Williams, Rawlings, and Hanson (2008) conducted qualitative research to explore the perspectives of healthcare professionals providing spiritual care at the end of life. Semi-structured interviews were used. The sample ($n = 12$) included physicians ($n = 8$), chaplains ($n = 2$), a nurse ($n = 1$) and housekeeping ($n = 1$). Barriers to spiritual care identified were lack of time, lack of privacy during the visit, and diversity of social, religious, and culture beliefs and values. The aspects identified to facilitate spiritual care were ample time, effective communication, and clinicians' personal experience with spiritual care.

Carr (2010) stated that time constraints were the number one barrier to spiritual care. The nurse who overextends himself or herself will not be able to meet the spiritual needs of the patient which leads to feelings of failure. This feeling of failure can extend to the nurse not attending to his or her own spiritual needs which can lead to burnout. Workload measurement systems broke tasks into time increments which does not take into account the amount of time to care for the whole person. The medical model and use of technology placed the focus on the disease of the patient and not the well-being of the total person. Professional boundaries could pose another barrier to spiritual care by

creating a social distance. Health care systems and the nurse must meet challenges to overcome the barriers that prevent or delineate the provision of spiritual care.

Abbas and Dein (2011) reported that it was difficult for staff on palliative care units to enquire about spiritual issues because of patients' and staff lack of vocabulary around spiritual issues, inability to deal with death and dying, training issues, feeling that spirituality is a private matter, fear of not being able to resolve the problem, confidence of own spirituality and lack of personal spiritual perspective, finding an appropriate time, and difficulties separating spiritual and religious needs. Training could build up the nurse's confidence through teaching how to cope with death and dying, how to conduct a spiritual assessment, teaching the differences of spiritual and religious needs, teaching spiritual care interventions, determining when it is appropriate to deliver spiritual care, and allowing the nurse to practice newly acquired skills within a safe environment. Spiritual care also requires time to be implemented.

Barriers could prevent RNs from delivering spiritual care. The three main barriers which have been identified were lack of educational preparation, lack of time, and lack of confidence (Abbas & Dein, 2011; Carr, 2010; Daaleman et al., 2008; Koenig, 2004; & McEwen, 2005). The study explored the practicing RNs perception if educational training was sufficient to provide spiritual care and why the spiritual care need is not able to be met.

Benefits of Spiritual Care

Coyle (2001) identified meaning and purposes as a dimension of spirituality which produces a positive frame of mind leading to healthy behaviors. Grant (2004) confirmed that nurses believed that spirituality and spiritual care can produce a particular

effect on patients. The sample, $n = 299$, was practicing nurses. The results confirmed the following effects on the patients: inner peace ($n = 299$, 100%), strength to cope ($n = 293$, 98%), physical relaxation ($n = 290$, 97%), self-awareness ($n = 287$, 96%), a greater sense of connection with others ($n = 281$, 94%), forgiveness of others ($n = 278$, 93%) and a more cooperative attitude ($n = 275$, 92%) (Grant). These effects could lead to physical healing, reduction of pain, and personal growth.

Koenig (2004) identified lower suicide rates; less anxiety; less depression and greater recovery from depression; greater sense of well-being, hope, and optimism; more purpose and meaning; high social support; and greater marital satisfaction and stability as marital benefits of addressing spiritual issues and concerns. Physical benefits would include lower death rates from cancer, less heart disease or better cardiac outcomes, better health behaviors, and increased longevity (Koenig). Pesut (2002), identified motivation, determining opportunities, and outcomes were benefits of talking to the patient about religious beliefs and values.

Swetz, Harrington, Matsuyama, Shanafelt, and Lyckholm (2009) conducted a study with physicians to determine ways that they could minimize their stress and prevent burnout in hospice and palliative medicine. The convenience sample ($n = 40$) was Hospice Palliative Medicine physicians (28 males, 12 females) from the state of Virginia. Specific strategies for promoting wellness were meditation, quiet time, reflection, prayer, religious services, spirituality, and enjoying nature as transcendental. Other thematic strategies were forgiving oneself, humor and laughter, and remembrance which have been considered as spiritual interventions that could reduce stress and prevent burnout.

Pereira, Fonseca, and Carvalho (2011) conducted a systematic review of burnout in palliative care. Protective factors of those nurses who work in palliative care were: individual and/or team prevention strategies, having time to spend with patients and families, effective communication, coping strategies for facing the death of a patient, building up a sense of understanding about patient's death, personal enrichment, caring for those who were dying as a significant feature, personal gratification, and personal and professional satisfaction (Pereira et al.). These protective factors employ components of spiritual care which help the nurse reduce the risk of burnout.

Benefits have been identified for provision of spiritual care. Coyle (2001) identified a positive frame of mind which can lead to healthy behaviors. Koenig (2004) identified psychological and physical benefits such as lower suicide rates, less anxiety, less depression, greater marital satisfaction, lower death rates from cancer, better cardiac outcomes, and increased longevity. Swetz et al. (2009) and Pereira et al. (2011) reported the nurses providing spiritual care could minimize their stress and prevent burnout in hospice and palliative medicine. The study explored the perceptions of practicing RNs toward spirituality and spiritual care providing an opportunity for forgiveness, finding meaning in life and in the illness, having a sense of hope, expression of concerns, and finding peace. An area that could be explored in future studies is the prevention of burnout in nurses related to the delivery of spiritual care and nurse satisfaction with his or her job in units besides hospice and palliative medicine.

Education Preparation

Piles (1990) reported that 89.2%, $n = 156$ practicing RNs felt that spiritual care should be included in every basic nursing program to help them prepare to provide

spiritual care to their patients. Approximately 57.9%, $n = 101$ felt that the assessment of the differences between psychosocial and spiritual needs/concerns was not addressed in basic nursing programs. Only 13%, $n = 22$ of the respondents included a spiritual concern or spiritual nursing diagnosis in the plan of care of their patients. Piles strategies for addressing spiritual care would be the following content areas: the spiritual dimension and how it differs from psychosocial dimension, parameters of spiritual needs and how they were manifested, assessment skills necessary to identify spiritual needs, appropriate intervention skills, and evaluation of care by patient outcomes.

Narayanasamy (1993) used *Chadwick's* 1973 modified questionnaire to determine nurses' awareness and educational preparation in meeting their patients' spiritual needs.

Narayanasamy asked the following questions:

Do you personally feel that patients have spiritual needs? How long has it been since you had recognized a spiritual need in your patients? To what degree do you feel your patients' spiritual needs are met? Would you like further education in meeting spiritual needs of patients? Open-ended response: Give an example of a nursing situation when spiritual care was given. (Narayanasamy, p. 199)

Data were analyzed with comparative analysis of descriptive statistics with the Chadwick (1973) findings (as cited in Narayanasamy). The sample ($n = 33$) was first level general nurses in England. All respondents felt patients had spiritual needs. Thirty-six percent ($n = 12$) had given spiritual care within the last month. Sixty-six percent ($n = 22$) felt that spiritual needs were not met. Approximately 91% ($n = 30$) would like additional education on meeting spiritual needs of patients. The top three examples of nursing situations where spiritual care was given were: care of the dying ($n = 11$), calling the

priest ($n = 8$), and terminal care ($n = 7$). Narayanasamy (1993) demonstrated that nurses' were aware of spiritual needs and felt that additional educational preparation was needed for the delivery of spiritual care.

Ross (1996) reported that formal teaching on descriptions and definitions of the spiritual dimension, spiritual needs, and spiritual care in the broadest terms along with the influence of the spiritual dimension on health and therefore the significance of spiritual care should be included in the content. Ross proposed that if nurses became aware of their own spiritual dimension it would open them up to the spiritual dimension of their patients. Nurses need to have efficiency in the referral process when it is beyond their limits to provide spiritual care.

Greenstreet (1999) stated that spirituality needs to be seen as a broad concept encompassing religion but not the same as religion. Fundamental to spirituality is the search for meaning within life. Teaching methods need to be participatory and student-centered for the means of assessing and meeting the spiritual needs through effective communication and being with the patient.

Grosvenor (2000) addressed components that should be assessed and determined in the teaching of spiritual care of nursing. The components were professional guidelines, integration of theory into practice, curriculum changes or by chance, who should teach the class, what content should be covered and who should decide, and peoples' spirituality. Grosvenor reported that nurses need to be able to take care of the spiritual needs independent of bodily and mental care.

Shih, Gau, Mao, Chen, and Lo (2001) used triangulation methods for empirical validation of a teaching course on spiritual care in Taiwan. The sample ($n = 22$) was

masters of science in nursing degree students. All of the students were Registered Nurses with at least one year of clinical practice with 17 years being highest amount of experience. The stages of the study were lecture, clinical implications, and presentation-appraisal. Course content was developed using four resources. Strategies for teaching were classroom lecture, field trips, observation of religious rituals, case study analysis, and reflection and evaluation through narratives. Ages of participants were 21 to 36 years of age. Data were analyzed using descriptive statistics. "Seventy-seven percent of the subjects ($n = 17$) reported having no experience with providing spiritual care" (p. 336). The course covered 14 topics. One hundred percent of the participants self-reported that the spiritual care course enhanced their understanding and delivery of spiritual care. Shih et al. reported that students had the confidence to recognize and deliver spiritual care to their patients through course evaluations.

Lemmer (2002) conducted a non-experimental survey with baccalaureate nursing programs. Six sections were incorporated: demographics, two open-ended questions defining spirituality and spiritual nursing care, *Spiritual Care Content Scale (SCCS)*, methods checklist, *Program Attitude Scale (PAS)*, and two open-ended questions based on the three instruments. The sample ($n = 132$) was baccalaureate nursing programs in the US. The mean number of hours was seven point two devoted to the spiritual dimension. The median amount of hours was five. Descriptive statistics and analysis of variance (ANOVA) were used to analyze data. Seventy-one point four percent ($n = 94$) of the programs identified the spiritual dimension in the philosophy and ninety-six point nine percent ($n = 127$) in the curriculum. There was not an agreed upon definition of spirituality and spiritual nursing care. The highest ranking instructional methods were

classroom lecture by faculty at 91.5% ($n = 120$) and classroom discussion at 85.4% ($n = 112$). Lemmer inferred that the nursing programs ($mean = 4.375$ out of 5) agreed that spiritual care is part of nursing and could be taught.

Meyer (2003) conducted a quantitative study to determine how effective nurse educators were preparing students in relation to providing spiritual care. There was a 79% response rate ($n = 280$) from the 355 students included in the convenience sample. A nine-item *Study Survey of Spiritual Care* tool was used to obtain data of perceived ability to deliver spiritual care. *Howden's 28-Spiritual Assessment Scale (SAS)* was used to measure the students' spirituality. Regression analysis was used to analyze the data. Programs with a religious affiliation showed a significant relationship between religion and spirituality ($r = .50, p < .01$). Students felt that spiritual care is an essential component of holistic nursing care ($p < .02$). Two hundred thirteen students indicated a positive change in views about spirituality since entering nursing school with comments such as being more open minded, a deeper understanding, and increased awareness of differing views.

Barnett and Fortin (2006) developed a workshop curriculum to address spirituality with medical students and residents. Components included in the workshop were social history with a spiritual assessment, the differences between religion and spirituality, prevalence of spirituality in the United States, how patients see spirituality in relation to health and illness, intentional harms of religious beliefs, barriers to and boundaries in addressing spirituality, spiritual assessment techniques, and pastoral care resources (Barnett & Fortin). Specific objectives, instructional strategies, and time allotted were

assigned to each content area. Two separate workshops were conducted, one lasted 2 hours and another lasted 1.5 hours.

Pre and post surveys were completed by participants on six statements. The statements were on attitudes toward spirituality and medicine, perception if spiritual and religious beliefs has an impact on health, perception if the individual medical student or resident's spirituality made a difference in communication and care of the patient, perceived competence in taking a spiritual history, perceived knowledge of pastoral care resources, and comfort working with hospital chaplains (Barnett & Fortin, 2006). Both medical students and residents increased scores, $p \leq .002$ regarding the appropriateness of inquiring about religious and spiritual beliefs in the medical encounter, perceived competence in taking a spiritual history, and perceived knowledge of available pastoral resources (Barnett & Fortin, p. 483). An increase of $p = .005$ was shown by students in perceived comfort in working with others on the healthcare team who emphasize caring for the patients' spirituality (Barnett & Fortin). This study demonstrated that educational preparation makes a difference in the assessment of spiritual needs and referral for spiritual care. The curriculum developed by Barnett and Fortin could be used with nurses to develop confidence in the recognizing and referring the patients for spiritual care. The study being conducted will look at the educational preparation of practicing RNs, their perceptions of their ability to recognize a spiritual need and delivery of spiritual care.

Lantz (2007) reported that it was imperative that nurse educators teach the art and science of spiritual care. Topics to be covered were definitions of spirituality versus religion, spiritual assessment techniques, nursing diagnoses related to spirituality, religious diversity, and methods to implement and evaluate spiritual care. Lantz

supported that legal implications, standards of practice, and ethical principles of spirituality must all be taken into consideration for teaching spiritual care in public institutions. The separation of Church and State could create a minefield for nurse educators about religion and spirituality, prayer, student-faculty discussion, religious symbols, and religious literature. These legal implications could become roadblocks to teaching spiritual care in the public institutions. On the other hand, accreditation agencies are calling on practitioners and educators to address spiritual care. Public institutions need to develop policies that would guide nurse educators to deliver quality education within the legal limitations (Lantz). Ethical principles should include respect for others and for human rights, autonomy, and advocacy. The nursing profession must understand and support teaching spiritual care to provide the best care possible for the patient.

Cerra and Fitzpatrick (2008) conducted a pilot test of a spiritual care educational in-service based on Narayanasamy's ASSET model within an acute care setting. The in-service was a two hour session on self-awareness, spirituality, and the spiritual dimension of nursing care. A pre- and posttest study design was used to determine the effect of the in-service on nurses' spiritual perspectives and the nurses' spiritual well-being. *Reed's Spiritual Perspective Scale (SPS)* and the *Spiritual Well-being Scale (SWBS)* were administered to the participants. The convenience sample, $n = 41$, was practicing RNs from medical, surgical, and telemetry units in the Northwest. A paired t -test was conducted to evaluate the impact of the in-service on the posttest SPS scores with a significant result of $p < .0005$, $t_{40} = - 4.94$ (Cerra & Fitzpatrick). There were no significant differences between the pre- and posttest results of spiritual well-being. A critical review of the study revealed the limitation of the generalizability. Cerra and

Fitzpatrick recommended that future research should be directed toward identifying the effectiveness of various strategies for teaching spiritual care in all types of nursing programs.

Baldacchino (2011) conducted a study on the perceived impact of teaching spiritual care to qualified nurses. The learning objectives were:

Define the terms spirituality, spiritual well-being, and spiritual care; increase awareness of personal spirituality; outline the spiritual distress-spiritual well-being continuum in illness; apply existing theories of stress/coping and research in care; assess the spiritual needs and coping of patients during illness; and foresee their role as change agent for holistic care. (Baldacchino, p. 48).

The mean years of clinical experience were 14.8, 16.6, and 17.5 between the three groups studied. The study unit was evaluated by completion of a five open-ended questions at the end of the unit. Study unit evaluation questions were:

Explain how you consider this study unit relevant to you personally and to your nursing care; explain how the various modes of teaching helped you to learn on spiritual care; how helpful was the assessment strategy; what impact did the study unit have on you; and comments and suggestions on the overall organization of the study unit.(Baldacchino, p. 50).

The data were analyzed using Burnard thematic analysis. Two themes and four categories emerged from the data. Theme one was updating with knowledge on the spiritual dimension in care. The two categories under the theme were increasing knowledge on spirituality and spiritual coping in illness and understanding the holistic impact of illness on the patients' life. A nurse from group B stated, "This study unit

helped me understand better the nature of patients' spiritual needs. I learnt that spirituality incorporates not only religiosity but any other coping strategy which may help the individual to find meaning and purpose in life" (Baldacchino, 2011, p. 50). One nurse from group C stated, "on considering the wholeness of spirituality in life, implementing spiritual care may facilitate holistic care which may enhance recovery of the whole person, irrespective of the specific illness" (Baldacchino, p. 50).

Theme two was self-awareness on the nurse's role in spiritual care. The two categories were becoming aware of own spirituality and nursing care and acknowledging the nurses' role as change agent. The nurse's self-awareness and the role of change agent were supported by statements from the participants. One nurse stated, "You can do nothing to inspire the person under your care if you do not inspire yourself. Unless the healthcare professionals become interested in holistic care and teamwork, the spiritual dimension in care will remain unnoticed" (Baldacchino, 2011, p. 51). Baldacchino reported that nurses increased knowledge about spirituality, spiritual distress, spiritual well-being, and spiritual care increased the implementation of holistic care. The research by Baldacchino demonstrated that educational preparation can have an impact on the nurses' perceptions during the delivery of spiritual care. The proposed study on spiritual care in nursing will explore practicing RNs perceptions on delivery of spiritual care by educational preparation, religious affiliation, and the environment of a faith based and non-faith based hospital.

Newbanks and Rieg (2011) conducted a qualitative study with parish nurses to determine if the basic preparation course prepared them to incorporate the spiritual

dimension into practice. The sample, $n = 15$, was female parish nurses who received their basic preparation course between 2004 and 2008. The research questions asked,

What degree of importance do you feel the spiritual dimension plays on holistic care? How do you perceive that the education you received from the faith community nursing educational program you attended prepared you to incorporate the spiritual dimension into your practice? Is there something you would like to see incorporated in the program that you feel would have better prepared you for your role in providing your clients with the spiritual dimension of their holistic care? (p. 150)

All fifteen participants chose very important for the importance of the spiritual dimension on holistic care. Two of the participants did not feel that the basic program prepared them to deliver spiritual care. Suggestions for improvement of the program included resources, networking, additional instruction on spiritual assessment and instituting a parish nurse program in the church, and discussion of non-Christian faiths.

Boswell, Cannon, and Miller (2013) conducted a cross sectional educational study of students' perceptions of holistic nursing care. A convenience sample, $n = 60$, was journal entries drawn from the traditional baccalaureate nursing students, RN-BSN completion students, and graduate level nursing students. The journal entries covered background information, lessons learned, opinions, and growth on spirituality and holistic care in nursing. A triangulation process was utilized with data, space, and person by each researcher. Boswell et al. identified key areas and commonalities between the groups. "Confusion between spirituality and religion was the primary concept verbalized in all three groups" (p. 332). Traditional undergraduate nursing students identified

communication, respect, self-reflection, knowledge deficit, and discomfort as concepts to be considered in spirituality and spiritual care (Boswell et al.). The RN-BSN students varying degrees of clinical experience bordered on the competency level in their thoughts on spirituality (Boswell et al.). Graduate nursing students identified the awareness of lifespan, journal entries express little or no need for spirituality to pediatric patients and the elderly needing spirituality (Boswell et al.). All three groups expressed a need for further education on spirituality and spiritual care delivery. Educational preparation should include the development of active listening skills, therapeutic touch, and open discussion of faith.

Educational preparation has been identified as a barrier to spiritual care (Abbas & Dein, 2011; Carr, 2010; Daaleman et al., 2008; Koenig, 2004; & McEwen, 2005). The study explored the nurse's educational preparation during nurse's training, courses or training after educational preparation, if the nurse felt that he or she received sufficient training on matters concerning spiritual care, and who should provide training on spiritual care. Educational preparation should impact the nurse's confidence in the delivery of spiritual care.

Nurses' and Student Nurses' Perceptions

Boutell and Bozett (1990) conducted research to determine if nurses assess patients' spirituality in Oklahoma. Findings reported that the older nurses were more likely to assess the patients' spiritual needs $F = 2.83, p = .0268$. Nurses working in psychiatric nursing were more likely to assess patients' spiritual needs $F = 3.52, p = .0049$. The four most frequently reported data collection methods were listening, observing cues, asking, and discussing the patient's needs with others. The four least

frequently used data collection methods were reading the patient's band or Kardex, discussing the patient's needs with clergy, reading the patient's medical history, and asking the significant other of the patient. Boutell and Bozett's study demonstrated that less than one-third of the 238 nurses placed emphasis on nursing assessment and interventions related to spiritual care.

Carroll (2001) conducted a phenomenological study to explore the nature of spirituality and spiritual care. The sample ($n = 15$) was hospice nurses. The hospice nurses received training to provide spiritual care. All of the data was examined extensively with the heuristic data analysis method. The themes which emerged were spirituality and soul; spirituality an interconnectedness with ourselves, God, others, and the universe; recognizing and assessing spiritual needs; demonstrating empathy and developing a trusting relationship; seeking help; recognizing when to let the patient be; and fostering the search for meaning (Carroll). The phenomenon of spirituality and spiritual care was dependent on the cultural, religious, and social background of the individual nurse. Spirituality extended into all aspects of life. Spiritual care is provided when trust is developed. Spiritual care can be delivered using an Interprofessional approach.

Vance (2001) conducted a descriptive correlational assessment through a survey to determine how acute care registered nurses (RNs) influence spiritual care delivery and to identify barriers to spiritual care. The mail survey was distributed randomly ($n = 425$) with a response rate of 40.7% ($n = 173$) to nurses in acute care areas. Three instruments were used: *Spiritual Well-Being Scale (SWBS)*, *Spiritual Involvement and Beliefs Scale (SIBS)* and *Spiritual Care Practice Questionnaire (SCP)*. The *SWBS* measured the meta-

physical and the existential dimension of spirituality (Vance). The *SIBS* assessed spiritual beliefs and actions free of religious and cultural bias (Vance). The *SCP* is separated into two areas: Part I measured assessment and intervention and Part II measured barriers. Content validity of the instrument was established by a panel of experts. Validity was assessed using the correlation of two separate spiritual inventories. Cronbach's alpha ranged from 0.64 for the *SCP Part II*, to 0.9 for the *SWBS*. A positive statistical significance ($p < .05$) was found between *SCP-Part I* and *SWBS* and *SIBS*. Only 34.6% ($n = 60$) provided spiritual support to their patients.

McSherry et al. (2002b) developed a tool to assess spirituality and spiritual care. McSherry et al. used quantitative research in the form of a descriptive survey to explore and analyze nurses' attitudes towards spirituality and spiritual care. The survey was mailed to 1029 nurses with a 55.3% response rate ($n = 559$). The initial scale was a 23-item tool, after the piloting of the tool it was reduced to a 17-item scale. Exploratory factor analysis was used to establish validity. The internal consistency reliability of Cronbach's alpha coefficient was 0.64 within the four subscales of religiosity, spirituality, personalized care, and spiritual care. The development of the *Spirituality and Spiritual Care Rating Scale (SSCRS)* has since been utilized to gain a deeper understanding of spirituality and spiritual care. The *SSCRS* will be utilized in the study to determine the practicing RNs perceptions of spirituality and spiritual care in a faith based and non-faith based hospital. The *SSCRS* will be analyzed with two categories: spirituality and spiritual care for the proposed study.

Cavandish et al. (2003) conducted a descriptive study that described spiritual perspectives, interventions, and attitudes. The sample ($n = 404$) was Sigma Theta Tau

International (STTI) Nursing Honor Society members who worked on a medical-surgical floor. Quantitative data were obtained for demographics and analyzed with descriptive statistics. Qualitative data were obtained from *Reed's Spiritual Perspective Scale (SPS)* and *Highfield's Nurses' Spiritual Care Perspectives Scale (NSCPS)*. Qualitative data were analyzed by comparison of conceptual linkages, theme identification, reduction, and validation. The findings demonstrated that the majority were female ($n = 384$, 96%), had completed a bachelor's degree ($n = 330$, 83%), and worked full-time ($n = 262$, 68%) (Cavandish et al.). The majority of the participants had a religious background with Protestant $n = 163$, 43%; Catholic $n = 137$, 41%; Jewish $n = 16$, 4%; and Buddhist $n = 12$, 3%. Ninety-seven (18%) nurses reported providing 32 spiritual care activities for patients. The top ten spiritual care activities identified were spiritual growth facilitation, spiritual support, presence, active listening, humor, touch, therapeutic touch, self-awareness enhancement, referral, and music therapy (Cavandish et al.). The majority of activities were under spiritual growth facilitation and spiritual support. Perceptions of nurses and patients concerning spiritual care activities were not congruent with each other.

Lundmark (2006) constructed a 17 item questionnaire after a literature review of spiritual care. Questions were answer with verbal comments and numerical value on a five point scale. The questionnaire was distributed to 68 respondents in a Swedish oncology clinic. SPSS was utilized for descriptive analysis methods, chi-square test with cross tables or, where the frequencies were too low to analysis the data, and Fishers precision test with cross tables. Fifty seven percent ($n = 38$) were Registered Nurses and 40% ($n = 30$) were nursing auxiliaries. The influencing factor of when nursing staff are

concerned with patient's spiritual needs was related to the sentiments of being at ease if/when giving spiritual care ($p = .014$). Other factors were faith in God ($p = .003$), belief in life after death ($p = .024$), and degree of education ($p = .019$). The design of the study did not determine cause and effect, it demonstrated influencing factors in the delivery of spiritual care.

Chung, Wong, and Chan (2007) utilized a correlational design to study the relationship of nurses' spirituality to their understanding and practice of spiritual care. The convenience sample ($n = 61$) was recruited from a Bachelor of Science nursing program in Hong Kong. A 27-item-five-point Likert scale was used with the *Nurses' Spirituality and Delivery of Spiritual Care (NSDSC)*. Data were analyzed by serial calculations and factor analysis. A statistical significant correlation was found among self and the dimension beyond self ($p < .001$), understanding of spiritual care ($p < .001$), and practice of spiritual care ($p < .05$). A positive correlation was found beyond dimension and understanding of spiritual care ($p < .05$). No significant findings were reported for relationship of demographic variables with spirituality, understanding, and practice of spiritual care. The delivery of spiritual care by the nurse was influenced by the nurses' spiritual development.

Burkhart and Hogan (2008) developed an experiential theory of spiritual care in nursing practice. "Spirituality is the expression of meaning and purpose in life, and religiosity is the expression of faith rites and rituals" (Burkhart & Hogan, p. 928). Burkhart and Hogan reported that a nurse with a strong spiritual well-being supports the ability to recognize a spiritual need. Once the nurse has identified a spiritual need, he or she will need to decide to engage or not engage in the spiritual encounter. Engagement in

the spiritual encounter will provide interventions to address the spiritual needs of the patient. The nurse will have a positive or negative emotional response. The nurse will search for meaning and purpose in the encounter which will bring about a spiritual memory. The actions of engagement, provision of spiritual care interventions, and development of a spiritual memory could enhance the nurses' spiritual well-being. Nurses could use this theoretical framework during their delivery of spiritual care. The current study explored the perceptions of recognizing a spiritual need, the ability to meet the spiritual needs of the patient, and if the practicing RNs religion plays a part in the delivery of spiritual care.

Chan (2009) conducted a study to examine nurses' attitudes to practicing spiritual care and determine factors associated with nurses' attitudes to practicing care. Studies on spiritual care in Hong Kong were rare (Chan). According to Chan "if the different levels of nurses' spiritual care practices affecting patients' well-being, then understanding nurses' spiritual care perceptions and their practices related to such care is important to future professional development" (p. 2130). Chan used a convenience sampling method and a structured self-report questionnaire to collect data. The sample ($n = 110$) was gathered from a targeted public hospital. The questionnaire was comprised of two parts. Part one was demographic data such as gender, marital status, religious status, and working unit along with experience aspects such as work experience and past hospitalization experiences (Chan). The data were used to determine differences between or within groups (Chan). "Part two was comprised of two sections, the first containing six statements formulated to measure nurses' perceptions of spiritual care (1 = strongly disagree and 5 = strongly agree)" (p. 2131). "The second section contained four

statements to evaluate nurses' spiritual care practices (1 = very unimportant, 5 = very important)" (p. 2131). The instrument was tested for satisfactory internal reliability using the typical alpha threshold. "The Cronbach's alpha for nurses' perceptions, practices, and overall on spiritual care scales was 0.83, 0.82, and 0.84" (p. 2131). The instrument was tested using confirmatory factor analysis to determine validity. Validity was acceptable with goodness of fit indices (Chan). Chan reported

the results showed that nurses who more likely had religious beliefs ($p = .028$), were more likely to be married ($p = .01$), had past hospitalization experience ($p = .009$), worked in obstetrics and gynecology department ($p = .001$) and had higher perception levels toward spiritual care ($p > .001$) were significantly more likely to be practicing spiritual care. (p. 2128)

The results indicated "a positive correlation between spiritual care perceptions and spiritual care practices among nurses, which means that the greater the nurse's spiritual care perceptions the more frequently spiritual care is included in that nurse's practice" (p. 2135). The findings were very important to nursing practice, "spiritual care is a nursing responsibility and not an optional extra" (p. 2135). Hospitals and nursing programs need to promote nurses' awareness of spiritual care and how to assess the spiritual coping strategies (Chan).

McSherry, Gretton, Draper, and Watson (2008) used a longitudinal design to explore student nurses' perceptions of spirituality and spiritual care. *The Spirituality and Spiritual Care Rating Scale* (SSCRS) was modified to assess the students' perceptions. A questionnaire was administered to 176 pre-registration nursing students, the response rate achieved was 76.7% ($n = 135$). It was composed of 119 females and 16 males. SPSS was

used to analyze the data. Data was tested with independent *t*-test and Pearson's correlation. Approximately 58% (*n* = 78) of students believed that spirituality is concerned with finding meaning, purpose, and fulfillment in life. Another finding of 34.8% (*n* = 47) demonstrated that spirituality applied to all people even those who were unsure or did not believe in God. Approximately 71.8% (*n* = 97) of the students felt they should be taught spirituality. Approximately 78% (*n* = 104) believed that spirituality included morality. Approximately 89% (*n* = 120) believed it was wrong to imply some people were better than others. The original *Spirituality and Spiritual Care Rating Scales* will be utilized in the proposed study.

Chism and Magnan (2009) completed a descriptive correlational design to explore the relationship among demographic variables, spiritual care perspectives, and expression of spiritual empathy among nursing students. Spiritual empathy was the verbal expression of understanding of a patient's spiritual concerns (Chism & Magnan). The sample (*n* = 223) was recruited from undergraduate-level and graduate-level nursing students in the Midwest. The characteristics of the sample were 86% (*n* = 192) female; 14% (*n* = 31) male; 82% (*n* = 183) white, 6% (*n* = 13) African American and Asian American, 1.3% (*n* = 3) Hawaiian/Pacific Islanders, 0.4% (*n* = 1) Hispanic/Latino and Native American, and 3% (*n* = 7) other; 74% (*n* = 166) traditional bachelor; 17% (*n* = 37) second degree, and 9% (*n* = 20) Doctor of Nursing Practice; and education prior to nursing: Associate 8% (*n* = 18), Bachelor 16% (*n* = 36), Master 12% (*n* = 26), and Doctorate 0.4% (*n* = 1). Some of the participants left education to nursing and ethnicity blank.

The data were collected by using three tools: *Spiritual Care Perspective Scale (SCPS)*, *the Expression of Spiritual Empathy Scales*, and a demographic worksheet.

Eighty-seven percent ($n = 195$) of the participants denied receiving any spiritual training. Eight-five percent ($n = 190$) reported a religious affiliation. Ninety three percent ($n = 206$) felt they were somewhat spiritual or spiritual individuals (Chism & Magnan, 2009). Small significant correlations ($r = -.22$ to 0.22 , $p < .001$) were shown for considering oneself spiritual and spiritual training with expression of empathy scores. Positive relationships with considering oneself spiritual and spiritual training lead to expression of empathy. Age, gender, and degree also were small but significant ($r = .16$, $.15$, and $.13$ respectively; $p < .05$ for all) in the *Expression of Spiritual Empathy Scale* (Chism & Magnan). There was no significance with religious affiliation and church attendance with empathy expression. Church attendance, gender, and religious affiliation showed small but significant correlations with nursing students' attitudes about spiritual care (Chism & Magnan). Considering oneself spiritual showed a moderate correlation. One implication for nursing education is to help nursing students' examine their own attitudes and beliefs about spiritual care. The findings suggest self-awareness lends itself to being more open to providing spiritual care. The proposed study could promote self-awareness of the practicing RNs in faith-based and non-faith based hospitals with the concepts of spirituality and spiritual care.

Shores (2010) conducted research on the spiritual perspectives of baccalaureate nursing students. *The Reed's Spiritual Perspective Scale (SPS)* was administered to 217 nursing students in the southeastern United States. Twelve questionnaires were incomplete or supported errors and were eliminated from the study. The sample was $n = 205$. The *SPS* is a 10-item questionnaire addressing the expression of spirituality and spiritual values. The items were ranked from 1 to 6, with the higher score indicating a

greater spiritual perspective. The Cronbach's alpha was .94 for this study. Seventy two percent, $n = 147$, discuss spiritual matters weekly and $n = 72$ discuss spiritual matters daily. Two-thirds, $n = 132$, engage in private prayer or meditation daily. Students reported that spirituality is important because it provides guidance in making decisions and helping to answer questions about the meaning of life. Shore recommended that in order for holistic nursing to be embraced in nursing education, the spiritual perspectives of nursing students must be addressed.

Burkhart et al. (2011) developed and tested the psychometric *Spiritual Care Inventory (SCI)* instrument. "The *SCI* was developed using data collected through a grounded theory study of the provision of spiritual care by nurses" (p. 2464). The convenience sample was $n = 298$ on study one and $n = 78$ on study two. The sample was gathered from Registered Nurses practicing in urban hospitals in the United States. The exploratory factor analysis was used to reduce the instrument from 48 items to 17 items. The instrument measures spiritual nursing interventions, meaning making, and faith rituals. Burkhart et al. provided a means by which to measure the nurse's perceived ability of providing spiritual care and how it may impact nurses' spirituality. "It is also interesting that two items in Meaning Making subscale suggest that providing spiritual care positively affects the nurses' perceptions of their profession" (p. 2468). This instrument could be used in future research to determine a relationship between spiritual care and nurse burnout (Burkhart et al.). "Providing spiritual care, meaning making and faith rituals could buffer burnout, but this relationship requires additional study" (p. 2468). "The *SCI* has the potential to measure the effectiveness of spiritual care curricular

content” (p. 2469). The proposed study of spiritual care in nursing looked at the impact of practicing RNs religion on the delivery of spiritual care.

McSherry and Jamieson (2011) conducted a descriptive online survey to determine nurses’ perceptions of spirituality and spiritual care. The survey was commissioned by the Royal College of Nursing (RCN). Three broad questions guided the survey. The questions were: “What do RCN members understand by the terms spirituality and spiritual care? Do RCN members consider spirituality to be a legitimate art of nursing practice? Do RCN member feel that they receive sufficient support and guidance in these matters?” (p. 1759). The survey incorporated the *Spirituality and Spiritual Rating Scale (SSCRS)*. Caring attributes and compassion displayed by nurses lead to spiritual care. Despite religious beliefs nurses considered spirituality to be an integral part of their nursing role. Further investigations with nurses and patient groups are needed to identify what nursing interventions are considered spiritual care.

Giske and Cone (2012) conducted a study to determine undergraduate nursing students’ perspectives on spiritual care and how they learn to assess and provide spiritual care to patients. Norway’s view of spirituality placed a challenge on the education of nursing students in relationship to spiritual care. “Norwegian values of individuality, equality and moderation also influence how spirituality is expressed and addressed” (Giske & Cone, p. 2007). “Norwegian nursing education is regulated by a national general plan. Spiritual care is not mentioned, but nurses are held responsible for holistic care and respecting patient integrity” (Giske & Cone, p. 2007). Giske and Cone used *Glaserian Grounded Theory (GT)* to guide the study. Inclusion criteria were nursing student of 18 years of age and English speaking. Focus groups were convened to answer

three questions. The three questions were: “What is spiritual care? How do you learn to assess and provide spiritual care? Tell us about your experiences related to spiritual care?” (p. 2008). The three phases identified were preparing for connection, connecting with and supporting patients, and reflecting on experiences. Clear learning outcomes and assignments were integral to the integration process. Further studies would need to be conducted to determine if the results could be generalized to the education of student nurses worldwide.

The review of the literature in the previous paragraphs explained how nurses’ and student nurses’ perceived self-awareness, assessment, implementation, and evaluation of spirituality and spiritual care. The nurses’ age, cultural, religious background, and educational preparation all played a role in addressing the spiritual needs of the patient (Boutell & Bozett, 1990; Burkhart et al., 2011; Burkhart & Hogan, 2008; Carroll, 2001; Cavandish et al., 2003; Chan, 2009; Chism & Magnan, 2009; Lundmark, 2006; Shores, 2010). Spiritual care competence can be developed through educational preparation and application of the spiritual care interventions. The study explored the practicing RNs perceptions self-awareness, assessment, implementation, and evaluation of spirituality and spiritual care.

Patients’ Perceptions to Spiritual Care

Stephenson, Draucker, and Martsof (2003) conducted a study using interpretive phenomenology to explore the experience of spirituality in the lives of hospice patients. Meaning, value, transcendence, connecting, and becoming were five attributes described in the literature when referring to spirituality. The sample ($n = 6$) was drawn from a rural Northeast Ohio community. Inclusion criteria met for the study was 18 years of age; alert

and oriented to person, time, and place; able to communicate with the investigator; legally able to consent to treatment; and physically strong enough to complete the interview. The sample was white, male Protestants, ranging in age from 46 to 99 years of age. The semi-structured interviews asked open ended questions. Stephenson et al. asked:

Describe the experience of spirituality in your life. Has your experience with spirituality changed since becoming ill? How do those changes compare with other difficult times in your life? Describe a spiritual experience that you have had that stands out to you. What are your spiritual needs now? Have nurses helped you meet these needs, and if so, how? What would you like to share with nurses about the spiritual needs of hospice patients? (p. 53)

All six participants provided descriptions about how they were dying, but also how they had lived before their diagnosis. The stories shared showed meaning, value, transcendence, and connecting. None of the participants had a significant spiritual transformation. Determining who was in charge allowed participants to make sense of their lives. Relationships helped participants determine meaning of one's life. Nurses can provide spiritual care by being present with the patient and allowing the patient to feel cared for and valued.

Steinhauser et al. (2008) conducted a pilot randomized control trial to determine if end of life preparation and discussion improve function and quality of life in seriously ill patients. Five different measurements tools: *Memorial Symptom Assessment Scale*, *Quality of Life and End of Life (QUAL-E)*, *Rosow-Breslau Activities of Daily Living (ADL) Scale*, *Profile of Mood States anxiety sub-scale*, *the Center for Epidemiologic Study of Depression (CESD) short version*, and *the Daily Spiritual Experience Scale* were

used to determine pre and post outcomes of functioning and quality of life. Quantitative analyses were conducted. The original sample ($n = 82$) was reduced by 40 participants due to functional decline or death of the participant. Three sessions were conducted with the treatment group: life story, forgiveness, and heritage and legacy. Group two met for three times for 45 minutes and listened to a non-guided relaxation tape. The control group had pre and post assessments of outcomes. Participants in the active discussion showed improvement in functional status, anxiety, depression and preparation for end of life even though significance was not demonstrated due to sample size.

Mok, Wong, and Wong (2009) conducted qualitative research to explore the phenomenon of spirituality and spiritual care among the terminally ill Chinese patients. The convenience sample ($n = 15$) was recruited from the hospital which provided palliative care. Data were collected using tape-recorded interviews. The interviews were conducted one to one and lasted from 40 minutes to 1.5 hours. Hermeneutic interpretation was used to analyze the sample. The beginning question was “Can you tell me about how you have experienced spirituality and its relationship to your illness?” (p. 362) Further questions were dependent upon the participant’s response. Findings demonstrated that spirituality was unique to each individual. Themes which emerged were life is an integrated whole, acceptance of death is a life process, finding meaning in life, and having a sense of peace. Mok et al. believed it is the professionals’ role to facilitate spiritual stirring in order for the patient to experience love, faith, hope, and having a sense of completion.

Hodges and Horvath (2011) conducted a qualitative meta-synthesis of clients’ perspectives of spiritual needs. Six interrelated themes emerged: meaning, purpose, and

hope; relationship with God; spiritual practices; religious obligations; interpersonal connections; and professional staff interactions (Hodges & Horvath). The client who found meaning, purpose, and hope had reduced frustration associated with reduced capabilities. The clients' relationship with God helped provide hope. Engagement with spiritual practices and religious obligations enhanced the clients' relationship with God leading to increased coping abilities. Interpersonal connections encouraged relationships with clergy, family, friends, etc. which lead to forgiveness, prayer, support, and appreciation. Professional staff interaction allowed the staff to demonstrate caring, kindness, trust, and compassion through delivery of care. The implication for social workers and all health professions would be continued development of cultural competency in the area of spirituality. Nurses who are more aware of the spiritual needs of self and the client would be influenced to engage in the spiritual encounter. The study on spiritual care in nursing explored the practicing RNs perceptions on spirituality and spiritual care, and determined if a relationship exist between the practicing RNs religious affiliation and the perception of meeting the spiritual care needs of the patient.

Tan, Wilson, Olver, & Barton (2011) conducted a qualitative study through unstructured interviews with patients and family members and semi-structured interviews with staff to determine if family meetings address spiritual needs. The interviews were approximately three days after the family meeting and were conducted in a variety of locations. The five part paradigm of the meetings were story of the journey, worries and fears, speaking of roots, the family speaks, and the closing or blessing based on Murphy's family meeting model. The sample included ($n = 12$) patients, ($n = 35$) family members, and ($n = 14$) health professionals. "All interviews were audio recorded, transcribed

verbatim and were analyzed using the software package QSR International NVivo 2.0” (p. 68). Ricoeur’s theory of interpretation was utilized. Patients and family members reported two categories with sub-themes: who would benefit (everyone, special circumstances, and not for all) and promoting the family meeting (general comments and specific means of promotion). Health professionals reported four categories and with sub-themes: a good thing (general positives and there is a need), practical barriers (funding, staff time/numbers, and other barriers), staff qualities (those needed and generalist versus specialist) and ideas for incorporation (promoting the meeting, participation, and other). Tan et al. findings demonstrated family meetings were beneficial for spiritual care.

A nurse-patient relationship can allow a nurse to intervene and provide spiritual care to a patient. Spiritual care can help the patient find meaning and purpose in one’s life (Hodges & Horvath, 2011; Mok et al., 2009; Stephenson et al., 2003). A variety of interventions could be used to achieve the purpose of finding meaning and purpose. The achievement of finding meaning and purpose in life can improve functional status, decrease anxiety and depression, and assist with preparation for end of life.

Conclusions

This chapter explored the literature to determine what studies had been conducted on spirituality and spiritual care. The concepts focused on the historical aspects, spirituality, spiritual care, barriers, benefits, educational preparation, nurses’ and student nurses’ perceptions and patient’s perceptions of spiritual care. Holistic care includes care for the mind, body, and spirit. Spiritual care is rooted throughout history in a variety of forms. Spiritual care continues to evolve as the world moves forward. Barriers such as lack of time, educational preparation, and lack of confidence (Abbas & Dein, 2011; Carr,

2010; Daaleman et al., 2008; Koenig, 2004; & McEwen, 2005) can affect the delivery of spiritual care. Spiritual awareness is one of the first steps toward spiritual competence (Campinha-Bachote, 2002). The more the nurse develops spiritual competence, his or her confidence level will increase which could impact the delivery of spiritual care. The delivery of spiritual care can have positive impacts on the patients by lowering the stress level, decreasing anxiety, decreasing depression, helping the patient to cope with his or her illness, leading to forgiveness, etc. (Koenig, 2004). The study explored the practicing RNs perceptions of spirituality and spiritual care in a faith based and non-faith based hospital.

Summary

The review of the literature identified that a study had not been conducted between a faith based and a non-faith based hospital in regards to spirituality and spiritual care of the practicing RNs. The study explored the perceptions of practicing RNs on 1. What differences exist in the perceptions of spirituality among practicing RNs in a faith based and non-faith based hospital? 2. What differences exist in the perception of spiritual care among practicing RNs in a faith based and non-faith based hospital? and 3. What relationship exists between the RNs who practice religion and do not practice religion and the perception of meeting the spiritual needs of the patient? The next chapter will display the results of the study.

CHAPTER III

METHODOLOGY

Introduction

The previous chapter provided a comprehensive review of the current literature on spirituality and spiritual care. The concepts focused on the historical aspects, spirituality, spiritual care, barriers and benefits of spiritual care, educational preparation, nurses' and student nurses' perceptions, and patients' perceptions of spiritual care. The delivery of spiritual care can have positive impact on the patients by lowering the stress level, decreasing anxiety, decreasing depression, helping the patient to cope with his or her illness, leading to forgiveness, etc. (Koenig, 2004). Campinha-Bachote (2002) identified awareness as the first steps of developing cultural competence which can be applied to spiritual competence. Studies have been conducted in hospital institutions on the nurses' perceptions of spirituality and spiritual care. The review of the literature identified that a study had not been conducted between faith based and non-faith based hospitals in regards to spirituality and spiritual care.

The purpose of the study was to explore the perceptions of spirituality and spiritual care of practicing Registered Nurses (RNs) in a faith based and non-faith based hospital in the Midwest in order to increase self-awareness among practicing RNs. The research questions were:

1. What differences exist in the perceptions of spirituality among practicing RNs in a faith based and non-faith based hospital?
2. What differences exist in the perceptions of spiritual care among practicing RNs in a faith based and non-faith based hospital?
3. What differences exist between Registered Nurses who practice religion and do not practice religion and perception of meeting the spiritual needs of the patients?

This chapter contains the research design, the population and sample characteristics, the methods of data collection, which analytical methods were used to process the data, and the limitations of the study.

Research Design

The study used a quantitative, quasi-experimental design. Leedy and Ormrod (2013) stated that rating scales facilitate evaluation and quantification of complex phenomena. Quantitative data was collected through the *Spirituality and Spiritual Care Rating Scale*. The data was analyzed using descriptive and inferential statistics through the SPSS Version 21. According to Robson (2011), “there are measurement scales where the function is not to test but to gain some insight into what people feel or believe about something” (p. 303). The *Spirituality and Spiritual Care Rating Scale* was utilized to gain insight into the perceptions of practicing RNs on spirituality and spiritual care in a faith-based and non-faith based hospital. Three different questionnaires were reviewed and were appropriate for the study of spiritual care in nursing. The researcher contacted each of the primary authors to ask for permission to utilize the instrument and permission was granted.

Burkhart et al. (2011) developed and tested the *Burkhart Spiritual Care Inventory (BSCI)*. The *BSCI* determines the delivery of spiritual care to patients and the impact that care has on the nurses' spirituality. A convenience sample $n = 298$, $n = 248$ nurses at the hospital and $n = 50$ graduate student nurses in study one. The *BSCI* was initially a 48 item questionnaire. Study two was streamlined down to 18 item questionnaire; $n = 78$, $n = 30$ staff nurses and $n = 48$ graduate student nurses. The *BSCI* was analyzed using exploratory factor analysis of spiritual care interventions, meaning making, and faith rituals with internal consistency measures for the subscales above 0.8 in study one and above 0.87 in study two (Burkhart et. al).

Chan (2009) developed an instrument to examine nurses' attitudes and factors associated with providing spiritual care. The instrument was tested for internal reliability by test and re-test with Registered Nurses, $n = 10$. The results were $\alpha = 0.83$ for nurses' perceptions, $\alpha = 0.82$ for nurses' practices, and $\alpha = 0.84$ for overall spiritual care. Validity was established by confirmatory factor analyses. The target population was all nurses with an identified hospital. The questionnaire was distributed, $n = 178$, the completed questionnaires was $n = 110$. The results were $\alpha = 0.83$ for nurses' perceptions and $\alpha = 0.82$ for nurses' practices. The correlation $r^2 = 0.15$ between perception and practices of spiritual care.

The *Spirituality and Spiritual Care Rating Scale (SSCRS)* by McSherry et al. (2002a) assessed the areas of spirituality and spiritual care along with how the individual felt about delivery of care. McSherry et al. (2002b) conducted a study where the authors developed a rating scale to assess spirituality and spiritual care of qualified nurses. The original scale was structured around nine fundamental areas pertaining to spirituality. The

SSCRS was initially a 23-item scale. The instrument was piloted with 70 nurses, six statements were found to be problematic to the participants. The statements were removed from the scale before it was administered to over 500 participants. The internal consistency reliability of Cronbach's alpha coefficient was 0.64. The development of the *SSCRS* has since been utilized to gain a deeper understanding of spirituality and spiritual care. The *SSCRS* was modified with a Likert scale for the research process to quantify the results. Review of the literature revealed that the *SSRCS* has been used to assess the nursing populations (McSherry & Jamieson, 2011). No studies had been conducted to do a comparative analysis of the perceptions of spirituality and spiritual care between practicing Registered Nurses in a faith based and non-faith based hospital. The researcher determined that the *Spirituality and Spiritual Care Rating Scale* was the most appropriate for the study being proposed to study the differences in perceptions of spirituality and spiritual care in a faith based and non-faith based hospital.

The *Spirituality and Spiritual Care Rating Scale (SSCRS)* was utilized to conduct the study on spirituality and spiritual care in a faith based and non-faith based hospital. The survey tool was organized into three sections for data collection part A, part B, and part C (See Appendix B). Part A of the survey tool focused on demographic data such as gender, age, educational level, educational content received on spiritual care, employment status, years working in specialty area, specialized instruction since becoming a RN, religious affiliation, type of religious affiliation, practicing, religion, frequency of religious practice, and receiving spirituality outside of a religious affiliation. Part B of the survey tool was the *SSCRS*. The *SSCRS* was modified with numbers for the Likert scale to produce quantifiable data. Part C of the survey tool assessed components

of spiritual care such as who the nurse felt was responsible for spiritual care, if a spiritual need was encountered within his or her practice, how the nurse became aware of the spiritual need, perception if the nurse was able to meet the spiritual need, and how often spiritual needs were addressed in practice, asking if sufficient instruction is provided for RNs, and if one is to receive instruction who should provide the instruction. The nurses who completed the survey examined their perceptions on spirituality and spiritual care in order to increase self-awareness.

Population

The target population studied was practicing Registered Nurses (RNs) from two hospitals in the Midwest. One hospital was a faith-based hospital and the other hospital was a non-faith based hospital. All practicing RNs were invited to participate in a study on the Perceptions of Spiritual Care in Nursing. The population of practicing RNs at the faith-based hospital was $N = 1554$. The population of non-practicing RNs at the non-faith based hospital was $N = 760$.

A convenience sample from the targeted population of practicing RNs was drawn from the two Midwest Hospitals. All RNs were invited to participate in the study. The sample was determined by those who complete the survey. The participants were invited by a flyer, through various meetings, personal conversation with the nurse managers and nurses, and electronic invitation. The sample for the faith-based hospital was $n = 209$ (50.4%). The sample for the non-faith based hospital was $n = 206$ (49.6%).

Part A on the survey instrument focused on demographic data. The representation of gender in the sample was 95.3 % female ($n = 366$); 3.9 % male ($n = 15$); .8% undisclosed ($n = 3$). The distribution of gender of the sample is illustrated in Table 1.

Table 1

Gender of Participants

Gender	<i>n</i>	%
Males	15	3.9
Females	366	95.3
Undisclosed	3	.8

Regarding age, the sample was well distributed, between the ages of 20 -29 at 21% (*n* = 81), 22.8% were between the ages of 30 -39 (*n* = 88), 23.8 % were between 40-49 (*n* = 92), 25.6% were between the ages of 50-59 (*n* = 99), and 6.7% (*n* = 26) were 60 or above. Table 2 illustrated the differences in population regarding age.

Table 2

Age of Participants

Age	<i>n</i>	%
20-29	81	21.0
30-39	88	22.8
40-49	92	23.8
50-59	99	25.6
60 or above	26	6.7

Regarding the educational level of the participants, 40.8% (*n* = 157) had associate degrees, 6.8% (*n* = 26) had a diploma, 41.6% (*n* = 160) had a baccalaureate, 10.1% (*n* = 39) and .7% (*n* = 3) had a doctorate. The distribution of educational level is illustrated in Table 3. Forty seven point eight percent (*n* = 184) reported receiving instruction during

educational preparation on spiritual care, 32.5% ($n = 125$) did not receive instruction, and 19.7 ($n = 76$) did not know if instruction was received.

Table 3

Educational Preparation

Education preparation	<i>n</i>	%
Associate degree	157	40.8
Diploma	26	6.8
Baccalaureate degree	160	41.6
Master degree	39	10.1
Doctorate	3	.8

Regarding employment status, 87.3% ($n = 324$) were employed full time and 12.7% ($n = 47$) were employed part time. The specialty area was divided into five categories: medical, surgical, pediatrics, intensive care, oncology, and other. Regarding specialty; area, 20.4% ($n = 76$) worked in medical, 16.7% ($n = 62$) worked in surgical, 1.3% ($n = 5$) worked in pediatrics, 9.4% ($n = 35$) worked in intensive care, 5.9% ($n = 22$) worked in oncology, and 46.2% ($n = 172$) listed other. Regarding the years worked in specialty area, 6.5% ($n = 24$) worked less than one year, 38.1% ($n = 141$) worked 1-5 years, 20.8% ($n = 77$) worked 6-10 years, 23.8% ($n = 88$) worked 11-25 years, and 10.8% ($n = 40$) worked 25 years or more in the specialty area. Two hundred eighty one (75.9%) of the participants reported that they had not received special instruction on spiritual care and 89 (24.1%) reported receiving special instruction since becoming employed. Sixteen provided details stating they were enabled to better meet spiritual needs. Employment information is illustrated in Table 4.

Table 4

Employment Information

Item	<i>n</i>	%
Employment Status		
Part-time	47	12.7
Full-time	324	87.3
Specialty Area		
Medical	76	20.4
Surgical	62	16.7
Pediatrics	5	1.3
Intensive Care	35	9.4
Oncology	22	5.9
Other	172	46.2
Years Working Specialty Area		
Less than one year	24	6.5
1-5 years	141	38.1
6-10 years	77	20.8
11-25 years	88	23.8
25 years or more	40	10.8
Special Education/Instruction *		
Yes	89	24.1
No	281	75.9

Note.* Education on Spiritual Care or Faith-based Nursing Since Employment.

Regarding religious status, 88.8% ($n = 325$) reported a religious affiliation and 11.2% ($n = 41$) did not report a religious affiliation. The type of religion was as follows: Christian 90.6 % ($n = 300$), Jewish .3% ($n = 1$), and other 9.1% ($n = 30$). The other category is broken down as follows: Catholic ($n = 20$), Atheist ($n = 2$), Fundamental Christian ($n = 1$), Baptist ($n = 1$), Mennonite ($n = 2$), Jehovah Witness ($n = 1$), Non-denominational ($n = 1$), and Evangelical Lutheran Missouri Synod ($n = 1$).

The majority of participants were practicing their religion 87.5% ($n = 293$) and 12.5% ($n = 42$) were not practicing their religion. The frequency of religious practice was daily 59% ($n = 186$), more than once a week 22.5% ($n = 71$), once a month 6.3% ($n = 20$), more than once a month 4.8% ($n = 15$), and once a year 7.3% ($n = 23$). Less than half of the participants received spirituality outside of their religious affiliation 44.8% ($n = 162$) and 55.2% ($n = 200$) did not receive spirituality outside of their religious affiliation. Religious and spirituality demographics were illustrated in Table 5.

Table 5

Religion and Spirituality Demographics

Item	<i>n</i>	%
Religious Affiliation		
Yes	325	88.8
No	41	11.2
Type of Religious Affiliation		
Christian	300	90.6
Jewish	1	.3
Other	30	9.1
Practicing of Religion		
Yes	293	87.5
No	42	12.5
Frequency of Religious Practice		
Daily	186	59
More than once a week	71	22.5
Once a month	20	6.3
More than once a month	15	4.8
Once a year	23	7.3
Receiving Spirituality Outside*		
Yes	162	44.8
No	200	55.2

Note. * Receiving spirituality outside religious affiliation

Part C of the survey tool assessed components of spiritual care such as who the nurse felt was responsible for spiritual care, if a spiritual need was encountered within his or her practice, how the nurse became aware of the spiritual need, perception if the nurse was able to meet the spiritual need, and how often spiritual needs were addressed in practice, asking if sufficient instruction is provided for RNs, and if one is to receive instruction who should provide the instruction. Regarding who nurses felt responsible for providing spiritual care was answered by selecting all that apply, nurses 17.7% ($n = 315$), chaplains/clergy 17.5% ($n = 310$), patients themselves 17.1% ($n = 303$), patients' family and friends 17.3% ($n = 308$), patients' own spiritual leader 17.4% ($n = 309$), patients' own religious leader 12% ($n = 214$), and other 1% ($n = 17$). There were 98.2% ($n = 321$) of the nurses who encountered a patient with spiritual needs and 1.8% ($n = 6$) who did not encounter a patient with spiritual needs. The nurses reported becoming aware of spiritual needs were by the patient himself/herself 37.1% ($n = 247$), patients' relative/friends 16% ($n = 125$), nursing care plan 6.2% ($n = 48$), other nurses 9.7% ($n = 76$), chaplains/religious leaders 15.6% ($n = 122$), nursing observations 20.1% ($n = 157$), and other 0.6% ($n = 5$).

Seventy seven point five percent ($n = 162$) of the nurses felt they met the spiritual needs of the patient and 22.5% ($n = 47$) felt they did not met the spiritual needs of the patient. Registered Nurses met the spiritual needs of the patient in the frequency of every time they worked and once a week at 48.1% ($n = 138$) each, once a month 9.7% ($n = 32$), and never and twice a week at 3.3% ($n = 11$) each. One hundred ten (39%) of the Registered Nurses felt they received sufficient instruction and sixty one (61%) felt they did not receive sufficient instruction. Regarding who Registered Nurses felt should be

providing instruction were Colleges of Nursing 28.8% ($n = 205$), training departments 26.8% ($n = 191$), nurses themselves 25.1% ($n = 179$), clergy/religious leaders 17.4% ($n = 124$), and other 1.8 ($n = 13$). Spiritual care components were displayed in Table 6.

Table 6

Spiritual Care Components

Item	<i>n</i>	%
Responsible for providing spiritual care *		
Nurses	315	17.7
Chaplains/Clergy	310	17.5
Patients themselves	303	17.1
Patients' family and friends	308	17.3
Patients' own spiritual leader	309	17.4
Patients' own religious leader	214	12.0
Other	17	1.0
Encountered a patient with spiritual needs		
Yes	321	98.2
No	6	1.8
Becoming aware of the spiritual need by *		
Patient himself/herself	247	31.7
Patient's relative/friends	125	16.0
Nursing care plan	48	6.2
Other nurses	76	9.7
Chaplains/religious leaders	122	15.6
Nursing observations	157	20.1
Other	5	0.6
Meeting your patient's spiritual needs?		
Yes	162	77.5
No	47	22.5
Frequency Meeting Needs		
Every time I work	138	41.8
Once a week while I work	138	41.8
Twice a week while working	11	3.3
Once a month while working	32	9.7
Never	11	3.3
Sufficient Instruction		
Yes	110	39.0
No	61	61.0
Responsible for providing instruction *		
Colleges of Nursing	205	28.8
Training Departments	191	26.8
Nurses themselves	179	25.1
Clergy/Religious Leaders	124	17.4
Others	13	1.8

Note *Participants were able to select more than one option.

Data Collection

The researcher approached four Midwest Hospitals, three faith based and one non-faith based hospitals to obtain permission to conduct research within the guidelines of the Institutional Review Boards. Three of the four hospitals were agreeable to participating in the study. The fourth hospital was withdrawn from the study related to recommendations to change the collection tool and methodology after data had already been collected from three hospitals. The data collected from the two faith based hospitals was merged into one data base to be referred to as the faith based hospital. The researcher complied with the policies and procedures concerning human subjects at all facilities. Hospital policy requires that one of the investigators be an employee of the facility. The co-investigator served as the point of contact and the data collector at the facility.

Data collection was done by the researcher and the hospital representative with the cooperation of hospitals and the practicing RNs. All participants provided voluntary and informed consent. Two forms of data collection were utilized. Data collection was conducted through a paper method and an online method through a software program called Qualtrics. The researcher designed a flyer and letter to invite participants to join the study.

Paper survey tools were color coded to discriminate which hospital was faith-based and which was non-faith based. The faith-based hospital was on pink paper. The non-faith based hospital was on blue paper. The researcher met a hospital representative to explain the data collection process. The hospital representative met with the managers, provided detailed instruction sheets for distribution of the survey tool, posted the flyers, and provided packets of surveys with attached informed consents and collection

envelopes to be distributed on the unit. The flyer was placed on units at the participating hospitals for 30 days. The surveys were available for a 30 day time period to the practicing RNs. The researcher returned to collect the data packets at agreed upon times with the agencies which were established at the beginning of the study. An incentive of two \$25 gift cards from Wal-Mart was offered for each hospital. The names of participants obtained from the informed consent were placed in a hat and two names were drawn from the hat for each hospital at the completion of data collection. The gift cards and thank you notes were given to the nurse managers of the participating units at both agencies. A generalized comment was placed on the acknowledgement page thanking the nurse managers for assistance with study.

Online data collection was conducted with the assistance of the hospital representative and the technology department. A letter was designed inviting participants to join the study. The letter was emailed to all of the practicing Registered Nurses (RNs) or placed on the hospital web page for employees inviting them to participate. The first page of the survey obtained informed consent. If the participant answered yes, the survey continued to be conducted. If the participant answered no, the participant was logged out of the survey. The surveys were available for a 30 day time period to the practicing RNs. Reminder notices were sent out at 10 days and 20 days in the study. An incentive of two \$25 gift cards from Wal-Mart was offered for each hospital. The departments who participated were placed in a drawing and two departments were drawn out to receive the \$25 gift cards. The gift cards were to be used at the discretion of the departments who received the incentive for nursing employees. Thank you notes were given to the departments who participated.

Analytical Methods

The purpose of the study was to explore the perceptions of spirituality and spiritual care of practicing Registered Nurses (RNs) in a faith based and non-faith based hospital in the Midwest in order to increase self-awareness among practicing RNs. Additionally, the researcher investigated the relationship between the reported religious affiliation and the perception of meeting the spiritual needs of the patient. Research Question One and Two had a between subject factor related to the assignment of the type of hospital whether it was faith based or non-faith based. Research Question Three had a between factor related to practice of a religion and non-practice of a religion. The data was collected with a survey tool which had the *Spirituality and Spiritual Care Rating Scale* embedded. The results were entered into the SPSS version 21 for analysis of the quantitative data. The fill in the blank answers were entered into NVivo 10 for analysis of the qualitative data.

Research Question One

What differences exist in the perceptions of spirituality among practicing RNs in a faith based and non-faith based hospital?

On the *SSCRS* five questions were asked about spirituality. The following five questions were asked on the *SSCRS* address spirituality:

I believe spirituality is about finding meaning in the good and bad events of life. I believe nurses can provide spiritual care by enabling a patient to find meaning and purpose in their illness. I believe spirituality has to do with the way one conducts one's life here and now. I believe spirituality is a unifying force which enables one to be at peace with oneself and the world. (McSherry et al., 2002b, pp. 732-733).

Registered Nurses rated the questions on a five point Likert Scale. The response options were as follows: 1 strongly disagree, 2 disagree, 3 uncertain, 4 agree, and 5 strongly agree. A variable for spirituality was computed from these scores. A Mann-Whitney U was utilized to determine if there was a difference between the perceptions of spirituality among practicing Registered Nurses in a faith based and non-faith based hospital. The researcher compared the significance of each item at a $p < .05$ level to determine statistically significant differences between the perceptions of spirituality among practicing Registered Nurses in a faith based and non-faith based hospital.

Research Question Two

What differences exist in the perceptions of spiritual care among practicing RNs in a faith based and non-faith based hospital?

On the *SSCRS* five questions were asked about spiritual care. The following five questions were asked on the *SSCRS* address spiritual care:

I believe nurses can provide spiritual care by arranging a visit by the hospital Chaplain or the patient's own religious leader if requested. I believe nurses can provide spiritual care by showing kindness, concerns, and cheerfulness when giving care. I believe nurses can provide spiritual care by spending time with a patient giving support and assurance especially in time of need. I believe nurses can provide spiritual care by listening and allowing patients' time to discuss and explore their fears, anxieties, and troubles. I believe nurses can provide spiritual care by having respect for privacy, dignity, and religious and cultural belief of a patient. (McSherry et al., 2002b, pp. 732-733)

Registered Nurses rated the questions on a five point Likert Scale. The response options were as follows: 1 strongly disagree, 2 disagree, 3 uncertain, 4 agree, and 5 strongly agree. A variable for spiritual care was computed from these rankings. A Mann-Whitney U was utilized to determine if there was a difference between the perceptions of spiritual care among practicing Registered Nurses in a faith based and non-faith based hospital. The researcher compared the significance of each item at a $p < .05$ level to determine statistically significant differences between the perceptions of spiritual care among practicing Registered Nurses in a faith based and non-faith based hospital.

Research Question Three

What relationship exists between RNs who practice religion and do not practice religion and the perception of meeting the spiritual needs of the patient?

Two questions were taken from Part A and two questions were taken from Part C to answer this question. Part A questions: “Are you practicing your religion? How frequently do you practice your religion?” (McSherry et al., 2002a, pp. 6-7) Part C questions: “As a regular part of your nursing practice do you feel that you are usually able to meet your patient’s spiritual needs? How often do you address the spiritual needs of your patients in practice?” (McSherry et al.) A Chi-Square was utilized to determine if there was a difference between Registered Nurses who practice religion and do not practice religion and perception of meeting the spiritual needs of the patients. The second questions in both parts will be analyzed using frequencies.

Limitations

The sample used in this study was one of convenience consisting of practicing Registered Nurses employed at two hospitals in the Midwest. All participation provided

voluntary and informed consent. Caution should be used before generalizing the results based on the limited geographic location.

The small amount of responses (less than 30) with the paper method within the 30 day time period at one hospital required the researcher to reopen the study in a different data collection method. The study was opened with online data collection which could have led to duplication of information. Another limitation was that participants started the study but did not complete the study due to time constraints at work. The frequency of delivery of care could be different for nurses working part-time and full-time. A common limitation of the survey research is that the data was self-reported (Leedy & Ormrod, 2013). Self-reported data may be reported in a favorable perspective or positive light by the respondent by answering the question in a way that they think the researcher might want to hear. There were limited responses to some questions where the participant chose not to answer the question.

Summary

The purpose of the study was to explore the perceptions of spirituality and spiritual care of practicing Registered Nurses (RNs) in a faith based and non-faith based hospital in the Midwest in order to increase self-awareness among practicing RNs. The study used a quantitative, quasi-experimental design. Three questions lead the research:

1. What differences exist in the perceptions of spirituality among practicing RNs in a faith based and non-faith based hospital?
2. What differences exist in the perceptions of spiritual care among practicing RNs in a faith based and non-faith based hospital?

3. What differences exist between Registered Nurses who practice religion and do not practice religion and perception of meeting the spiritual needs of the patients?

The population and sample consisted of practicing Registered Nurses in a faith based and non-faith based hospital. The survey tool with the embedded *Spirituality and Spiritual Care Rating Scale* was used for data collection. Data collection was done through a paper method and an online method. Both methods allowed the study to be open for 30 days. Demographic characteristics of the population was analyzed with SPSS Version 21 to produce descriptive statistics. The research questions were answered with inferential statistics using the Mann-Whitney U and Chi-Square. The limitations of the study were identified as lack of participants by paper method of data collection, type of sample, one geographic location, and self-reporting of information. The following chapter will provide the findings and conclusions of the study.

CHAPTER IV

FINDINGS AND CONCLUSIONS

Introduction

Spiritual care in nursing has been mandated by the accreditation organizations of health care and institutions of higher learning for nursing. According to Hood et al. (2013), “despite mandates to provide spiritual care, confusion persists among nurses about spirituality, spiritual needs, and related roles” (p. 198). It is suspected that this issue was due to the lack of self-awareness, educational preparation, or confidence in identifying a need for spiritual care (Abbas & Dein, 2011; & Narayanasamy, 1993). Registered Nurses (RNs) need to examine the relevance of spirituality and spiritual care and provide this type of care to their patients. Therefore, Registered Nurses were asked to examine their perceptions of spirituality and spiritual care in order to determine their delivery of spiritual care. The purpose of the study was to explore the perceptions of spirituality and spiritual care of practicing Registered Nurses (RNs) in a faith based and non-faith based hospital in the Midwest in order to increase self-awareness among practicing RNs. The study was guided by the following three questions:

1. What differences exist in perceptions of spirituality among practicing RNs in a faith based and non-faith based hospital?

2. What differences exist in perceptions of spiritual care among practicing RNs in a faith based and non-faith based hospital?
3. What relationship exist between RNs who practice religion and do not practice religion and the perception of meeting the spiritual needs of the patient?

In order to answer the three questions a survey tool with the embedded *Spirituality and Spiritual Care Rating Scale* was utilized. This chapter contains the findings, conclusions, implications of the results, and recommendations for future research.

Findings

The survey tool with the embedded *Spirituality and Spiritual Care Rating Scale* (SSCRS) was used to collect data. McSherry et al. (2002b) tested the reliability and validity of the instrument in a pilot study of 70 nurses. Six problematic statements were eliminated and the instrument was administered to 500 participants. The internal consistency reliability of Cronbach's alpha coefficient was 0.66 for spirituality and 0.73 for spiritual care. The instrument was used to collect data about the perceptions of RNs in a faith based and non-faith based hospital in regards to spirituality, spiritual care, and the perception of meeting the patients' spiritual need.

1. What differences exist in perceptions of spirituality among practicing RNs in a faith based and non-faith based hospital?

Research question one regarding spirituality was analyzed with five statements pertaining to spirituality. McSherry et al. (2002a) grouped item f, h, i, j, and l on the SSCRs (See Appendix B). The five statements make up the existential elements of spirituality. The five statements used from the SSCRs used ordinal data through a

Likert scale as follows: 1 Strongly Disagree, 2 Disagree, 3 Uncertain, 4 Agree, and 5 Strongly Agree. The groups used nominal data through two options: faith based or non-faith based. The Mann-Whitney U, a non-parametric test, was utilized because the researcher was looking at nominal and ordinal data. The results of the Mann-Whitney U test were $U = 11277$, $p = 0.016$, $r = 0.14$. There was a significant difference on spirituality in the perceptions of practicing RNs between a faith-based and non-faith based hospital. The effect size of 0.14 suggests a small relationship between the type of hospital and the perception of spirituality. The mean rank of the faith based hospital was 175.85, the mean rank of the non-faith based hospital was 150.70. The faith-based hospital demonstrated a higher score in the perception of spirituality.

2. What differences exist in perceptions of spiritual care among practicing RNs in a faith based and non-faith based hospital?

Research question two regarding spiritual care was analyzed with five statements pertaining to spiritual care. McSherry et al. (2002a) grouped items a, b, g, k, and n on the *SSCRS* (See Appendix B). The five statements make up the spiritual care variable. The five statements used from the *SSCRS* used ordinal data through a Likert scale as follows: 1 Strongly Disagree, 2 Disagree, 3 Uncertain, 4 Agree, and 5 Strongly Agree. The groups used nominal data through two options: faith based or non-faith based. The Mann-Whitney U, a non-parametric test, was utilized because the researcher was looking at nominal and ordinal data. The results of the Mann-Whitney U test were $U = 10194$, $p = 0.001$, $r = 0.3$. There was a significant difference on spiritual care in the perceptions of practicing RNs between a faith-based and non-faith

based hospital. The effect size of 0.3 suggests a small relationship between the type of hospital and the perception of spiritual care. The mean rank of the faith based hospital was 186.69, the mean rank of the non-faith based hospital was 143.42. The faith-based hospital demonstrated a higher score in the perception of spiritual care.

3. What relationship exist between RNs who practice religion and do not practice religion and the perception of meeting the spiritual needs of the patient?

Research question three regarding the relationship between RNs who practice religion and who do not practice religion and the perception of meeting the spiritual needs of the patient was analyzed with descriptive and inferential statistics. Two questions were taken from Part A and three questions were taken from Part C to answer this question. Part A questions: “Are you practicing your religion? How frequently do you practice your religion?” (McSherry et al., 2002a, pp. 6-7) The data was present in Table 7.

Table 7

Practicing Religion and Frequency of Religious Practice

Item	<i>n</i>	%
Practicing of Religion		
Yes	293	87.5
No	42	12.5
Frequency of Religious Practice		
Daily	186	59
More than once a week	71	22.5
Once a month	20	6.3
More than once a month	15	4.8
Once a year	23	7.3

Part C questions: McSherry et al., (2002a)

As a regular part of your nursing practice do you feel that you are usually able to meet your patient's spiritual needs? If yes, please give examples of how you address your patient's spiritual needs. How often do you address the spiritual needs of your patients in practice? (pp. 6-7)

The results are presented in Table 8 and Table 9.

Table 8

Perception of Meeting a Spiritual Need and Frequency of Addressing a Spiritual Need

Item	<i>n</i>	%
Meeting a Spiritual Need		
Yes	162	77.5
No	47	22.5
Frequency of Addressing a Spiritual Need		
Every time I work	138	41.8
Once a week while working	138	41.8
Twice a week while working	11	3.3
Once a month	32	9.7
Never	11	3.3

Table 9

Spiritual Care Interventions

Item	Number of times provided
Acceptance	28
Acknowledge Faith	35
Being present	28
Care Communication	7
Collaboration	6
Comfort Measures	18
Contacting Clergy/Chaplain/Spiritual Leader	76
Counseling	1
Discussion of End of Life	4
Generalization	11
Healing Touch	1
Incorporating Preferred Food into Care	2
Listening	73
Meditation	1
Music	4
Performing rituals	2
Prayer	76
Provide Resources	23
Provide Privacy	5
Provide Support	49
Reading Scripture	8
Building Relationship	1
Sharing Beliefs	6
Spiritual Assessment	11
Talking with the Patient	43
Treatment Options	4

A Chi-Square was utilized to determine if there was a relationship between Registered Nurses who practice religion and do not practice religion and perception of meeting the spiritual needs of the patients. Both religion and perception of meeting the spiritual need were nominal data. The question concerning the frequency of practicing religion defined practicing religion. Examples of how the spiritual need is addressed provided descriptive data. The descriptive data was coded and analyzed for frequencies with NVivo (See Table 8). The question concerning the frequency of meeting the spiritual need defined how often the nurse addressed the spiritual need. The Chi-Square test results were: $\chi^2 (1, N = 196) = 1.780, p = .182, \text{Cramer's } V = .095$. There was not a statistically significant difference between those RNs who practice religion and do not practice religion and the perception of meeting the spiritual need of the patient. The top three interventions being utilized by the practicing RNs were contacting clergy, chaplain, or spiritual leader; prayer, and listening to the patient.

Conclusions

Research Question One: What differences exist in perceptions of spirituality among practicing RNs in a faith based and non-faith based hospital?

The findings in this study revealed that there were differences in the perceptions of spirituality among practicing RNs in a faith based and non-faith based hospital. The significance was small. The practicing RNs in the faith based hospital were more aware of their perceptions of spirituality than those who practice in a non-faith based hospital.

Research Question Two: What differences exist in perceptions of spiritual care among practicing RNs in a faith based and non-faith based hospital?

The findings in this study revealed that there were differences in the perceptions of spiritual care among practicing RNs in a faith based and non-faith based hospital. The significance was small. The practicing RNs in the faith based hospital were more aware of their perceptions of spiritual care than those who practice in a non-faith based hospital

Research Question Three: What relationship exists between RNs who practice religion and do not practice religion and the perception of meeting the spiritual needs of the patient?

The findings in the study did not revealed a difference between those RNs who practice religion and do not practice religion and the perception of meeting the spiritual need of the patient. The perceptions were that practicing RNs in both facilities were delivering spiritual care through a variety of spiritual interventions. The top three interventions being utilized by the practicing RNs were contacting clergy, chaplain, or spiritual leader; prayer, and listening to the patient.

Implications and Recommendations

The purpose of the study was to explore the perceptions of spirituality and spiritual care of practicing Registered Nurses (RNs) in a faith based and non-faith based hospital in the Midwest in order to increase self-awareness among practicing RNs. The review of the literature showed that there was a gap in the literature concerning the comparison of a faith based and non-faith based hospital on the awareness of spirituality and spiritual care among the practicing RNs. Many times assumptions are made that the practicing RNs will be more aware in a faith based hospital than a non-faith based hospital. However, the individual should not make any assumptions unless there was research to support the assumption. The findings of this research showed that there was a

significant difference between the perceptions of practicing RNs awareness of spirituality and spiritual care in a faith based and non-faith based hospital. The findings of the study may serve as a guide that the environment of the practicing RNs can influence the RNs perception of spirituality and spiritual care. Recommendations are for replication of the study, in similar settings to determine if it is consistently found that the faith based environment will demonstrate increases in the practicing RNs perceptions of spirituality and spiritual care. Another recommendation for further study would be to determine which factors are present for practicing RNs to feel confident in the delivery of spiritual care.

An open environment that supports spiritual care can remove barriers. Barriers could prevent RNs from delivering spiritual care. The three main barriers which have been identified were lack of educational preparation, lack of time, and lack of confidence (Abbas & Dein, 2011; Carr, 2010; Daaleman et al., 2008; Koenig, 2004; & McEwen, 2005). Barriers need to be removed in order for nurses to provide spiritual care. The study also confirmed by self-report that the majority of Registered Nurses did not feel adequately prepared to meet the spiritual care needs of the patients. Educational preparation was a conceived barrier to spiritual care. One recommendation would be to conduct a study of the nurses to ask what type of educational preparation is needed.

Another recommendation would be to design and pilot a program on spiritual care interventions. The program could be designed with input from faith community nurses, training departments, chaplains/clergy, and colleges of nursing. Topics that could be included in the training are spiritual assessment, spiritual care interventions, and evaluation of the effectiveness of the spiritual care. Another option might be the

development of a spiritual care tool kit. Concurrently the researcher is working with another researcher to design and implement a spiritual care tool kit with a portion of the practicing RNs from the faith based hospital. In addition to the spiritual care tool kit, the targeted population will receive weekly instructions on spiritual care. The researchers will assess whether the spiritual care tool kit was effective in meeting the spiritual care needs of the patient.

Self-awareness was the first step in becoming competent in spiritual care. The RNs who participated in the study examined their own awareness of spirituality and spiritual care. The practicing RNs could use this opportunity to continue to build their competency in spirituality and spiritual care. Practicing RNs that develop competence will feel confident in assessing, implementing, and evaluating the effectiveness of spiritual care. The delivery of spiritual care has been shown to have benefits to both patients and nurses. Coyle (2001) identified a positive frame of mind which can lead to healthy behaviors. Koenig (2004) identified psychological and physical benefits such as lower suicide rates, less anxiety, less depression, greater marital satisfaction, lower death rates from cancer, better cardiac outcomes, and increased longevity. Swetz et al. (2009) and Pereira et al. (2011) reported the nurses providing spiritual care could minimize their stress and prevent burnout in hospice and palliative medicine. Recommendations would be to conduct additional research on the benefits of spiritual care for patients and for nurses in all healthcare environments.

The study found that there was a significant difference between the perceptions of spirituality and spiritual care among practicing RNs in a faith based and non-faith based hospital. The study can add significant knowledge to the body of literature since there

was a lack of literature comparing the two environments. The concepts of spirituality and spiritual care needs to be continually explored through scholarly work to change and impact the holistic care being provided to patients in a variety of setting.

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Appendix A

Survey Tool with Embedded Spirituality and Spiritual Care Rating Scale

RESEARCH ADDRESSING NURSES' PERCEPTIONS OF SPIRITUAL CARE

PLEASE CAN YOU GIVE THE NECESSARY INFORMATION ABOUT YOURSELF.

IT IS VERY IMPORTANT THAT YOU COMPLETE THE QUESTIONNAIRE BY YOURSELF AND THAT YOU ANSWER ALL THE APPROPRIATE QUESTIONS

Although the questionnaire looks quite lengthy it shouldn't take you long to complete.

(There are no right or wrong answers so please answer honestly)

Part A- Demographic Data

Please select the appropriate box

1) Are you?

Male Female

Undisclosed

2) What is your age?

21-29 30-39

40-49 50-59

60 or above

3) What type of education did you receive?

Associate Degree Diploma

Baccalaureate Master

Doctorate

4) During the course of your nursing education did you receive any educational content concerning Spiritual Care? (i.e., I attended one class on assessing spiritual needs, I watched a video on spiritual care needs of the elderly.

Yes No

I do not know

4a) If yes, please give details _____

- 5) How long have you been licensed as a Registered Nurse?
- | | | | |
|--------------------|--------------------------|-------------|--------------------------|
| Less than one year | <input type="checkbox"/> | 1-5 years | <input type="checkbox"/> |
| 6-10 years | <input type="checkbox"/> | 11-25 years | <input type="checkbox"/> |
| 25 years and above | <input type="checkbox"/> | | |
- 6) Are you currently working:
- | | | | |
|-----------|--------------------------|-----------|--------------------------|
| Part-time | <input type="checkbox"/> | Full-time | <input type="checkbox"/> |
|-----------|--------------------------|-----------|--------------------------|
- 7) What is your specialty area?
- | | | | |
|------------|--------------------------|----------------|--------------------------|
| Medical | <input type="checkbox"/> | Surgical | <input type="checkbox"/> |
| Pediatrics | <input type="checkbox"/> | Intensive Care | <input type="checkbox"/> |
| Oncology | <input type="checkbox"/> | Other: _____ | |
- 8) How long have you been working as a licensed RN in your specialty area?
- | | | | |
|--------------------|--------------------------|-------------|--------------------------|
| Less than one year | <input type="checkbox"/> | 1-5 years | <input type="checkbox"/> |
| 6-10 years | <input type="checkbox"/> | 11-25 years | <input type="checkbox"/> |
| 25 years and above | <input type="checkbox"/> | | |
- 9) Since becoming a licensed Registered Nurse have you received any specialized education/instruction on Spiritual Care or Faith-Based Nursing? (i.e., classes, workshops)
- | | | | |
|-----|--------------------------|----|--------------------------|
| Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|-----|--------------------------|----|--------------------------|
- 9a) If yes please give details stating whether you feel this has enabled you to better meet your patient's spiritual needs _____
-
- 10) Are you affiliated with a religion? If you answer no to this question skip to # 14
- | | | | |
|-----|--------------------------|----|--------------------------|
| Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|-----|--------------------------|----|--------------------------|
- 11) What is your religious affiliation?
- | | | | |
|-----------|--------------------------|----------|--------------------------|
| Christian | <input type="checkbox"/> | Buddhist | <input type="checkbox"/> |
| Hindu | <input type="checkbox"/> | Jewish | <input type="checkbox"/> |
| Muslim | <input type="checkbox"/> | Sikh | <input type="checkbox"/> |
| Other: | _____ | | |

12) Are you practicing your religion?

Yes No

13) How frequently do you practice your religion?

Daily More than once a week

Once a month More than once a month

Once a year

14) Do you receive spirituality outside of a religious affiliation?

Yes No

Part B - SPIRITUALITY AND SPIRITUAL CARE RATING SCALE

FOR EACH QUESTION PLEASE CIRCLE ONE ANSWER WHICH BEST REFLECTS THE EXTENT TO WHICH YOU AGREE OR DISAGREE WITH EACH STATEMENT

Item	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
a. I believe nurses can provide spiritual care by arranging a visit by the hospital Chaplain or the patient's own religious leader if requested.	1	2	3	4	5
b. I believe nurses can provide spiritual care by showing kindness, concern, and cheerfulness when giving care	1	2	3	4	5
c. I believe spirituality is concerned with a need to forgive and a need to be forgiven	1	2	3	4	5
d. I believe spirituality involves only going to Church/Place of Worship	1	2	3	4	5
e. I believe spirituality is not concerned with a belief and faith in a God or Supreme being	1	2	3	4	5
f. I believe spirituality is about finding meaning in the good and bad events of life	1	2	3	4	5
g. I believe nurses can provide spiritual care by spending time with a patient giving support and reassurance especially in time of need	1	2	3	4	5
h.					

i. I believe nurses can provide spiritual care by enabling a patient to find meaning and purpose in their illness	1	2	3	4	5
j. I believe spirituality is about having a sense of hope in life	1	2	3	4	5
k. I believe spirituality has to do with the way one conducts one's life here and now	1	2	3	4	5
l. I believe nurses can provide spiritual care by listening to and allowing patients' time to discuss and explore their fears, anxieties, and troubles	1	2	3	4	5
m. I believe spirituality is a unifying force which enables one to be at peace with oneself and the world	1	2	3	4	5
n. I believe spirituality does not include areas such as art, creativity, and self-expression	1	2	3	4	5
o. I believe nurses can provide spiritual care by having respect for privacy, dignity, and religious and cultural belief of a patient	1	2	3	4	5
p. I believe spirituality involves personal friendships or relationships	1	2	3	4	5
q. I believe spirituality does not apply to Atheists or Agnostics	1	2	3	4	5
r. I believe spirituality includes people's morals	1	2	3	4	5

Part C – Spiritual Care

- 1) Who do you feel should be responsible for providing Spiritual Care? (Please select the appropriate box(es) which apply)
- Nurses Chaplains/Clergy
 Patients Themselves Patients' Family and Friends
 Patient's Own Spiritual Leader Patient's Own Religious Leader)
 Other (please specify) _____
- 2) In your clinical practice have you ever encountered a patient(s) with a spiritual need(s)?
- Yes No

- 3) If yes to question two how did you become aware of this need(s)? Please select the box(es) which apply.
- | | | | |
|------------------------------|--------------------------|----------------------------|--------------------------|
| Patient himself/herself | <input type="checkbox"/> | Patient's relative/friends | <input type="checkbox"/> |
| Nursing Care Plan | <input type="checkbox"/> | Other Nurses | <input type="checkbox"/> |
| Chaplains/religious leaders' | <input type="checkbox"/> | Nursing observations | <input type="checkbox"/> |
| Other (please specify) _____ | | | |
- 4) As a regular part of your nursing practice do you feel that you are usually are able to meet your patient's Spiritual Needs?
- Yes No
- 4a) If yes, please give examples of how you address your patient's spiritual needs:

- 5) How often do you address the spiritual needs of your patients in practice?
- | | | | |
|----------------------------|--------------------------|----------------------------|--------------------------|
| Every time I work | <input type="checkbox"/> | Once a week while working | <input type="checkbox"/> |
| Twice a week while working | <input type="checkbox"/> | Once a month while working | <input type="checkbox"/> |
| Never | <input type="checkbox"/> | | |
- 6) Do you feel Registered Nurses receive sufficient instruction and training on matters concerning Spiritual Care?
- Yes No
- 7) If Registered Nurses are to receive instruction concerning Spiritual Care which of the following do you feel should be responsible for this? Please select the box(es) which apply.
- | | | | |
|-----------------------------|--------------------------|--------------------------|--------------------------|
| Colleges of Nursing | <input type="checkbox"/> | Training Department | <input type="checkbox"/> |
| Nurses themselves | <input type="checkbox"/> | Clergy/Religious Leaders | <input type="checkbox"/> |
| Other please specify: _____ | | | |

**THANK YOU FOR TAKING THE TIME TO COMPLETE THIS
QUESTIONNAIRE.**

McSherry W., Draper P, & Kendrick D. (2002). Construct validity of a rating scale designed to assess spirituality and spiritual care. *International Journal of Nursing Studies*, 39(7), 723 – 734.

(Slight modifications were made on the questionnaire with permission.)