SPIRITUALITY IN NURSING

Nurses' Perceptions About Providing Spiritual Care

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Providing spiritual care is an important foundation of nursing and is a requirement mandated by accreditation organizations. Spiritual care is essential in all clinical areas but particularly in home care and hospice. Clinicians may be unable to respond to spiritual needs because of inadequate education or the assumption that spiritual needs should be addressed by clergy, chaplains, or other "spiritual" care providers. In reality, clinicians in the home may be in the best position to offer spiritual support when caring for patients at home at end of life. The purpose of this pilot study was to examine relationships between spirituality and nurses' providing spiritual care. Professional nurses (n = 69) working in 2 large healthcare organizations completed the Perceptions of Spiritual Care Questionnaire. Approximately, 33% of the nurses worked in home care. Significant correlations were found among those nurses whose reported nursing education programs adequately prepared them to meet spiritual needs and taught ways to incorporate spiritual care into practice and those who did not.

Background and Significance

Spirituality and religious beliefs and practices are important elements of health and well-being. Providing spiritual care is a vital component of providing holistic nursing care. Spiritual care includes building intuitive, caring, interpersonal relationships with patients that reflect patients' spiritual/religious reality. The impact of spirituality, as a component of psychological well-being, is becoming more recognized by health professionals as well as by national organizations.

Standards for accreditation now include criteria for addressing the spiritual needs of patients. The Joint Commission has an accreditation standard that includes the patient's right to spiritual care and support (2013). This includes a spiritual assessment when providing care, treatment, and services. In nursing, there are accepted nursing diagnoses of spiritual distress or at risk for spiritual distress (NANDA International, 2011) as part of the nursing process. Schools of nursing should be preparing graduates to provide spiritual care. According to the Essentials of Baccalaureate Education for Professional Nursing Practice (American Association of Colleges of Nursing, 2008), the baccalaureate generalist graduate practices form a holistic caring framework that is comprehensive and focuses on the body, mind, and spirit, as well as emotions.

According to the literature, many healthcare providers report discomfort or feel unprepared to deal with their patients' spiritual needs because of a lack of preparation and education in this area (Malinski, 2002). Although nurses recognize the need to provide holistic care, many are uncomfortable asking questions about spirituality or religion. Spiritual competence is not a criterion for graduation from most nursing schools or for practice, although this may not be true for all schools. Providing specific spiritual care education to nursing students may teach them the importance of patients' spiritual needs as well as how to assess and meet these needs. In addition, nurses must also explore their own spirituality and the relationship to caregiving, as this may have an important impact on the nurse's awareness and sensitivity to patients' spiritual needs. The nursing profession should develop and nurture nurses who are more competent at assessing and responding to patients' spiritual needs.

The purpose of this study was to pilot test the Perception of Nurses' Ability to Provide Spiritual Care Questionnaire. The aim of the study was to improve nurses' ability to provide spiritual care to patients by identifying experiences, comfort level, and attitudes associated with nursing and spiritual care. This study focused on gaining information about such topics as the nurse's personal beliefs related to spirituality and religion, the nurse's comfort level related to providing spiritual care to patients, the nurse's knowledge about basic spiritual/religious concepts, nurse–patients interactions related to patient's spiritual needs, spiritual support in the healthcare setting, and the inclusion or lack of inclusion of spiritual concepts in the nurse's basic educational program. The research questions for this study were:

1. Is there a relationship between nurses whose basic nursing education program emphasized spiritual care and the nurses' comfort level, knowledge, and nurse–patient interactions related to spiritual care than those whose program did not emphasize spiritual care?
2. Is there a relationship between the nurse's own spiritual/religious beliefs and the nurse's comfort level and ability to provide nurse–patient interactions related to spiritual care?
3. Is there a relationship between the nurse's comfort level and the assessment of patients' spiritual needs?

This study seeks to make a contribution to the knowledge base as it expands other studies addressing spirituality and the ability of nurses to meet the spiritual needs of patients. Meeting spiritual needs is not well defined into nurses' role and not always taught fully in nursing schools. Some healthcare practitioners question whether anyone can be taught to deliver spiritual care (Kruse, Ruder, & Martin, 2007).

Spirituality as a Component of Care

The relationship between spirituality and coping abilities is relatively new in the nursing literature, but the number of studies addressing spirituality and health has increased dramatically during the last decade. According to Weaver, Pargament, Flannelly, and Oppenheimer (2006), the rate of publications on spirituality and health has increased by 688% in the last 30 years. A preliminary MEDLINE search

indicated that 88% of the spiritual needs articles were published after 1990 (Galek, Flannelly, Vane, & Galek, 2005). However, studies find that nurses in practice are often confused about the nature of spiritual care (Narayanasamy & Owens, 2001). Others might be uncomfortable with their own spirituality and beliefs. This is not surprising when one looks at the history of spirituality in nursing curricula. In early hospital-based schools of nursing, students were taught to care for the body, mind, and spirit, and spiritual care easily included reading the Bible to a patient or praying. As nursing moved to a more scientific model, nurses now cared for the bio-psycho-social individual where everything was subject to scientific inquiry. Fewer schools of nursing were associated with religious organizations and public schools of nursing often distanced themselves from God (Barnum, 2003).

Recognition of a patient's spiritual needs may be more accepted as a part of practice in some specialties such as hospice/palliative care settings or faith-based specialties. Providing spiritual care for patients is especially important in home care and hospice and palliative care settings where the focus is on meeting the patient's and families' spiritual needs and on quality of life (Kellehear, 2000). The specialized practice of faith community nursing focuses on intentional spiritual care as an integral part of promoting holistic health (American Nurses Association and Health Ministries Associations, 2005). Faith-based nurses usually have formal educational preparation and continuing education that has a focus on spiritual health and well-being. Core curricula, as standard preparation for faith community nurses and coordinators, were developed to ensure quality faith-based practice and continue to be revised and updated (Solari-Twadell & McDermott, 2006).

Spirituality and Religion Defined
It is important to distinguish between spirituality and religion. Religion is defined as specific practices and beliefs that may be associated with an organized group (Thoresen, Alex, & Harris, 2002). "Spirituality is a person's search for, or expression of, his/her connection to a greater and meaningful context" (Barnum, 2003, p. 1). Spirituality is a natural part of human existence and can mean different things to different people.

Being spiritual is part of being human as it forms the root of one's identity and gives life meaning (Koenig, 2002). All people are spiritual regardless of their religious beliefs, although spirituality may be expressed through religious practices and/or a belief in God or a higher being. Nurses need to recognize the distinction between these two concepts so that attention to both domains may be provided.

Kruse, Ruder, and Martin (2007) identified the relationship between spiritual well-being and factors such as comfort, peacefulness, and serenity to better understand the effects of spirituality on health for persons at the end of life. In this model (Figure 1), smaller circles representing the overlap between religion and spirituality with a patient's overall health, ability to cope, and find peace and comfort have been added. This model represents how each of these concepts works to support religion and spirituality. As nurses, it is important to recognize both spiritual and religious needs. Both spirituality and religion can help people cope with illness or other life challenges and find comfort. It is also important to recognize that each person is different, and religious and spiritual care must reflect the patient's individualized reality.

Spiritual Development
There is little in the literature to measure spiritual development in nurses. Central to understanding spirituality is a basic knowledge of the spiritual development of a person. A number of theories attempt to describe spiritual development. One of the most significant is in James Fowler's *Stages of Faith Development* (1981), in which he identified seven faith stages and their approximate corresponding age categories across the life span. Fowler views faith as deeper than organized religion as it has to do with finding shared meaning and purpose in life. In practice, healthcare providers can use Fowler's theory with age categories as a guideline for supporting patient's spiritual development.

It is vital that nurses assess patients' spiritual needs and respond to these needs in a competent and sensitive manner. Exploring and gaining insight and comfort with one's own faith, shared meaning, and purpose may be the first step in being able to develop awareness of other's spiritual needs.

Basic Educational Preparation to Include Spirituality

Studies have reviewed nursing and whether nurses are prepared to provide spiritual care. In one study of British nurses, Narayanasamy (1993) found that nurses perceived spiritual care as the role of the chaplain and that nursing education was responsible for the inadequate preparation of nurses for spiritual care. In another survey of 132 baccalaureate nursing programs in the United States, Lemmer (2002) found that the majority of programs included the concept of spiritual dimension in their curriculum but few defined spirituality or spiritual nursing care. In addition, there was uncertainty about faculty knowledge and comfort with teaching spirituality (Lemmer, 2002). These studies suggest that nurses may not be educationally prepared to provide spiritual care. In addition, it demonstrates that schools of nursing may need to identify how the spiritual dimension is addressed throughout the nursing curriculum.

Spirituality, Religion, and Health

The importance of spirituality and religion in the lives of Americans cannot be ignored. In a recent Gallop Poll, 55% of Americans responded that religion was "very important" in their life and 26% responded that it was "fairly important" (Gallop Poll, 2011). In a study by Kruse, Ruder, and Martin (2007), highly significant positive correlations were found between spiritual well-being and peacefulness, comfort, and serenity in participants who were at end of life. In this study, 73% of the participants reported that illness had strengthened their spiritual life and increased their religious practices. These religious practices included praying, reading the Bible, attending church or mass, visits from the chaplain, and receiving support from the church community (Kruse, Ruder, & Martin, 2007).

In a study by McMillan (2006), hospice patients identified spiritual needs that were always or frequently needed. These included being with family, seeing smiles of others, thinking happy
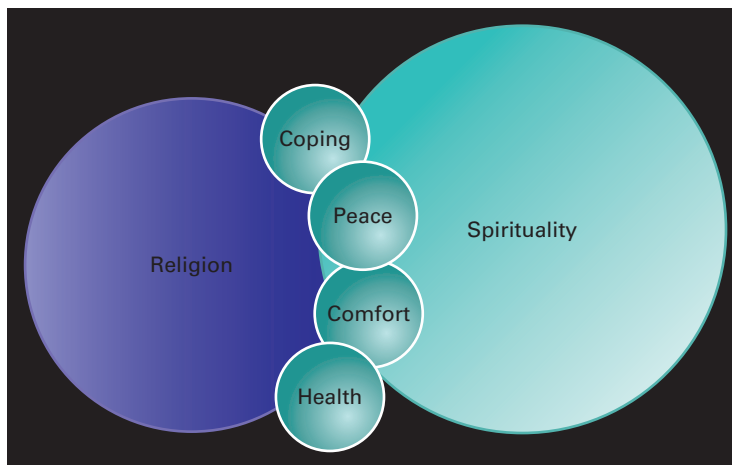

Figure 1. Well-being factors as they relate to religion and spirituality.
Source: Developed by S. Ruder & B. Kruse. From Ruder, S (2008). Incorporating Spirituality Into Home Care at the End of Life, *Home Healthcare Nurse, 26*(3), p 158-163. Copyright © 2008 Wolters Kluwer Health. Reprinted with permission.

thoughts, laughing and talking about day-to-day things, and being with friends.

In addition, some research indicates a potential relationship between religion and positive health outcomes. Nurses must address patients' spiritual needs to provide a powerful inner source for coping and finding comfort and peace at end of life (Post, Puchalski, & Larson, 2000). One study by Kaufman, Anaki, Binns, and Freedman (2007) discovered that individuals with higher levels of spirituality and private religious practices had a slower rate of cognitive decline. Another study by Oxman, Freeman, and Manheimer (1995) found that patients who received comfort and religious support had reduced mortality rates after surgery. Pargament, Koenig, Tarakeshwar, and Hahn (2001) also found that higher religious struggle scores were predictive of greater risk of mortality. The literature supports the positive relationship between spirituality and health and offers a sound basis for the current study. Spirituality and religion and their relationship to health, coping, and illness is indeed essential in providing holistic care at end of life.

Methods
Design
A descriptive qualitative survey design was used for this pilot study. The study used correlation analysis to examine the relationship among variables related to nurses' perceptions of providing

spiritual care. Questionnaires were administered to a convenience sample of registered nurses (RNs) recruited from two regional medical centers: one in southwest Michigan and one in northeast Indiana. The inclusion criterion was that the subjects be RNs, practicing in any practice setting in one of the two approved systems-based organizations. Case managers at the hospitals distributed questionnaires to nurses who volunteered to participate in this study. Participants came from the medical surgical units, outpatient clinic, and the system's home healthcare agency (HHA). Approximately, 33% of the sample were nurses who worked in home health.

Accompanying the questionnaire was a letter explaining the study, and a consent form that participants signed. Participation in the study was strictly voluntary. Data were coded and SPSS (SPSS, Inc., Chicago, IL) was used to calculate the statistics.

The study received Institutional Review Board approval from the university and both organizations. Participants were assured that data would be reported in aggregate form and would not be possible to identify specific individuals, and that responses would be kept confidential and used only for the purpose of the study.

Study Measures
Instrument
The Perceptions of Spiritual Care Questionnaire

The Perceptions of Spiritual Care Questionnaire (See Appendix), developed for this study, is a 23-item questionnaire developed and was used to collect data measuring nurses' perceptions of their ability to provide spiritual care to their patients. Each statement has a 5-point Likert scale that ranges from 1 (strongly disagree) to 5 (strongly agree). The construction of the questionnaire required two stages. Stage 1 consisted of an extensive literature review that identified potential components and items to be identified. The questions were developed through the identification of emerging themes, recommendations from experts, and from nursing diagnoses related to the assessment, interventions, and evaluation of spiritual well-being and spiritual distress. Six domains were identified: (a) the nurses' personal beliefs about religion/spirituality (Questions 1, 2, 3, 6, 7, 8, 11, 16, and 17); (b)

knowledge of the concepts of spirituality and religion (Questions 4, 5, 12, and 13); (c) comfort level in discussing spiritual/religious issues with the patient (Question 10); (d) implementation of spiritual/religious interventions into his or her practice (Questions 9, 14, 15, 18, and 19); (e) support for spiritual/religious interventions in practice (Question 20); and (f) spirituality in nursing education program (Questions 21, 22, and 23).

Stage 2 consisted of testing for reliability and validity of the instrument. To assure validity of the instrument, a 10-member panel determined to be experts in the field of research and spirituality evaluated the initial bank of 21 statements using criteria developed by Gilmore (Kruse, Melhado, Convertine, & Stecher, 2008). The panel consisted of nurses, physicians, social workers, palliative care/end-of-life researchers, clergy, and a hospice educator and coordinator. Analysis consisted of calculating the mean for each statement. Statements with a mean of 3.0 or higher were retained since a rating of 3.0 was selected as acceptable. This process resulted in the addition of two statements and revision of eight statements. This resulted in the final 23-item questionnaire.

A test–retest analysis was used for verifying the stability of the scale. A total of 12 nurses from a major healthcare facility agreed to be part of this initial testing. This sample of nurses was similar to the population of nurses for the pilot study. After a 2-week interval, the same 12 nurses again completed the questionnaire. The consistency of a measured item was calculated by considering the two responses. For a tool to be considered reliable or stable, a level of .80 or higher is considered to be an acceptable level of reliability (Polit & Beck, 2012). The reliability of the instrument appeared to be relatively stable (Cronbach's alpha = 0.82–0.911).

Sixty-nine questionnaires were collected over a 6-month period. Data were coded and analyzed using SPSS to calculate the statistics. Demographic data were analyzed by calculating percentages and means. A two-dimensional correlation matrix was used to display correlation coefficients for the Sp (total) and the subscales of beliefs, knowledge, comfort, ability to implement, degree of support, and educational preparation. Statistical inferences were drawn from the sample to the larger population.
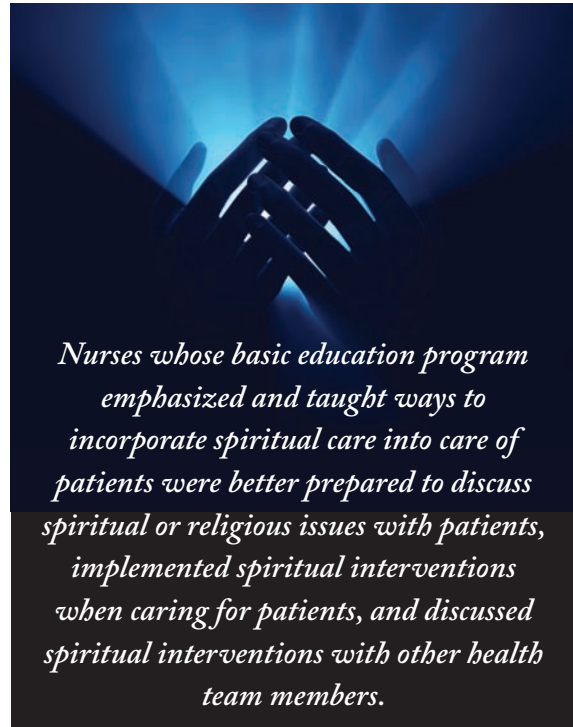
Results

Demographics

The nurses who completed the questionnaire were all RNs. Ages ranged from 25 to 73 years, with a mean age of 49. Seventy percent of the survey group was older than 43 years. Eighty-seven percent of the sample was female and 78.3% had more than 10 years' experience in nursing practice. These statistics seem consistent with the general population of nurses where nurses are getting older and are mostly female. Eighty-eight percent of the sample identified that they were part of a religious community, identifying themselves as Catholic (24.6%), protestant (31.9%), Seventh Day Adventist (2.9%), or Muslim (1.4%). Others identified themselves as Lutheran, Mormon, Baptist, Methodist, or Christian with no specific affiliation (27.6%) and 11.6% with no religious affiliation.

Fifty-one percent of the sample graduated from associate degree programs, 31.9% had bachelor's degrees in nursing, 2.8% had master's degrees in nursing, and 5.4% had master's degrees in other fields. Seventy-five percent attended public nursing education programs, 21% attended private religious nursing education programs, and 4% attended private nonsectarian institutions. Seventy-eight percent of the respondents reported not having received any additional education in spiritual care since graduating (Table 1).

Perceptions of Beliefs

The majority of respondents (68 respondents) agreed or strongly agreed that they believe in a higher power and 96% (66 respondents) responded that their religious beliefs support their nursing practice and that they find comfort in their faith and/or spiritual beliefs. Ninety-seven percent (67 respondents) reported that they consider themselves to be spiritual and 81% (56 respondents) consider themselves to be religious. Forty-eight percent (33 respondents) agree or strongly agree that patients and/or families seek spiritual care from nurses, whereas 29% (20 respondents) disagree or strongly disagree with this statement and 23% (16 respondents) are uncertain. Fourteen and a half percent (10 respondents) agree or strongly agree that most patients' spiritual needs are met, whereas 38% (26 respondents) disagree or strongly disagree with this statement and 48% (33 respondents) are uncertain if patients' spiritual needs are met. Interestingly,

Nurses whose basic education program emphasized and taught ways to incorporate spiritual care into care of patients were better prepared to discuss spiritual or religious issues with patients, implemented spiritual interventions when caring for patients, and discussed spiritual interventions with other health team members.

in this category, 42% (29 respondents) strongly disagree or disagree that nurses are prepared to discuss spiritual or religious issues with patients and 38% (26 respondents) report being uncertain. Only 20% (14 respondents) agree or strongly agree that nurses are prepared to discuss spiritual or religious issues with patients.

Perceptions of Knowledge

Ninety-seven percent (67 respondents) indicated that they understood the definition of spirituality and 96% (66 respondents) said that they understood the definition of religion. Ninety-eight and a half percent (68 respondents) agree or strongly agree that spirituality and/or religion can have a positive impact on health and well-being, and 97.1% or 67 responded agree or strongly agree that it is important to respond to patients' spiritual/religious needs.

Perceptions of Comfort

Eighty-one percent (56 respondents) agree or strongly agree that they reported feeling comfortable communicating with patients and families about religious or spiritual issues. Nine percent (6 respondents) disagree or strongly disagree with this statement and 10% (7 respondents) are uncertain.

Perceptions of Implementation in Practice

Thirty-nine percent or 27 of the respondents agree or strongly agree that they regularly conduct a spiritual assessment of their patients, whereas 38% (26 respondents) disagree or strongly disagree with this statement and 23% (16 respondents) are uncertain. Forty-five percent (31 respondents) indicated that they regularly engage in nursing interventions to support patients' spiritual needs, 36% (25 respondents) disagree or strongly disagree with this statement, and 17% (12 respondents) are uncertain. Forty-eight percent (33 respondents) said that they prefer a pastor or professional from spiritual services to assess and address their patients' spiritual needs. Forty-two percent (29 respondents) indicated that they are familiar with the nursing diagnoses that address spiritual well-being or spiritual distress but only 14.5% (10 respondents) reported using those diagnoses when planning or providing care.

Perceptions of Support in Practice

Twenty-two percent (15 respondents) agree or strongly agree that they regularly discuss patients' spiritual issues with other members of the health team, whereas 65% (45 respondents) disagree or strongly disagree with this statement.

Perceptions of Basic Nursing Education Program

Twenty-nine percent or 20 of the respondents agree or strongly agree that their formal nursing education adequately prepared them to meet patients' and families' spiritual and religious needs, whereas 55% or 38 of the respondents disagree or strongly disagree with this statement. Fifty-eight percent or 40 respondents indicated that their nursing education did not emphasize spiritual care, whereas 51% or 35 of the respondents said that it did not teach ways to incorporate spiritual care in the planning and delivery of patient care.

Table 1. Demographics of Sample (*n* = 69)

| Gender	Female = 87% Male = 13%
Age	Mean = 49 y 70% > 43 y
Religion	Catholic 24.6%, Jewish 0%, Protestant 58.1%, Muslim 1.4%, Other: Seven Day Adventist 2.9%, Native American 1.4%, No affiliation 11.6%
Nursing education	Associate's degree 51%, Bachelor's degree 31.9%, Master's degree in nursing 2.8%, Master's degree in other field 5.4%
Type educational program	Public 75%, Private religious 21%, Private nonsectarian 4%
Any additional continuing education in spiritual care since graduating	Yes 22%, No 78%
Years in nursing practice	Less than 1 y 3%, 1–5 y 10%, 5–10 y 9%, More than 10 y 78%
Current employment	Public or private nonsectarian agency 64%, Private religious 36%

Correlations Among Concepts

The first research question, "Is there a relationship between nurses whose basic nursing education program emphasized spiritual care and the nurses' comfort level, knowledge, and nurse–patient interactions related to spiritual care than those whose program did not emphasize spiritual care" was addressed in a correlation analysis between questions 21–23 and the other variables. Significant positive correlations were found between nurses' education and programs that emphasized and taught ways to incorporate spiritual care and nurses' beliefs that nurses are prepared to discuss spiritual or religious issues (r = .466–.497; $P < 0.01$), that patients and families seek spiritual care from nurses (r = .441–.320; $P < 0.01$), that most patients' spiritual needs are met (r = .503–.362; $P < 0.01$), that regularly conducting a spiritual assessment with patients (r = .379–.394; $P < 0.01$), that use spiritual nursing diagnoses in practice (r = .351–.375; $P < 0.01$, r = .311; $P < 0.05$), and that have nurses regularly discuss patients' spiritual issues with other members of the health team (r = .470–.360; $P < 0.01$). In addition, there were positive correlations between nursing education programs that taught ways to incorporate spiritual care into patient

care and nurses who find comfort in their faith or spiritual beliefs ($r = .262$; $P < 0.05$), understand the definition of spirituality ($r = .250$; $P < 0.05$) and religion ($r = .256$; $P < 0.05$), are comfortable with communicating ($r = .488$; $P < 0.01$), and recognize that spirituality and religion are important and can have a positive impact on health ($r = .288$; $P < 0.05$ and $r = .348$; $P < 0.01$). These results demonstrate that nurses whose basic educational program emphasized spiritual care had a better understanding of spiritual care and were implementing more spiritual interventions in practice.

The second research question was "is there a relationship between the nurse's own spiritual/religious beliefs and the nurse's comfort level and ability to provide nurse–patient interactions related to spiritual care?" Significant positive correlations were found between nurses who recognize that patients and families seek spiritual care from nurses and those who regularly conduct a spiritual assessment ($r = .513$; $P < 0.01$), those who regularly engage in nursing interventions to support patients' spiritual or religious needs ($r = .380$; $P < 0.01$), and those who use nursing diagnoses that address spiritual well-bring, spiritual distress, or at risk for distress ($r = .273$; $P < 0.05$).

The third research question was "is there a relationship between the nurse's comfort level and the assessment of patients' spiritual needs?" Significant correlation was found between respondents who perceive that nurses are prepared to discuss spiritual or religious issues with patients and those who regularly conduct a spiritual assessment of his or her patients ($r = .534$; $P < 0.01$).

As expected, there are significant negative correlations between nurses who prefer that a pastor or professional from spiritual services address patients' spiritual needs and nurses who believe in God ($r = -.294$; $P < 0.05$), with nurses whose religious beliefs support his or her nursing practice ($r = -.339$; $P < 0.01$), who find comfort in his or her faith ($r = -.303$; $P < 0.05$), who have high comfort levels in communicating with patients about spiritual needs ($r = -.382$; $P < 0.01$), who regularly conduct spiritual assessments ($r = -.331$; $P < 0.01$), who recognize that spirituality and religion can have a positive impact on health and well-being ($r = -.292$; $P < 0.05$), and who believe that is important to respond to patients' spiritual/religious needs ($r = -.253$; $P < 0.05$).
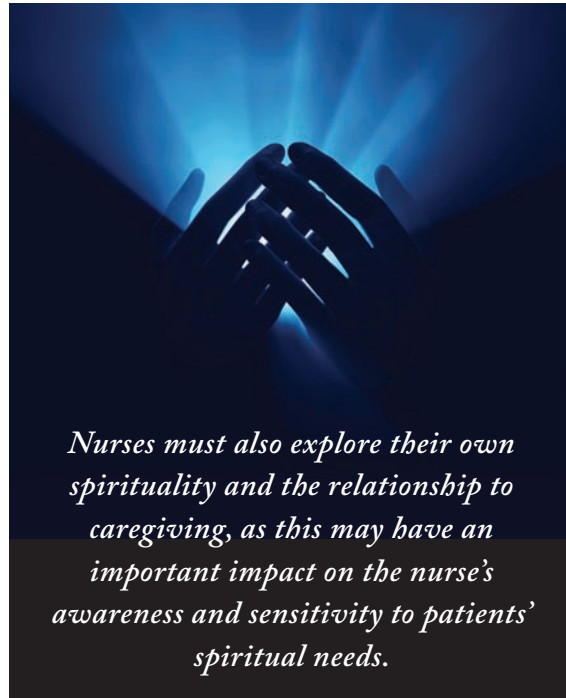
Nurses must also explore their own spirituality and the relationship to caregiving, as this may have an important impact on the nurse's awareness and sensitivity to patients' spiritual needs.

Discussion

Highly significant positive correlations were found among nurses whose basic nursing educational programs emphasized spiritual care and the nurses' comfort level, knowledge, and nurse–patient interactions related to providing or supporting spiritual care. Holistic nursing care cannot exist without recognizing the spiritual/religious aspects of care. From the results of this study, nurses who had spiritual care in their basic nursing curriculum and have been taught to incorporate spiritual care into the planning and delivery of care are more spiritually competent and prepared to address spiritual issues with patients. Those nurses with little basic spiritual education indicated they were uncomfortable discussing spiritual issues and incorporating spiritual care into the care of patients and preferred that others address the patient's spiritual needs. Nurse educators need to develop nursing curricula that address strategies for increasing students' awareness of spiritual care. Nurse educators who are uncomfortable or are not prepared to address spiritual care in the nursing curriculum should receive further education or training on how to provide class and clinical environments that address and

offer experiences for nursing students to explore the spiritual domain. These results support previous studies that suggest that nurses may not be prepared to provide spiritual care or may not feel comfortable doing so.

In addition, nurses and other healthcare clinicians who report not being comfortable providing spiritual care must be educated about spiritual care through formal curricula or continuing education.

Limitations

One factor not addressed in this study was the relationship between where the nurse worked and the effect on the variables. This study does not identify if home healthcare nurses are more comfortable with, implement more nursing interventions related to, and have more knowledge of spiritual care than nurses in other practice areas. One of the institutions used in this study was faith based and one was not. This study did not examine if the nurses who worked in the faith-based hospital were more comfortable providing spiritual care. Regardless of the institution where one works, all nurses must be educated in spiritual care and incorporate spirituality into the care of patients.

Variations in age, years in practice, and type of educational program (religious vs. public) may also have influenced the results. Lack of randomization of the sample and the geographic limitations may have also influenced the study. The relatively small sample size limits the exploration of complex relationships among the variables.

Implications for Practice and Future Research

This study may lead to further studies, which will then examine patterns of and relationships among the concepts of personal beliefs, knowledge of the concepts of spirituality and religion, degree of comfort, ability to assess and implement spiritual/religious interventions, support for interventions in practice, and degree of spiritual education in basic nursing education programs. Further studies can then ask: What interventions have the greatest impact on changing nurses' ability to meet patients' spiritual needs. The more nurses are exposed to content and feel comfortable and supported in

practice with providing spiritual care, the more they will be able to provide interventions to improve quality of life and assist patients with coping. More research is needed within institutions and all specialty areas to determine which practices ensure optimum patient outcomes.

This study demonstrated that nurses whose basic education program emphasized and taught ways to incorporate spiritual care into care of patients were better prepared to discuss spiritual or religious issues with patients, implemented spiritual interventions when caring for patients, and discussed spiritual interventions with other health team members. It also demonstrated that nurses who know that patients and families seek spiritual care from nurses do provide spiritual interventions.

Results from future studies can be used to provide the rationale for strengthening the spirituality component in basic nursing education programs that either do not address spirituality or do not incorporate spiritual care in the planning and delivery of patient care. Future studies could focus on best strategies to help students learn this domain, and help educators teach within school of nursing curricula. Future studies are also needed to identify specific spiritual care interventions that assist in meeting patients' spiritual needs. Results from this study can also be used to identify weaknesses in nursing practice and to develop resources and support for nurses who are uncomfortable assessing and providing spiritual/religious care to their patients. This may lead to further studies that identify what interventions have the greatest impact on changing nurses' abilities to provide spiritual care in both the educational and practice setting. Nurses and others whose educational programs did not address spiritual care may benefit from continuing education specific to their disciplines. Additional studies could address spiritual development in nurses and strategies to teach spiritual competence. It is vital that clinicians address spiritual needs to assist patients, particularly in coping with illness and end of life, and in supporting patients in finding their own sense of meaning and purpose. The more the nurses are exposed to spiritual content and feel comfortable and supported in practice with providing spiritual care, the more these

nurses will be able to provide requested spiritual care, including interventions to improve patients' quality of life and assist with coping. ♠

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The author extends special thanks to Saint Joseph Regional Medical Center in Mishawaka, Indiana, and Lakeland HealthCare at Niles and St. Joseph, Michigan, for participation in the study.

The author declares no conflicts of interest.

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Appendix. Perceptions of Spiritual Care Questionnaire

Description of study: This is a research project to study nurses' perceptions of readiness to meet patient's spiritual needs. The researcher appreciates your willingness to answer the following questions to the best of your ability. There are no right or wrong answers.

Demographic Date:

Age in years _____   **Gender ____F _____M**

Religious affiliation:
Protestant _____   Catholic _____   Jewish _____   Jehovah's Witness _____   Buddhist _____
Other (Please specify) _____   No affiliation _____

Nursing education:
Associate's degree _____   Diploma _____   Bachelor's of nursing _____   Master's of nursing _____
Master's in other field _____

Type of Program:
Public _____   Private nonsectarian _____   Private religious _____

Have you received continuing education units in spiritual care of patients since graduating?
Yes _____   No _____

Years in nursing practice:
Less than 1 year _____   1–5 years _____   5–10 years _____   Over 10 years _____

If working in healthcare, is agency:
Public or private nonsectarian _____   Private religious _____

Perceptions of Spiritual Care Assessment Scale

Instructions: Please check the response category which best identifies your personal belief about the item.
Response categories: Strongly Agree, Agree, Uncertain, Disagree, Strongly Disagree

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
1. I believe in a higher power (God or supreme being).	1	2	3	4	5
2. My religious beliefs support my nursing practice.	1	2	3	4	5
3. I find comfort in my faith and/or spiritual beliefs.	1	2	3	4	5
4. I understand the definition of spirituality.	1	2	3	4	5
5. I understand the definition of religion.	1	2	3	4	5
6. Patients' spiritual needs are important.	1	2	3	4	5

(*continues*)

Appendix. Perceptions of Spiritual Care Questionnaire, Continued

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
7. I consider myself a spiritual person.	1	2	3	4	5
8. I consider myself a religious person.	1	2	3	4	5
9. I regularly conduct a spiritual assessment of my patients.	1	2	3	4	5
10. I am comfortable communicating openly with patients and families about religious or spiritual issues.	1	2	3	4	5
11. Patients and/or families seek spiritual care from nurses.	1	2	3	4	5
12. Spirituality and/or religion can have a positive impact on health and well-being.	1	2	3	4	5
13. It is important to respond to patients' spiritual/religious needs.	1	2	3	4	5
14. I regularly engage in nursing interventions to support my patients' spiritual or religious needs (praying, reading scripture, being with loved ones, or other activities).	1	2	3	4	5
15. I prefer a pastor or a professional from spiritual services assess and address my patients' spiritual needs.	1	2	3	4	5
16. Nurses are prepared to discuss spiritual or religious issues with patients.	1	2	3	4	5
17. Most patients' spiritual needs are met.	1	2	3	4	5
18. I am familiar with the nursing diagnoses that address spiritual well-being, spiritual distress, or at risk for spiritual distress.	1	2	3	4	5
19. When planning nursing care, I use the nursing diagnoses that address spiritual well-being, spiritual distress, or at risk for spiritual distress.	1	2	3	4	5
20. I regularly discuss patient's spiritual issues with other members of the health team.	1	2	3	4	5
21. I feel my formal nursing education adequately prepared me to meet my patients and/or families spiritual and religious needs.	1	2	3	4	5
22. My formal nursing education program emphasized spiritual care.	1	2	3	4	5
23. My formal nursing education program taught ways to incorporate spiritual care in the planning and delivery of patient care.	1	2	3	4	5

Thank you very much for completing the questionnaire.