Nurse’s Views of Spirituality and Spiritual Care in the Republic of Ireland

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Aims: The purpose of this study was to examine nurses’ views of spirituality and spiritual care in the Republic of Ireland.
Background: While information exists internationally regarding nurses’ attitudes to spirituality and spiritual care, there is little information available about nurses’ views in the Republic of Ireland. As 'religious heritage' can shape and influence beliefs about spirituality, it is of interest to know the views of nurses working in a health care context that increasingly reflects a multi-faith society but yet has a strong Christian background.
Methods: A self-reporting survey was used to collect data based on the Nurses’ Perception of Spiritual Care Inventory (SSCRS).
Results: Nurses in this study had positive views about their role in the provision of spiritual care and did not appear to equate religion with spirituality. Although the majority reported being able to provide responsive spiritual care it is of concern that much of this was based upon the nurse’s own personal experience.
Conclusions: As nurses are actively involved in providing for patients' spiritual needs, without specific training in most cases, education in this area is urgently required.

KEYWORDS nurses, spirituality, attitudes, spiritual care

Introduction

Internationally, increasing attention is being paid to the requirement for nurses to address patients’ spiritual needs in practice (WHO 2012; McSherry and Jamieson 2011), with some guidance emerging (NMC 2012; RCN 2011; ICN 2000). These are welcome initiatives as nurses generally place a high value placed on providing spiritual care to patients. Studies have found that nurses have a consistently positive view of the need to provide spiritual care to patients across both general and mental health settings (Wong et al 2008; Ray and McGee 2007; Van Leeuwen et al. 2006; Grant 2004), although specific knowledge and direction for this practice is sometimes lacking (McSherry and Jamieson 2011). There is also debate as to whether nurses should embark on this activity without specific direction as to what it entails and how it should be done (Pesut and Sawatzky 2006).

In the Republic of Ireland (ROI), the need for nurses to provide spiritual care has been publicised (*Irish Independent* 2011; *Irish Times* 2011) but there are few specific national guidelines on this practice. There is, however, increasing awareness of the need to recognise and address patients’ spiritual needs (ABA 2011) and spiritual care teaching forms part of the undergraduate nursing curriculum (ABA 2005). There is a generalised requirement for holistic nursing practice (ABA 2005: 14,33,17) that 'creates and maintains a physical, psychosocial, and spiritual environment that promotes safety, security and optimal health' and includes an understanding of the 'philosophical foundations of spiritual well-being' and 'individual and the bio/psycho/socio/economic/cultural/spiritual and political factors'

influencing health and development. Beyond this there is little specific guidance provided to nurses in ROI regarding this aspect of patient care. As a first step in addressing this gap, this survey seeks to establish nurses' views of spirituality and spiritual care in order to identify gaps in service provision.

Background

Modern nursing owes much to its religious heritage (McSherry 2006a), particularly in the ROI, where a strong Christian tradition and religious order nursing were historically very influential in nurse education and hospital management (Fealy 2006). In keeping with trends in modern Western society, nursing care is now generally considered to be secular, in so far as religion no longer holds a central position in the social fabric of a modern society (Wilson 2009). However a predominant religious world view has the potential to bias the spiritual care that patients may receive. For example it may affect the facilities available for patients depending on resources and availability, and there could be an inherent bias towards dominant religions, leaving the patients from minority religions and those with no professed faith under facilitated (Radford 2008). Indeed, simple issues such as the availability of space for prayer or other forms of worship or contemplation, termed 'ecumenical space' (Radford 2008: 34), are causing dissatisfaction among patients and their relatives in ROI as they seem geared more towards the dominant Christian religions. Since differing religious and cultural backgrounds of nurses can influence spiritual care delivery (Tiew and Drury 2012) it is timely to examine nurses' views of spirituality and spiritual care in this context. A systematic literature review underpinned this examination, the findings of which will now be discussed.

Literature Review

Process

A search was conducted using CINAHL database spanning the years 1999-2013 with the key words 'spirituality', 'nurses' and 'views' or 'attitudes'. This search yielded 22 citations. A pre-determined protocol for inclusion/exclusion criteria within the study was used (Centre for Reviews and Dissemination 2008). It included published research papers from 1999-2013 that examined nurses' views of spirituality and/or religiosity, or where personal [spiritual/religious] characteristics that influenced spiritual care delivery were examined (n=5). Emergent themes were: nurses' understandings of spirituality and spiritual care, the nurse's role in the provision of spiritual care and barriers to spiritual care provision.

Nurses' Understandings of Spirituality and Spiritual Care

All studies isolated examined spiritual and/or religious inclination of nurses (Vance et al. 2001; Tuck et al 2001; Gielen et al 2009; Christopher 2010; Ronaldson et al. 2012); no studies originated from the ROI. Most studies that examined nurses' views had predominantly Christian samples. The studies used a variety of surveys to collect data, thus making pooling of data (Polit and Beck 2012) from across these studies difficult. Although spirituality is a broader holistic concept that transcends religion (McSherry 2006a), it is of interest to note that many studies, used the terms 'religiosity' and 'spirituality' interchangeably. The study by Tuck et al (2001: 441), for example, concerns 'spirituality and spiritual care provided by parish nurses' but primarily explores a religiously orientated community nursing service.

Overall, the nature and meaning of spiritual care provided by nurses is neither clear nor consistent across the studies and both the methods and the findings indicate a

predominantly Christian perspective. While Ronaldson et al (2012: 2127) postulated that 'the definition of spirituality in nursing has followed … from the Judeo-Christian tradition…to more secular identities in modern times', there was little evidence of a secular approach in any of the papers examined.

Furthermore, there is a lack of consensus on [or absence of] definitions of spirituality and spiritual care. Vance's (2001) paper was the only one that defined spirituality. This focused on three elements: interconnectedness with God or god being; the ability to transcend oneself; and finding purpose and meaning in life. Christopher's (2010: 251) was the only paper to define religiosity, suggesting it related to 'behaviours and attitudes a person has with regards to a particular religion'.

The Role of the Nurse in Providing Spiritual Care

There was little information given by way of specific guidance regarding spiritual interventions in the studies examined. Tuck et al (2001) examined parish nursing, a healing-based approach to nursing care that supports patients' health needs. This is described as a nursing service involving an 'interrogation' of 'faith and health'; health education; health counselling/advocacy; referral to services and facilitation of support groups (p.443). These researchers found that parish nurses believed that they spent time providing 'holistic care'; 'health promotion' and 'education', although frequencies for these latter were less than 23%. Activities reported were screening [undefined] (43%); educating (40%) and visiting (29%). Specific spiritual interventions were described as 'prayer' (25%); listening (23%); and presence (12%). It is not entirely clear whether or not parish nurses delivered physical care, but health promotion and referral to services featured heavily in the service.

A referral role was also reported by Galek et al (2007). These researchers examined 1,500 survey responses (37.5%), which included nurses (n=230). Aimed at examining referrals to chaplains in the USA, findings revealed that nurses found it moderately important to refer patients to chaplains when they were faced with issues related to 'meaning, loss and death'; 'treatment issues'; 'pain and depression' and 'anxiety and anger' (p.368). Interestingly those working in 'religiously affiliated hospitals' were more inclined to emphasise the importance of referral.

The role of the nurse in referring patients to established hospital chaplaincy services is well established and supported (Radford 2008; Scottish Executive Health Department 2002). In conjunction with the hospital chaplain, the nurse is a key person in the health care setting in relation to spiritual care provision (McSherry 2006a). However, one recent Irish study (Radford 2008) found that even within the chaplaincy framework patients' spiritual needs may be unmet. Additionally, as chaplaincy in the ROI operates within the traditional Judeo Christian model it does not specially cater for the many non-Christian religions (Radford 2008).

Barriers to Providing Spiritual Care

Although the nature of spiritual care was not outlined in the literature examined, barriers to providing spiritual care were clearly elucidated (Ronaldson et al. 2012; Vance 2001). These included time; insufficient education; patient privacy; lack of confidence; difference in spirituality between nurse and patient; and confusion about proselytizing (Ronaldson et al. 2012; Vance 2001). These findings mirror qualitative findings from the ROI where nurses and other health care staff report a lack of confidence and frustration about their lack of knowledge concerning non-Christian religions and their requirements around health related encounters and spiritual needs (Radford 2008).

The literature review revealed no information regarding Irish nurses' views or practices in this area, and difficulty with interpretation and application of the mostly USA-

based findings. Anecdotally, nurses in Ireland report a lack of confidence and preparation for the role (Radford 2008) which, while resonating with the literature (Ronaldson et al. 2012; Vance 2001) is a cause for concern. These latter factors, together with lack of understandings of spirituality and spiritual care, limited direction about specific interventions, and existing barriers render it timely to explore nurses' attitudes to spirituality and spiritual care provision in the ROI.

The Study

This project aimed to examine nurses' attitudes to spirituality within the acute hospital setting.

Objectives

1. To ascertain and measure nurses' attitudes towards and understandings of spirituality within the acute hospital setting.
2. To administer a structured questionnaire to measure nurses' attitudes to spirituality.

Method

The Questionnaire

Data were collected in 2008. A self-reporting survey was used to collect data. This employed a quantitative research approach using for its basis a pre-designed questionnaire: the Nurses' Perception of Spiritual Care Inventory (SSCRS) (McSherry et al. 2002). The SSCRS was chosen due to its potential cultural sensitivity for the population under scrutiny (Kishi et al. 2011; Papadopoulos and Lees 2002). The SSCRS had also undergone previous rigourous testing and development (McSherry et al. 2002) and has been used in several international studies (McSherry and Jamieson 2011; Lovanio and Wallace 2007). Permission was obtained from the author to use and adapt this tool. The questionnaire is specifically directed towards measuring nurses' attitudes towards spirituality and spiritual care.

Content validity of the questionnaire by a panel of research experts in the ROI resulted in number of formatting changes to the SCCRS. While the overall content remained changes were required in the demographic section (to accurately reflect nurses' roles in ROI) and the number of statements in Section Two was expanded (from 17 to 51) for purposes of clarity. Several statements had more than one possible response, and these double barrelled statements were suggested to be avoided (Olson 2013). There was also a recommendation that statements relating to the provision of spiritual care to the family were also included.

The Sample

Non-Probability sampling was used: a selection of registered nurses from a variety of wards within one acute general hospital in Ireland on duty during a specific two-week period, were sampled. Rather than sampling directly from a hospital database, this approach was chosen for ethical reasons. In total 468 questionnaires were distributed, representing 41% of all registered nurses employed. One hundred and fourteen were returned (response rate 24%). While the response rate is low, this is a typical response for surveys of this kind (Timmins et al. 200; Cochrane et al. 2009). Questionnaires were sent directly to Advanced Nurse Practitioners and Clinical Nurse Specialists (n=70) and returned by stamped addressed envelope (n=24). The response rate for this group was 34%. The total response rate was 26%. The full sample was thus 138.

Ethical Considerations and Consent

The local Research Ethics Committee for the hospital granted ethical approval to conduct the study. In order to ensure informed consent, the authors provided the respondents with written information explaining that completion and return of the questionnaire implied consent to participate.

Data Collection

The questionnaire was distributed to qualified nursing staff on duty on one particular week in 26 relevant clinical areas. This was arranged following an initial meeting with area managers. Of these 26 areas, 7 choose not to partake.

One questionnaire was provided for each registered nurse on duty during this period. A specifically-designed box was left at each unit for collection of the questionnaires. This remained in place for a period of two weeks in an attempt to capture as many staff responses as possible and to maintain volunteerism in return of questionnaire. It was not possible to ascertain absolute truthfulness, or avoid collaborative responses with this survey. However all self-report surveys carry this risk (Polit and Beck 2012).

The original questionnaire was previously tested for reliability within earlier research studies (Mc Sherry et al. 2002) whereby the level of internal consistency and inter-relater reliability revealed a score of 0.65. The Cronbach's Coefficient Alpha in this current study was 0.6.

Rigour

Content validity of the tool was assessed by presenting the instrument to a panel of six experts. To increase validity of the tool, specific guidance was given to respondents regarding interpretation of the terms. Spirituality was defined as 'aspects of human existence that provide meaning and purpose to life' (Coyle 2002); religion as an 'outward practice of a spiritual understanding through the use of frameworks for a system of beliefs, values, codes of conduct and rituals' (King et al. 2001). Definitions were chosen for their consistency with the majority of definitions and ease of understanding. A secular approach to the understanding of spirituality was chosen to reflect the multi-faith society of ROI and to avoid the overt religious orientation of previous studies. Both definitions were outlined on the front cover of the instrument. While it is acknowledged that this could influence perceptions of spirituality before respondents completed the questionnaire, thus introducing a potential bias, operational definitions are best practice in quantitative research to improve validity (Polit and Beck 2012).

Data Analysis

Data were analysed using SPSS. Open-ended items in section three were coded in order to be quantified (Polit and Beck 2012). This means assigning a numerical code to each item and quantifying its occurrence within the study.

The Findings

The majority of the registered nurses were female (89.1%, n=123), 9 (2.3%) were male. Most nurses (94.9%, n=131) reported that they had encountered a patient, or patients, in clinical practice with spiritual needs, the frequency of which was not reported. Most stated that they felt able to meet these needs (86.2%, n=119). Mostly these needs were expressed by the patient him or herself (37%, n=51). Opportunities also arose through the nurse listening to and observing the patient (32.6%, n=45). In some cases it was expressed by a patient's relative or friend (15.9%, n=22). Most (69.6%, n=99) reported having received instruction in spirituality in their initial nurse education programme; 26.8% did not (n=37). When providing spiritual care most nurses (65%, n=47.1) used their own experience as a guide. Thirty-four (24.6%) based this upon what they had learned at their preparatory nurse education programme, and 10 (n=7.2%) learned skills at a post registration nurse education programme. Twenty-two (n=15.9%) used their own spirituality as a guide. When asked whether they had received subsequent instruction in spirituality at education programmes since qualification, 71.1% had not (n=99), although 26.1% had (n=36). Most belonged to an organised religion (85.5%, n=118); 11.6% did not (n=16). For ethical reasons specific religions were not asked, however it is acknowledged that religious beliefs and practices of respondents could influence the findings.

Nurses were presented with a list of 12 statements related to spirituality in its broadest sense and they were invited to respond using a Likert scale of 1 to 5. Five referred to strongly agree, whereas one related to strongly disagree. There was also a *not applicable* option. Nurses′ responses to these items are outlined in Table 1. Nurses were also presented with a list of 12 statements about spiritual care, religion and personal care and were invited to respond using a Likert scale. Responses to these items are outlined in Tables 2, 3 and 4.

Table 1 Nurses' views of spirituality

Scale / Question (Item)	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	Not Applicable/ missing value
1. Spirituality is about having a sense of hope in life	43 (31.2%)	67 (48.6%)	15 (10.9%)	7 (5.1%)	3 (2.2%)	3 (2.2%)
2. Spirituality is to do with the way one conducts one's life here and now	32 (23.3%)	57 (41.3%)	21 (15.2%)	20 (14.5%)	4 (2.9%)	4 (2.9%)
3. Spirituality is about finding meaning in the good experiences in life	37 (26.8%)	67 (48.6%)	16 (11.6%)	12 (8.7%)	4 (2.9%)	2 (1.4%)
4. Spirituality is about finding meaning in the bad experiences in life	29 (21%)	58 (42.3%)	23 (16.7%)	12 (8.7%)	13 (9.4%)	3 (2.2%)
5. Spirituality is a unifying force which enables one to be at peace with oneself and the world	55 (39.9%)	59 (42.8%)	16 (11.6%)	5 (3.6%)	2 (1.4%)	1 (0.7%)
6. Nurses can provide spiritual care to patients by encouraging them to derive some meaning from positive experiences related to their illness experiences	37 (26.8%)	58 (42%)	26 (18.8%)	14 (10.1%)	3 (2.2%)	0
7. Nurses can provide spiritual care to families by encouraging them to derive some meaning from positive experiences related to illness	38 (27.5%)	60 (43.5%)	21 (15.2%)	15 (10.9%)	4 (2.9%)	0
8. Nurses can provide spiritual care to patients by encouraging them to derive some meaning from negative experiences related to their illness experiences	23 (16.7%)	48 (34.8%)	33 (23.9%)	25 (18.1%)	9 (6.5%)	0
9. Nurses can provide spiritual care to families by encouraging them to derive some meaning from negative experiences related to illness	18 (13%)	47 (34.1%)	35 (25.4%)	28 (20.3%)	9 (6.5%)	1 (0.7%)
10. Spirituality includes an appreciation of aesthetics such as art	5 (3.6%)	19 (13.8%)	35 (25.4%)	59 (44.2%)	14 (10.1%)	3 (2.2%)
11. Spirituality includes an appreciation of aesthetics such as music	5 (3.6%)	19 (13.8%)	33 (23.9%)	60 (43.5%)	19 (13.8%)	2 (1.4%)
12. Spirituality includes an appreciation of aesthetics such as nature	7 (5.1%)	16 (11.6%)	27 (19.86)	66 (47.8%)	21 (15.2%)	1 (0.7%)

Table 2 Nurses' views on spiritual care

Scale / Question (Item)	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	Not Applicable/ missing value
1. Nurses can provide spiritual care in hospital by facilitating visits by the hospital Chaplain	53 (38.4%)	71 (51.4%)	6 (4.3%)	2 (1.4%)	3 (2.2%)	3 (2.2%)
2. Nurses can provide spiritual care in hospital by facilitating visits by the patient's own religious leader	52 (37.7%)	70 (50.7%)	9 (6.5%)	2 (1.4%)	1 (0.7%)	4 (2.9%)
3. Nurses can provide spiritual care in hospital by facilitating visits to the chapel or place of worship	53 (38.4%)	73 (52.9%)	4 (2.9%)	2 (1.4%)	2 (1.4%)	4 (2.9%)
4. Nurses can provide spiritual care by showing kindness to patients when providing care	64 (46.4%)	61 (44.2%)	2 (1.4%)	2 (1.4%)	2 (1.4%)	7 (5.1%)
5. Nurses can provide spiritual care by showing kindness to patients' family when providing care	66 (47.8%)	56 (40.6%)	3 (2.2%)	2 (1.4%)	2 (1.4%)	9 (6.5%)
6. Nurses can provide spiritual care by showing concern to patients when providing care	61 (44.2%)	62 (44.2%)	4 (2.9%)	2 (1.4%)	2 (1.4%)	6 (4.3%)
7. Nurses can provide spiritual care by showing concern to patients family when providing care	61 (44.2%)	62 (44.2%)	5 (3.6%)	3 (2.2%)	2 (1.4%)	5 (3.6%)
8. Nurses can provide spiritual care by demonstrating cheerfulness towards patients when providing care	55 (39.9%)	54 (39.1%)	16 (11.6%)	10 (7.2%)	2 (1.4%)	1 (0.7%)
9. Nurses can provide spiritual care by demonstrating cheerfulness towards patients' family when providing care	54 (39.1%)	57 (41.3%)	15 (10.9%)	9 (6.5%)	2 (1.4%)	1 (0.7%)
10. Nurses can provide spiritual care by spending time with a patient	60 (43.5%)	56 (40.6%)	7 (5.1%)	5 (3.6%)	3 (2.2%)	7 (5.1%)
11. Nurses can provide spiritual care by spending time with a patient's family	56 (40.6%)	59 (42.8%)	7 (5.1%)	4 (2.9%)	3 (2.2%)	9 (6.5%)
12. Providing support to patients is a form of spiritual care	56 (40.6%)	62 (44.2%)	9 (6.5%)	4 (2.9%)	2 (1.4%)	5 (3.6%)
13. Providing support to patients' families is a form of spiritual care	54 (39.1%)	63 (45.7%)	10 (7.2%)	3 (2.2%)	3 (2.2%)	5 (3.6%)
14. Providing reassurance to patients is a form of spiritual care	56 (40.6%)	60 (43.5%)	10 (7.2%)	4 (2.9%)	3 (2.2%)	5 (3.6%)
15. Providing reassurance to patients' family is a form of spiritual care	55 (39.9%)	58 (42%)	12 (8.7%)	5 (3.6%)	3 (2.2%)	5 (3.6%)

16.	Nurses can provide spiritual care by listening to patients	59 (42.8%)	59 (42.8%)	7 (5.1%)	5 (3.6%)	2 (1.4%)	6 (4.3%)
17.	Nurses can provide spiritual care by listening to patients' families	58 (42%)	59 (42.8%)	8 (5.81%)	5 (3.6%)	2 (1.4%)	6 (4.3%)
18.	Nurses can provide spiritual care by encouraging patients to express their concerns	60 (43.5%)	56 (40.6%)	7 (5.81%)	8 (5.81%)	2 (1.4%)	5 (3.6%)
19.	Nurses can provide spiritual care by encouraging patients' families to express their concerns	59 (42.8%)	56 (40.6%)	7 (5.1%)	9 (6.5%)	2 (1.4%)	5 (3.6%)

Table 3 Nurses' views on religion

Nurse's views on religion						
Scale / Question (Item)	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	Not Applicable/ missing value
1. Spirituality requires commitment to a recognized religion	9 (6.5%)	13 (9.4%)	14 (10.1%)	41 (29.7%)	57 (41.3%)	4 (2.9%)
2. Spirituality involves attending church regularly	5 (3.6%)	8 (5.8%)	13 (9.4%)	50 (36.2%)	60 (43.5%)	2 (1.4%)
3. Spirituality involves attending a place of Worship regularly	6 (4.3%)	9 (6.5%)	10 (7.2%)	53 (38.4%)	58 (42%)	2 (1.4%)
4. Spirituality is concerned with a need to forgive	20 (14.5%)	40 (29%)	26 (18.8%)	30 (21.7%)	19 (13.8%)	3 (2.2%)
5. Spirituality is concerned with a need to be forgiven	18 (13%)	40 (29%)	33 (23.9%)	23 (16.7%)	22 (15.9%)	2 (1.4%)
6. During patient admission I take cognizance of patients religion	23 (16.7%)	72 (52.2%)	13 (9.4%)	13 (9.4%)	7 (5.1%)	10 (7.2%)
7. When planning nursing care I take cognizance of patients religion	21 (15.2%)	69 (50%)	13 (9.4%)	19 (13.8%)	9 (6.5%)	7 (5.1%)
8. I respect all individuals from all religious groups equally	64 (46.4%)	58 (42%)	1 (0.7%)	4 (2.9%)	2 (1.4%)	9 (6.5%)
9. I treat all individuals from all religious groups with dignity	72 (52.2%)	53 (38.4%)	1 (0.7%)	1 (0.7%)	2 (1.4%)	9 (6.5%)
10. Where necessary I support patients with their religious needs when in hospital	58 (42%)	64 (46.4%)	2 (1.4%)	4 (2.9%)	2 (1.4%)	8 (5.8%)
11. I am equipped with the necessary skills to provide relevant support for varied religious needs that arise in this hospital	16 (11.6%)	29 (21%)	37 (26.8%)	39 (28.3%)	12 (8.7%)	5 (3.6%)
12. Spirituality does not apply to those with no professed religion	9 (6.5%)	6 (4.3%)	9 (6.5%)	47 (34.1%)	65 (47.1%)	2 (1.4%)
13. Attending to religious needs of patients and their families can cause a conflict of interest with my own religious beliefs	9 (6.5%)	13 (9.4%)	11 (8%)	58 (42%)	44 (31.9%)	3 (2.2%)
14. Attending to religious needs of patients and their families can cause a conflict of interest with care being provided	9 (6.5%)	21 (15.2%)	22 (15.9%)	49 (35.5%)	34 (24.6%)	3 (2.2%)

Table 4 Nurses views' on personal care

Scale / Question (Item)	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	Not Applicable/ missing value
1. Nurses can provide spiritual care by respecting patients' privacy	46 (33.3%)	66 (47.8%)	14 (10.1%)	8 (5.8%)	2 (1.4%)	2 (1.4%)
2. Nurses can provide spiritual care by respecting the families' privacy	45 (32.6%)	66 (47.1%)	13 (9.4%)	8 (5.8%)	4 (2.9%)	3 (2.2%)
3. Nurses can provide spiritual care by respecting patients' dignity	55 (39.9%)	61 (44.2%)	10 (7.2%)	5 (3.6%)	3 (2.2%)	4 (2.9%)
4. Nurses can provide spiritual care by respecting the families' dignity	56 (40.6%)	61 (44.2%)	9 (6.5%)	5 (3.6%)	3 (2.2%)	4 (2.9%)
5. Spirituality involves personal friendships and relationships	40 (29%)	61 (44.2%)	17 (12.3%)	9 (6.5%)	4 (2.9%)	7 (5.1%)
6. Nurses can provide spiritual care by encouraging and facilitating visits by family and friends	45 (32.6%)	68 (49.3%)	13 (9.4%)	3 (2.2%)	2 (1.4%)	7 (5.1%)
7. Spirituality is concerned with peoples' morals	27 (19.6%)	52 (37.7%)	31 (22.5%)	17 (12.3%)	8 (5.8%)	3 (2.2%)

Discussion

Understandings of Spirituality and Spiritual Care

Spiritual care provision and religious understandings overlapped in many areas within the literature (Christopher 2010, Gielen et al 2009, Tuck et al 2001), with nurses showing concern that providing spiritual could be perceived as proselytizing or conflicting with their own religious views (Ronaldson et al 2012, Vance 2001). Conversely nurses in this study clearly understood that commitment to a recognised religion is not a requirement for spirituality, while at the same time they supported patients' religious and/or spiritual needs when in hospital. Concerns regarding personal religious differences were negligible. However there was an emerging view in the study findings that linked forgiveness and spirituality, suggestive of Judeo Christian influences and not necessarily a component of current understandings of spirituality. However, overall there appears to be an acceptance and respect for all religions by nurses in this study, which is very reassuring and reflective of the sensitivity required in a modern multi-faith society (Papadopoulos and Lees 2002).

Nurses' understandings of spirituality within this study were consistent with contemporary secular interpretations of spirituality that focus on *meaning making* (La Cour and Hidvt 2010, Narayanasamy 2004). La Cour and Hidvt's (2010: 1292) uncovering of 'existential meaning making' in life suggests that it takes three forms: secular, spiritual, and religious. These authors suggest that an acceptance and understanding of these three elements of human experience can provide a more authentic basis for clinical practice in a secular age. Nurses in this study could be said to concur with this approach, particularly in relation to supporting patients' religious beliefs and activities. While definitions and understandings of spirituality can appear overtly optimistic at times, nurses (in keeping with the overarching context of spirituality as *meaning making*) took a realistic view and agreed that supporting patients' spirituality also meant helping them to derive meaning from negative experiences related to illness. However the extent to which the nurses' responses were influenced by the definitions provided [for the study] is not certain. Further research in the area would be useful to explore nurses' understandings in more depth.

Another issue with definitions and understandings of spirituality is that they imply the need for an intellectual capacity. So it is not clear how nurses relate definitions of spirituality to those groups of people who are unable to intellectualise appropriately, such as people with dementia, profound learning disability, neurological or mental health disorders. Indeed Gielen et al (2009) found intellectual ability to be one of four necessary dimensions in religiosity; presumably spirituality requires an intellectual dimension too. However, nurses in this study appeared to provide spiritual support to both families and patients, so in the latter cases the patients' family may be the conduit for spiritual care provision and could contribute to understandings of the patients' *apriori* spiritual disposition. This exposition of the family as a recipient of spiritual care, which emerged from the nurses' responses as being of equal importance to the care required by patients, is a new finding in this field and one that requires further research. While family centred care is well established in other disciplines (Coyne 2010), the direct care that patients receive or require from nurses in general hospital settings is less well understood.

Nurses' Role in the Provision of Spiritual Care

In keeping with the literature (Ronaldson et al 2012, Tuck et al 2001, Vance 2001), nurses in this study had positive views of spirituality. Unlike Vance (2001) most were providing spiritual support to patients. There was also a greater clarity emerging with regard to their

role in the provision of spiritual care. Many nursing actions, directed at both patient and family, served to demonstrate and communicate spiritual care delivery. Listening; providing time and privacy; showing concern and kindness are examples of these. While the latter could be said to be aspects of a rather more generic nursing role (Paley 2008), such as those outlined by national regulatory bodies (NMC 2012; ABA 2005), and not specific to spiritual care, in this study these functions are clearly used and understood within the context of spiritual care. Furthermore this is consistent with interpretations of nursing practice in the ROI where nurses are expected to provide holistic care that addresses spiritual (and other) needs simultaneously (ABA 2011, 2005). Unlike parish nurses (Tuck et al 2001), nurses are not expected to provide *specific* spiritual interventions.

In keeping with findings by Galek et al (2007) chaplaincy referrals were a key feature of the nurses' role in spiritual care provision. However, there has been concern expressed that this chaplain/nurse interface is becoming one of *referral* only (Buswell et al 2006); although clearly from this study this is not the case. The findings also fit with contemporary UK based models for guiding spiritual care [based on the testimony of nurses, chaplains, patients, public and other health care workers] which places responsibility for spiritual care with *all* hospital staff (McSherry 2006b).

Barriers to Spiritual Care Provision

The large numbers of nurses who reported identifying patients with spiritual needs is testament to the awareness of the discipline in this area, and contrary to some literature in the field (Vance 2001; Ronaldson et al 2012). Although the majority of nurses felt able to provide responsive spiritual care, it is of concern that much of this was based upon the nurses' own personal experience. Basing spiritual care provision on personal experience could be problematic as ultimately personal spiritual (Vance 2001) and religious views (Christopher 2010) can be influential. From an ethical perspective, the religious orientation of staff may create issues for patient care delivery in a typically secular health service (Polzer Casarez and Engebretson 2012). Spiritual care may be perceived as interference or 'confusion over proselytizing' (Vance et al 2001; Ronaldson et al 2012). Ethical issues arise from this as there is a tension between 'omission' (not providing spiritual care) and 'commission' (providing spiritual care that might appear coercive) (Polzer Casarez and Engebretson 2012: 2099). However, there has been little attempt to raise or address these ethical issues within the literature (Ronaldson et al 2012; Christopher 2010; Gielen et al 2009; Vance et al 2001; Tuck et al 2001).

In keeping with the findings of Ronaldson et al (2008) and Vance (2001), a lack of education in spirituality and spiritual care provision was evident. Though many nurses in the study had received education at pre-registration level, few reported having received education at post-graduate level or in recent times. As this has already been identified as a major barrier to providing spiritual care, it is imperative that consideration is given to the provision of education to this group, in addition to the development of local guidelines in the area (Radford 2008). This needs to be aligned with core competency requirements of the profession (ABA 2005), while being mindful to prevent this topic becoming over expansive (McSherry and Ross 2002). Programmes of study need to focus on practical realties of the clinical situation while at the same time underpinning concept definition and development with an evidence base.

Conclusion

Lack of knowledge and variances in the nurses' role in providing spiritual care, needs to be addressed to ensure that nurses have the skills to assist patients with spiritual needs, and mangers need to develop a stronger leadership role in this area (Jenkins et al 2009). Guidance, such as that provided by the RCN (2011), needs to be utilized and educational workshops provided as required. Standardised approaches to care also need to be developed, and supported by relevant evidence and policy guidelines. There is also a need for future research in this area to formalise understandings of spiritually and spiritual care; develop assessment tools; test educational interventions; and to determine the impact, if any, of nurses' spiritual care on patients and their families.

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