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A Survey of Hospice and Palliative Care Nurses' and Holistic Nurses' Perceptions of Spirituality and Spiritual Care

Julia Lukovsky, DNP, RN, ANP-BC
Elizabeth McGrath, DNP, APRN, AGACNP-BC, AOCNP, ACHPN
Carolyn Sun, PhD, RN, ANP-BC
Daniel Frankl, PhD
Michelle A. Beauchesne, DNSc, RN, CPNP, FAAN, FNAP, FAANP

The provision of spiritual care is referred to in professional practice guidelines and mandated in nurses' ethical codes. Still, a gap exists regarding essential training in spiritual conversation and assessment, leaving some health care providers feeling uncomfortable when assessing spiritual support needs. The purpose of this study was to assess hospice and palliative nurses' and holistic nurses' perceptions of spirituality and spiritual care. It was assumed that the standards of care for hospice and palliative nurses and holistic nurses stipulate that spiritualty is addressed within the framework of their specialties and provide education for spiritual care, thus making these nurses proficient in providing spiritual care. This exploratory, descriptive study utilized a web-based survey to measure perception of spirituality and spiritual care giving using a modified Spirituality and Spiritual Care Rating Scale. A convenience sample was recruited from members of the Hospice and Palliative Nurses Association and the American Holistic Nurses Association (n = 250). Descriptive statistics summarized data as well as qualitative analysis of written narratives. Content analysis of open-ended survey questions was used to identify themes until saturation. This study found that given adequate resources and education, nurses can be positioned to address the spiritual needs of patients and provide appropriate care. This study adds to an emerging body of evidence suggesting that training in spiritual care should be an important component of the foundational nursing curriculum.

KEY WORDS
education, holistic, palliative, perceptions, spiritual care, spirituality

Spiritual care is the recognition and support of the religion and/or spirituality dimensions of illness.[1] The establishment of spiritual care is progressively being referred to in professional practice guidelines and government policy[2] and is nationally and internationally mandated in nurses' ethical codes, philosophy, and competencies.[3,4] Spiritual care embraces sincere communication and encouragement, companionship, emotional support, open-mindedness, and active listening to the patient.[5,6] Three defining attributes of spirituality are identified in the literature: connectedness, transcendence, and meaning in life, and for some patients, it has been exemplified as their purpose for being.[7,8]

Most recently, there has been an evolving distinction between the concepts of spirituality and religion in the literature. Durkheim's classic definition of religion displays a set of beliefs and practices that unite groups into a moral community around a sense of the sacred.[9] It is characterized by boundaries, which distinguish religion from spirituality, a phenomenon with intangible limits. Spirituality may be embraced by individuals who desire to move outside of institutional religion and may or may not include religious practices, traditions, and rituals such as prayer and worship, ministry, or referral to clergy or chaplain.[10-12]

Nurses are responsible for preserving the holistic health and integrity of their patients. Although hospice and palliative care nurses (HPNs) and holistic nurses (HNs) are not mutually exclusive, inclusivity of spiritual care intersects these 2 specialty practices of nurses. Health care providers (HCPs) may be educated to assess and care for the entire

Julia Lukovsky, DNP, RN, ANP-BC, is registered nurse/nurse practitioner, New York Presbyterian Hospital, Matrix Medical Network.

Elizabeth McGrath, DNP, APRN, AGACNP-BC, AOCNP, ACHPN, is assistant professor of medicine, Geisel School of Medicine, Hanover, New Hampshire.

Carolyn Sun, PhD, RN, ANP-BC, is assistant professor, Hunter-Bellevue School of Nursing, and Nurse Researcher, New York Presbyterian Hospital.

Daniel Frankl, PhD, is professor, California State University, Los Angeles.

Michelle A. Beauchesne, DNSc, RN, CPNP, FAAN, FNAP, FAANP, is professor emeritus, Northeastern University, Boston, Massachusetts.

Address correspondence to Julia Lukovsky, DNP, RN, ANP-BC, 147 E 82nd St #4E, New York, NY 10028 (Jluk0704@gmail.com).

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well-being of the patient including physical, psychological, and cultural aspects, but the movement toward more holistic care supports that nurses also deliver spiritual care. Yet, graduates of conventional training programs may receive little or no education to adequately address the spiritual aspect of care.[13,14]

LITERATURE REVIEW

According to the National Consensus Project Guidelines, spirituality is recognized as a fundamental aspect of compassionate, patient- and family-centered care that honors the dignity of all persons.[15] The National Consensus Project defines spirituality as "a dynamic and intrinsic aspect of humanity through which individuals seek meaning, purpose, and transcendence and experience relationship to self, family, others, community, society, and the significant or sacred."[16]

Holistic care can be threatened through the traditional medical health care model, which focuses on physical aspects of illness and often overlooks religious and spiritual needs.[17] Research reflects a high level of patient interest in discussing spirituality with their HCPs. It affords an opportunity to build trust and develop relationships.[18] For HCPs, the most commonly identified barriers to discussing spirituality and religion were lack of knowledge and/or training, lack of time, and personal discomfort.[18] Minimal spiritual content is cited in nursing textbooks, and nursing programs do not sufficiently prepare nurses in matters of spirituality.[19] Relatively few studies have investigated whether nurses have had satisfactory educational preparation.

The Hospice and Palliative Nurses Association (HPNA) Position Statement on Spiritual Care asserts that the recognition of spirituality, spiritual distress, and spiritual care as essential components of palliative and hospice care and encourages health care organizations to provide continuing education and distribute resources that enhance both the provider's and patient's ability to reduce spiritual distress.[20]

The American Holistic Nurses Association (AHNA) asserts that its members, "nurture wholeness, peace, and healing by valuing each person's physical, mental, emotional, spiritual, and environmental strengths and challenges and honoring each person's values, health beliefs and health experience. The condition of the whole person is taken into account during the nurse's assessment, diagnosis, planning, and evaluation of the results."[21] Yet, in a recent editorial, it asserts that although nurses are committed to guiding others in "mind-body-spirit, relationship-centered care," often the "spirit" component of caring is missing among the priorities, tasks, and skill acquisition in today's health care environment.[22] Graduates of conventional nursing programs may lack essential preparation for the role of spiritual facilitator and feel uncomfortable in initiating spiritual conversation and assessments. This existing gap between education and assessment of spiritual beliefs has been attributed in part to the abstract nature of spirituality.[23]

The HPNA and the AHNA recognize the importance of providing evidence-based spiritual care and actively support the practice through research and education. While addressing spiritual care needs in health care may not be an easy task, the ever-growing body of evidence that points out the material benefits of the introduction of the spirituality factor into patient care makes it a viable topic for further study and exploration.[24]

Purpose

The purpose of this project was to assess HPNs' and HNs' perceptions of spirituality and spiritual care and explore the influence of additional spiritual care training on nurses' ability to provide spiritual care.

The aims were as follows:

- Aim 1: Assess HPN and HN nurses' perceptions of spirituality and spiritual care utilizing the Spirituality and Spiritual Care Rating Scale[25] (SSCRS)
- Aim 2: Describe the association between demographic variables (ie, gender, age, education level, degree of spiritual continuing education, years as an RN/advanced practice RN [APRN], nature of nursing specialty, years as an RN/APRN in current specialty, work status, religious affiliation, frequency of religious practice) and nurses' perceptions about spirituality and spiritual care.
- Aim 3: Compare the current study results with an existing study examining perceptions of generalist nurses.

It was assumed that the standards of care for HPNs and HNs stipulate that spirituality is addressed within the framework of their specialties and provide education for the provision of spiritual care, and as a result, these nurses will be able to demonstrate a high level of perceived ability to provide spiritual care.

METHODS

Theoretical Framework

Kang's[26] Psycho-Spiritual Integration, which articulates 6 permeating dimensions of spirituality as becoming, meaning, being, centeredness, connectedness, and transcendence, provides the theoretical underpinning for this study. Psycho-Spiritual Integration intends to propose a technique of observing spirituality and to provide a connection between theory and practice of empowering spirituality. The congruence of these 6 dimensions allows each to flow naturally from one into the next. Rogers and Wattis[8] demonstrate that by using Kang's[26] Psycho-Spiritual Integration framework, an opening can be provided to help discover patients' spiritual needs while faced with illness. Determining a personal and unique conceptualization of spirituality and integrating it into professional practice can support nurses'

TABLE 1 Demographics

Variables		Frequencies (%)	
Gender	Male	15	6.0%
	Female	228	91.2%
	Other/(blank)	7	2.8%
Age, y	22-34	22	8.8%
	35-44	43	17.2%
	45-54	47	18.8%
	55-64	121	48.4%
	≥65	11	4.4%
	(Blank)	6	2.4%
Education	Associate's	15	6.0%
	Baccalaureate	71	28.4%
	Diploma	2	0.8%
	Doctorate	47	18.8%
	Master's	109	43.6%
	(Blank)	6	2.4%
Received educational content concerning spiritual care			
	I do not know	19	7.6%
	No	105	42.0%
	Yes	120	48.0%
	(Blank)	6	2.4%
Years as registered nurse	<1	1	0.4%
	1-5	19	7.6%
	6-10	32	12.8%
	11-25	74	29.6%
	≥25	118	47.2%
	(Blank)	6	2.4%
Work status	Full-time	209	83.6%
	Part-time	31	12.4%
	(Blank)	10	4.0%

(continues)

TABLE 1 Demographics, Continued

Variables		Frequencies (%)	
Specialty area of practice	Intensive care	6	2.4%
	Medical	20	8.0%
	Oncology	15	6.0%
	Other	197	78.8%
	Pediatrics	5	2.0%
	Surgical	1	0.4%
	(Blank)	6	2.4%
Length of employment in specialty	<1 y	13	5.2%
	1-5 y	57	22.8%
	6-10 y	48	19.2%
	11-25 y	73	29.2%
	≥25 y	51	20.4%
	(Blank)	8	3.2%
Specialized education	No	92	36.8%
	Yes	152	60.8%
	(Blank)	6	2.4%
Religious affiliation	No	73	29.2%
	Yes	176	70.4%
	(Blank)	1	0.4%
Specific religious affiliation	Buddhist	2	0.8%
	Christian	141	56.4%
	Hindu	2	0.8%
	Jewish	6	2.4%
	Other	13	5.2%
	(Blank)	86	34.4%
Religious practice	No	13	5.2%
	Yes	151	60.4%
	(Blank)	86	34.4%

(continues)

TABLE 1 Demographics, Continued

Variables		Frequencies (%)	
Frequency of religious practice	Daily	85	34.0%
	More than once a month	8	3.2%
	More than once a week	48	19.2%
	Once a month	8	3.2%
	Once a year	8	3.2%
	(Blank)	93	37.2%
Exposure to spirituality outside of religious affiliation	No	60	24.0%
	Yes	170	68.0%
	(Blank)	20	8.0%

assimilation and lead to an improved therapeutic connection with patients and a re-engagement with the meaning and purpose of their work.

Project Design

This exploratory, descriptive study utilized a web-based survey (Qualtrics, Provo, Utah) to measure HPNs' and HNs' perception of spirituality and spiritual caregiving using a modified SSCRS. The SSCRS was developed to measure nurses' perception of spirituality and spiritual care.[25] The tool has been used in 42 studies in 11 countries. Through its administration, survey data as well as demographic data can be collected to explore spirituality by quantifying participants' perceptions of the extent to which they hold certain spiritual views and engage in certain spiritually related activities. In addition, the scale is designed to assess the areas of spirituality and spiritual care along with how the individual felt about delivery of care.

The SSCRS was modified to include a part A designed to collect demographic and professional information such as gender, age, educational level, and related items of work history. Part B comprises the original survey, including 17 items of spirituality and spiritual care. Part C was added to address spiritual care issues such as awareness of an experience with spiritual care. The modified SSCRS elicited contributory data and was adopted, after obtaining the authors' permission, to determine the nurses' perception of spirituality and provision of spiritual care.

Setting and Sample

A convenience sample was recruited from members of the HPNA and the AHNA after receiving permission from both the associations. The inclusion criteria targeted HPN and HN nurses (RNs and APRNs who are listed on the mailing list of the HPNA and AHNA) who are literate in English and have basic computer skills. Excluded from the study were nonnursing members, LPNs, RNs, or APRNs who have opted out of mass email communication, are illiterate in English, or lack in basic computer skills. All respondent data from the survey were analyzed. The survey remained open for 4 consecutive weeks.

Data Collection

Survey answers were sent to a link at Qualtrics with SSL encryption where data were stored on a password-protected hard drive.

Data Analysis

Descriptive statistics (ie, frequency distributions, percentages, means, SDs, and ranges) were used to summarize quantitative data collected from the Likert scale, Part B. Content analysis of open-ended survey questions on parts A and C of the modified questionnaire was used to identify themes until saturation and to highlight important findings. To ensure trustworthiness, these qualitative narrative data were reviewed by 2 members of the study team using an iterative, constant comparative method to identify themes.[27] The online survey Qualtrics platform was utilized to collect all responses, and data were transferred into Minitab 18 (LLC, State College, PA) and R Studio version 3.4.3 (RStudio, Boston, MA) for analysis. Data were organized in a tabular format. Sample proportions with 95% confidence intervals were calculated, and a frequency table was derived. Surveys were made available to both the HPNA and AHNA membership comprising approximately of 16 500 nurses, yielding a response rate of 1.75% (n = 289). Of the 289 respondents, 250 were completed and utilized in the data analysis. All completed questions were used; therefore, the number of responses per question varies.

Frequency and percentage of demographic characteristics and summary scores were calculated for the standardized measure of the SSCRS. This included the subscales of the questionnaire. Summary scores were compared among sectors and demographic characteristics.

Ethical Considerations

Approval to conduct the study was received from the university institutional review board committee, as well as from the research committees of the HPNA and AHNA, as per respective organizational research policy. No identifying information was collected.

FINDINGS

Of the 289 entries on the online survey, 250 questionnaires (86.5%) were appropriately completed and therefore used for the purpose of this study (Table 1).

Summary of Qualitative Data Derived From Part A of the Questionnaire

Part A, demographic data, question 4 provided a space for a narrative detailing one's exposure to educational content concerning spiritual care during nursing education. Of the 252 responses, 124 (49.21%) indicated having exposure, 107 (42.46%) indicated no exposure, and 21 (8.33%) left the field blank. Of the 124 who said yes, 121 provided statements with various levels of detail regarding their exposure. Space was provided for a narrative detailing one's exposure to specialized educational content concerning spiritual care during nursing education since becoming an RN. Of the 251 responses, 156 (62.15%) indicated that they did have exposure; 95 (37.85%) indicated that they did not have exposure. Of the 156 who said yes, 150 provided statements with various levels of detail regarding their exposure, such as spiritual care continuing education, specialty training, graduate-level education, and work-based learning opportunities.

Spirituality and Spiritual Care Rating Scale Results

Table 2, presents the summary of the responses as frequency distribution and percentages of the 5-Likert categories (strongly agree to strongly disagree) on the 17 SSCRS items. The noteworthy points in the table have been highlighted in bold font. Seven items on the SSCRS scored 50% or higher.

Part C Spiritual Care: Summary of Qualitative and Quantitative Data About Spirituality

Of the 241 respondents, 53 (22%) indicated that the primary provider of spiritual care should be a chaplain/clergy, whereas 146 respondents (60.6%) felt that spiritual care should be provided by all involved parties. A small number of respondents ranging between 0.5% and 5.0% indicated that spiritual care should be mainly provided by patients' family and friends and patients themselves, respectively.

All respondents (100%) indicated they had encountered a patient with spiritual needs throughout their nursing clinical practice. Fifty-three percent (n = 128) said that they became aware of their patient's spiritual need from the patient, whereas 22% (n = 53) pointed out that they became aware of the spiritual needs of their patients through the combination of 2 or more sources provided in the question. Fifty respondents (22%) became aware through their own personal observations. Eight respondents (3.3%) became aware through communications with patient's relatives and friends. Less than 1% became aware of the patients' spiritual needs through a nursing care plan or other nurses. Of 239 respondents, 155 (64.85%) answered that they are able to meet the patient's spiritual needs as a regular part of practice, whereas 84 (35.1%) answered that they do not. Themes resulting from open-ended questions on meeting spiritual needs included respect and support, presence/therapeutic listening, meaning/purpose in life, teamwork, and exploration of feelings (Table 3).

More than 80% (n = 194) indicated that they address their patients' spirituality in their daily practice. Twenty-two (9.13%), answered that they addressed patients' spiritual needs once a week, 10 (4.15%) twice a week while working, 11 (4.56%) once a month, and 4 (1.66%) said that they never address the spiritual needs of their patients while practicing.

The vast majority of respondents felt nurses received insufficient instruction and training on matters concerning spiritual care (n = 219 [91.63%]). Of the total responses, 173 (30.19%) indicated that the proper venue for delivering instruction concerning spiritual care would be programs of nursing, 134 (23.39%) training department, 126 (21.99%) nurses themselves, 113 (19.72%) clergy/religious leaders, and 27 (4.71%) pointed out that instruction for spiritual care should be delivered through the combination of 2 or more sources provided in the question.

Of the 239 respondents, 229 (95.82%), indicated that there is a referral process to chaplaincy in place for additional support if spiritual concerns are identified, and only 10 (4.18%) indicated that no such referral process was available.

DISCUSSION

It was assumed that the population studied has had an adequate preparation throughout its nursing specialty education in matters of spirituality and therefore possesses a high level of perceived ability to provide spiritual care. The sample of nurses studied conveyed a broader characterization of spirituality to encompass both concrete actions of caring as well as aspects of religiosity. Given the ages and advanced education, we are shown a mature, highly educated respondent pool with an abundance of work experience.

Results addressing training of spiritual care in nursing programs reveal that approximately 50% had exposure to some spiritual care training in the course of their nursing education. However, of those 50% who indicated they had exposure, further inspection of comments following the answer yes indicated limited exposure to substantial training in spirituality. The results of this study can help to recognize gaps and limiting factors in the nursing curriculum with the hope of determining future educational needs of nursing students. Spiritual care content received during nursing education informs us that many opportunities for growth

TABLE 2 Summary of Responses to the Spirituality and Spiritual Care Rating Scale

	Strongly Disagree		Disagree		Uncertain		Agree		Strongly Agree	
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
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.	3	1.3	4	1.7	4	1.7	**74**	**31.8**	**148**	**63.5**
b. I believe nurses can provide spiritual care by showing kindness, concern, and cheerfulness when giving care.	2	0.9	10	4.3	12	5.2	**67**	**28.8**	**142**	**60.9**
c. I believe spirituality is concerned with a need to forgive and a need to be forgiven.	11	4.8	35	15.2	40	17.3	**88**	**38.1**	**57**	**24.7**
d. I believe spirituality involves only going to church/ place of worship.	177	**77.3**	**42**	**18.3**	1	0.4	2	0.9	7	3.1
e. I believe spirituality is not concerned with a belief and faith in a God or Supreme Being.	**37**	**16.2**	**64**	**27.9**	46	20.1	**54**	**23.6**	**28**	**12.2**
f. I believe spirituality is about finding meaning in the good and bad events of life.	11	4.7	19	8.2	17	7.3	**98**	**42.2**	**87**	**37.5**
g. I believe nurses can provide spiritual care by spending time with a patient giving support and reassurance especially in time of need.	1	0.4	4	1.7	7	3.0	**68**	**29.3**	**152**	**65.5**
h. I believe nurses can provide spiritual care by enabling a patient to find meaning and purpose in their illness.	2	0.9	7	3.0	19	8.2	**69**	**29.9**	**134**	**58.0**
i. I believe spirituality is about having a sense of hope in life.	2	0.9	18	7.8	25	10.8	**93**	**40.3**	**93**	**40.3**
j. I believe spirituality has to do with the way one conducts one's life here and now.	3	1.3	24	10.3	30	12.9	**97**	**41.8**	**78**	**33.6**
k. I believe nurses can provide spiritual care by listening to and allowing patient's time to discuss and explore their fears, anxieties, and troubles.	1	0.4	3	1.3	1	0.4	**69**	**29.6**	**159**	**68.2**
l. I believe spirituality is a unifying force that enables one to be at peace with oneself and the world.	6	2.6	9	3.9	15	6.4	**87**	**37.3**	**116**	**49.8**
m. I believe spirituality does not include areas such as art, creativity, and self-expression.	**133**	**57.1**	**79**	**33.9**	11	4.7	5	2.1	5	2.1
n. I believe nurses can provide spiritual care by having respect for privacy, dignity, and religious and cultural belief of a patient.	1	0.4	1	0.4	2	0.9	**57**	**24.5**	**172**	**73.8**
o. I believe spirituality involves personal friendships or relationships.	3	1.3	10	4.3	32	13.7	**104**	**44.6**	**84**	**36.1**
p. I believe spirituality does not apply to atheists or agnostics.	**150**	**64.7**	**63**	**27.2**	9	3.9	6	2.6	4	1.7
q. I believe spirituality includes people's morals.	8	3.4	19	8.2	37	15.9	**103**	**44.4**	**65**	**28.0**

within the spiritual realm are met in institutions with religious affiliation and electives in nursing programs.

Nevertheless, when asked about postgraduate specialized instruction on spiritual care or faith-based nursing, 62% indicated that they did receive some education in spirituality since becoming an RN. Therefore, HPN and HN receive supplementary training concerning the assessment and provision of spiritual care. Findings further

TABLE 3 Themes and Exemplars of Commonly Recurring Statements Addressing Patients' Spiritual Needs

Respect and support
"Respect, compassion, acceptance"
"Walking beside the person on their journey"
"Dignified and respectful care"
"Showing up in their experience"
Presence and deep/therapeutic listening
"I ask, I listen, I am present, I support"
"Accepting of them where they are and providing comfort"
"Praying for them and with them"
"Read scripture, poems, sing, etc"
"Being an authentic presence, listening, maintaining dignity, providing safe sacred space, being respectful and nonjudgmental, staying open to possibility, not objectifying, serving the person behind the task, holding a belief that we are all one"
Meaning and purpose in life
"Validating existential needs, feelings, concerns"
"Talking about death, meaning, anxiety"
"Connectedness, working toward faith, and fulfillment"
"Discussion on hope, allowing the patient to guide the conversation"
Teamwork
"Calling in rabbi, priest, minister at patient request"
"Bringing in patient's personal faith/community leader/spiritual director if present"
"It takes a team to address spiritual needs; collaborating with SW [social worker], volunteers, chaplains"
"Working with the patient/family to identify what is nourishing spiritually and how to incorporate that into the plan of care"
Exploration of feelings
"Being available"
"Asking questions and allowing the patient to lead the conversation"
"Silent presence, exploring beliefs, examining fears, outlining hopes, providing human kindness"
"Working with the patient to identify what is nourishing spiritually and how to incorporate into the plan of care"
"Taking a needs assessment"

support the notion that nurses receive a greater amount of education regarding spirituality during their postbaccalaureate education.

As noted by McSherry and Jamieson,[28] the diverse approach to spirituality is not merely a juxtaposition of those with religious beliefs and those without. Despite their personal feelings of religiosity, these nurses display a high level of open-mindedness and compassion as validated by the SSCRS. When asked who they feel should be responsible for providing spiritual care, 60.6% of the nurses suggested that care should be provided by all involved parties, which presents a capacity to take responsibility

and play a pivotal role in the delivery of spiritual care. When asked if they had an encounter with a patient with a spiritual need, 100% of the respondents specified that they did have such an encounter during their nursing clinical practice.

Subsequently, results of this study were consistent with previous findings that spirituality can be an extremely valuable and powerful coping mechanism in managing the stressors associated with chronic illness. This finding warrants further exploration into the ways spiritual care is being incorporated into the standard nursing curriculum in order to minimize ambivalence and anxiety to integrate spirituality into nursing care.

Nearly 65% of the nurses felt that they were able to meet the spiritual needs of their patients. McSherry and Jamieson[28] reported that 41.3% of nurses surveyed agreed and 38.0% strongly agreed that they do not receive sufficient education and training in spirituality. Thus, in that study, almost 80% felt that spirituality should be addressed in programs of nursing education. Similar trends were also found in the current study where the choice "programs of nursing" was selected by the largest subgroup.

McSherry and Jamieson[28] distributed a UK survey of nurses' perception of spirituality and spiritual care with 4054 respondents. The 2 largest age groups in the UK study were 34.8% (ages 40-59 years) and 39.2% (ages 50-59 years) for a total of 74% for both age groups. These demographics are somewhat similar to those in the current study. McSherry and Jamieson[28] reported that almost 93% of the nurses surveyed believed spiritual care should be addressed, yet only 5.3% felt always able to meet the spiritual need of patients on a regular basis. Some 80% of respondents in the current study reported that they could meet their patients' spiritual care needs in their daily practice. The significant responses in the current study confirm that specialty nurses such as HPN and HN are better prepared to address their patients' spiritual needs. Fewer than 2% of respondents in the current study indicated that they never address the spiritual needs of their patients while practicing. The data derived from this study strongly support the belief that both HPN and HN are confident in their abilities to address spiritual care needs.

However, despite the reported high level of comfort in the delivery of spiritual care, approximately 92% of the nurses disclosed that they do not feel as though RNs receive sufficient training pertaining to spiritual care. In addition, more than half of the nurses (53.6%) surveyed stated that programs of nursing or training departments are responsible for educating nurses about spiritual care practices.

An examination of the current study's SSCRS scale results as compared with McSherry and Jamieson's[28] study revealed similar general trends in items b, d, g, h (providing spiritual care by enabling a patient to find meaning and purpose in their illness), k, n, and p. For example, frequency of answers to item (b) for strongly-agree category was indicated by 60.9% of respondents in the current study and 46.6% in McSherry and Jamieson's[28] study. On the strongly-disagree answers on item (b), the frequency of responses in the current study was 0.9%, whereas in McSherry and Jamieson's[28] study, it was 2.5%.

Answers to item (d) on the current study and McSherry and Jamieson's[28] study indicate that the majority of respondents, 77.3% and 68.2%, respectively, strongly disagreed with the notion that spirituality involves only going to church/place of worship. Therefore, there is consensus between the 2 studies about the notion that religious beliefs and ability to provide spiritual care are not mutually exclusive. Also, as seen in item (n) in both studies, respondents strongly agreed (73.8% and 61.6%, respectively) with the notion that "one can provide spiritual care by having respect for privacy, dignity, and religious beliefs of a patient." Again, affirmation of the nurses' openness and sense of inclusion is shown in responses to item (n), which display a nondogmatic perspective that respects beliefs that may not be one's own.

A majority of respondents in the current study (70.4%) indicated a religious affiliation; 60.4% indicated an involvement in religious practice, and 53.2% practiced their religion daily or more than once a week. In this study, most of the respondents describe themselves as observant but fully respect those with no/different religious affiliation.

Further emphasized is what is seen in items (g, k); that is, nurses strongly agree they can provide spiritual care by delivering support and reassurance (65.5%; in McSherry and Jamieson,[28] 49.3%) while listening to patients and exploring their fears and anxieties (68.2%; in McSherry and Jamieson,[28] 51.2%). Moreover, concerning responses to item (p), 64.7% in the current study and 51.0% in McSherry and Jamieson's[28] study strongly disagreed with the statement that "spirituality does not apply to atheists or agnostics." These findings are aligned with the stronger trends seen in items (d, p) as compared with McSherry and Jamieson's[28] study. Nurses in the current study show openness to a more flexible view of spirituality that may also be measured via concrete actions.

Regarding item (h), 58% of respondents in the current study strongly agreed with the belief that "nurses can provide spiritual care by enabling a patient to find meaning and purpose in their illness," whereas 22.8% in McSherry and Jamieson's[28] study held that same belief. This vast discrepancy may be explained by the current study's sample, consisting of HPN and HN.

Beliefs about spirituality and spiritual care among specialty nurses in the current study followed similar trends to those found in McSherry and Jamieson's[28] study yet were stronger. This finding reinforces the belief that further training in spiritual care can grow confidence, increase

perceptions, and develop self-efficacy in nurses. Thus, this finding confirms our assumption that spirituality is an integral part of the framework of these 2 specialties as compared with general nursing practice. It has been validated that spirituality is perceived as a widespread phenomenon with findings revealing that nurses are equipped with the wherewithal to be involved in the provision of spiritual care, and the inclusion of spiritual care in nursing can be influenced by nurses' perceptions.[28]

For nurses to feel more proficient in providing spiritual care to patients, additional spiritual care training courses may be necessary if not included in formal nursing education. Training should embrace the components of providing spiritual care, strategies to aid in identification of spiritual needs of patients, and ways to address identified needs. A positive association between the ability of nurses who have received spiritual care training and their capability to deliver such care lends itself to the notion that environments fostering nurses' acquisition of these skills could be effective.[17]

LIMITATIONS

This exploratory, descriptive study has some limitations. First, because of time constraints, the data collection was restricted to a window of 4 weeks. Second, the author had no control over email reminders that were sent out by the hosting organizations on 1 to 2 occasions. Third, although response rate was low, the researchers did not have access to data on the number of members who met eligibility for inclusion or to which organization they belonged. In the responses within the demographic categories, the highest number of missing information (fields left blank) was in the questions regarding religious affiliation and practice (34.4%-37.2%).

In other categories such as gender, age, work status, and length of employment for example, missing information (fields left blank) ranged between 0.4% and 4.0%. Lastly, the choices in the specialty area of practice of the questionnaires were medical, surgical, pediatrics, oncology, intensive care, and other. In the questionnaire, the "other" category did not provide a space to enter a specific description of what the "other" entails. Therefore, one can only speculate about the distribution of HPN and HN among those 79%.

IMPLICATIONS FOR NURSING AND RECOMMENDATIONS

The HPNA position statement "encourages organizations to recognize and support the provision of spiritual care through education and allocation of resources as well as expresses the commitment to providing education and resources to enhance information for health care providers on spirituality."[20] As evidenced in the current study, the 2 specialty groups were highly educated and not only expressed ability to provide spiritual care, but also took action to meet those needs during their daily practice. Baldacchino,[17] in concluding health care professionals may shy away from addressing the provision of spiritual support, recommends requiring a more standardized spiritual and palliative care component in nursing curricula.

Adib-Hajbaghery and Zehtabchi[29] designed an indigenous instrument to assess Iranian nurses' competencies in providing spiritual care, which has demonstrated initial validity and reliability. Puchalski and colleagues[30] developed an outcomes-based global initiative, Interprofessional Spiritual Education Curriculum, intended for both classroom and online learning.

Its purpose is to improve spiritual care for all persons with serious illness using a clinicians-chaplains train-the-trainer approach. It has been implemented thus far in 16 countries showing effectiveness. Hospice and palliative care nurses and HNs should serve as role models, teachers, and leaders in the nursing spiritual care arena.

CONCLUSION

Nurses who feel well prepared in spiritual matters are more comfortable within the spiritual domain of care. Although holistic care and hospice and palliative care are not taught consistently during conventional nursing programs, health policymakers should consider transforming the standard nursing curriculum to encourage nurses' sense of preparedness, fostering a culture where patient's spirituality is discussed and reflected upon in everyday practice. Longitudinal research is needed to identify the most appropriate and effective approaches to the instruction of spiritual care practice to nurses.

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