

THE IMPACT OF PRE-REGISTRATION NURSES'
SPIRITUALITY EDUCATION ON CLINICAL PRACTICE: A
GROUNDED THEORY INVESTIGATION

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Dedication

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Abstract

The purpose of this Constructivist Grounded Theory investigation is to discover the impact that spirituality education delivered throughout the pre-registration nursing programme has on the clinical practice of the study participants.

Although a number of previous studies have looked at pre-registration spirituality education, to date, the transferability and sustainability of such education in clinical practice is unknown, so this is the unique purpose of this investigation.

Furthermore, a qualitative approach was used to gain insight from the subjective stance of participants into their on-going understanding and experience of spirituality and spiritual care.

The study involved thirteen adult branch participants who all happened to be female, and enrolled on a pre-registration nursing programme at the same university in the West Midlands, United Kingdom (UK). This investigation was in two phases. Phase 1 took place during the participants' final year as student nurses, to enquire about their understanding of education about spirituality and spiritual care. Additionally, it was necessary to know about their practical application of such knowledge, and understanding in the clinical areas then, and Phase 2 six to eight months after qualification. So each individual in-depth interview was digitally recorded and transcribed before analysis in the cyclical tradition of grounded theory. From Phase 1 three main categories were developed: Perceptions of spirituality, accruing spirituality education, and

opportunities to provide spiritual care. Finally the core category of 'Enablement' was constructed.

The above main categories were explored further in Phase 2 to confirm any changes and developments in participants' perceptions, knowledge, understanding, skills, and practice concerning spirituality and spiritual care. The main categories developed during Phase 2 were: essence of spiritual care, knowledge and skills for spiritual care, and delivering spiritual care. The analysis in Phase 2 revealed the core category of 'Efficacy'. Consequently, the core categories from both Phase 1 and Phase 2 were combined to construct the theory, 'Continuing with Enablement for Efficacy'. This theory explains how the participants resolved their main concerns of: transient recognition of some aspects of spiritual care, dominance of physical care, low priority of spiritual care in most clinical areas, and insufficient knowledge about spirituality and spiritual care. So the findings from this investigation support growing concerns in the literature for more spirituality education in nurse programmes, to enable them to feel more prepared and competent to consistently address the spiritual needs of patients in all clinical areas.

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Abbreviations

BNI	British Nursing Index
BSP	Basic Social Process
Crc	Critical care
CINAHL	Cumulative Index and allied health literature
DH	Department of Health
Elc	Elderly Care
FSC	Fundamental Spiritual Care
HRA	Human Rights Act
ICN	International Council of Nurses
ITU	Intensive Therapy Unit
Med	Medical
MEDLINE	Medical literature on-line
NHS	National Health Service
NMC	Nursing and Midwifery Council
NICE	National Institute for Health and Care Excellence
Ortho	Orthopaedic
RCN	Royal College of Nursing
SPSS	Statistical Package for the Social Science
Sur	Surgical
Thea	Theatre
UK	United Kingdom
UKCC	United Kingdom Council for Nurses, Midwives and Health Visitors
USA	United States of America
WHO	World Health Organisation

CHAPTER ONE: INTRODUCTION

Introduction

This chapter will set out the direction and main issues in this thesis concerning spirituality education in pre-registration nursing programmes. Spirituality is a matter for much debate, as there remains more emphasis on the biopsychosocial domains within a holistic care concept. Furthermore, the impact of such education in clinical practice is under-researched, and in particular its transferability and sustainability.

Transferability which may also be referred to as external validity, is the degree to which the results of a qualitative investigation can be generalised or transferred to other contexts or settings (Bowling, 2009). It is about confirming that what is meaningful in one specific setting or with one specific group is also meaningful in a different setting or group. Accordingly, in the context of this investigation, it is the participants' pre-registration knowledge, understanding and skills acquired, relating to spirituality and spiritual care, being applicable and usable in different clinical settings. On the other hand, sustainability is the potential to continue with something for example, for participants in this investigation to facilitate spiritual care indefinitely in their nursing practice. Such advancements in practice should ensure that patients receive optimum spiritual care, which contributes to their wellbeing. In addition, some assurance is provided that investments made in knowledge acquisition and transfer are not wasted (Virani et al., 2009). Thus the question for this investigation is: 'What is the impact of pre-registration spirituality education on clinical practice?'

This leads me¹ to consider nurse education in the UK where this investigation takes place, before discussing spirituality and nursing practice. The professional context of nursing is addressed, followed by theoretical nursing frameworks, and a discussion of spiritual wellbeing, also gender considerations. Finally, an overview of this thesis is presented.

Brief overview of UK nurse education

Nurses in the UK are required to complete a three year course of study that includes theoretical education and practice in various clinical areas. These standards are laid down by the Nursing and Midwifery Council (NMC) (2010a). Within these guidelines the NMC advocates a flexible approach to learning that allows various institutions to design their own nursing programmes. The aim is to prepare nurses that are competent for their professional role. There is also a requirement for nurses to practice in a holistic way (NMC, 2010a), but in reality the spiritual domain receives little attention in nurse education and practice compared to other domains of patient care, and this situation warrants more attention, and will be engaged with in this investigation. But it is necessary to consider how spirituality is perceived in nursing practice.

Spirituality and nursing practice

O'Brien (2008) a professor of nursing and a Catholic nun , with reference to spirituality suggests that: nurses practicing holism should foresee that the spiritual needs of patients deserve equal consideration for attention, the same as

¹ The first person will be used on occasions in this investigation to demonstrate personal engagement with the subject matter and ownership.

is required for their physical and psychological concerns, which is supported in a guide for nursing staff (RCN, 2011a). So attending to the individual patient as a whole which includes the spiritual aspects is a necessary part of good nursing care. This being the case, initial and on-going patient assessment will assist this foreseeing of spiritual needs (Narayanasamy, 1999c, Gordon and Mitchell, 2004, Rumbold, 2007, NMC, 2010a, McSherry, 2010). However, from an applied philosophical point of view Paley (2008a) argues that spirituality should not be the direct concern of nurses' practice because it is a concept from theology that is 'stretched', and is being constructed for application to nursing. Furthermore, Swinton (2006b) having a nursing and theology background, suggests that spirituality is still in the process of forming an identity within nursing. These various arguments are valid and useful for nurses to engage further with the concept of spirituality; thus assisting understanding of the spiritual needs of patients, and is crucial to facilitating the same – a significant aspect of this investigation. But nurse education should respond adequately to the concept of spirituality and spiritual care to equip nurses for this aspect of their role.

A professional context

My experience as an adult branch nurse lecturer, and realising the virtual absence of spirituality in the pre-registration programmes at the university in Greater London where I worked, was a lingering concern. Furthermore, the majority my colleagues appeared to be desensitised and fairly disinterested about the significance of the spiritual domain within holistic nursing. But while the literature supports efforts to address this existing shortfall within the nursing profession, (Greenstreet, 1999, Lemmer, 2002, Callister et al., 2004, Burkhart

and Schmidt, 2012), this did not negate my resolve to investigate spirituality and spiritual care in nurse education and practice now, to gain insight into the experience of students about the relevance they attach to this concept as they engage in the 'hands-on' care of patients. Nonetheless, the education and practice of nursing operates within relevant theoretical frameworks, which are briefly discussed next.

Theoretical nursing frameworks

There are a number of nursing frameworks for professional practice, and the central concepts which form the structure of contemporary nursing knowledge and practice are displayed in Table 1.1 below. Nursing theories are important because they provide a systematic and knowledgeable approach to nursing practice (Masters, 2015). But in order to apply nursing theory in education and practice, nurses should have knowledge of the theoretical components of the nursing profession (Fawcett and Desanto-Madeya, 2013). These consist of: philosophies – general ideas about nursing that form a foundation for theory development; conceptual models – abstract concepts and statements that are meaningful and provide a reference point for members of a discipline; theories – organised, coherent, and systematic expression of a set of statements that relate to specific questions in nursing (Fawcett and Desanto-Madeya, 2013).

Table 1.1 Four concepts of nursing (Fawcett and Desanto-Madeya, 2013 p.61)

Human being/person	Individuals, families, communities, and other team members or groups who are participants in nursing.
Environment	Human beings' significant others and physical surroundings as well as the settings in which nursing occurs - local, regional, and worldwide cultural, social, political and economic conditions that are associated with the health of human beings.
Health	Human processes of living and dying.
Nursing	The actions taken by nurses on behalf of or in conjunction with human beings, and the goals or outcomes of nursing actions. These are mutual processes between the participants in nursing and nurses. The process encompasses activities that are referred to as assessment, labelling, planning, intervention, and evaluation.

Table 1.1 displays the concepts of human being/person, environment, health, and nursing. All these factors are represented in nursing frameworks.

Choosing a theoretical nursing framework

For this investigation, it is necessary to establish the relevance and benefits of spirituality in nursing care. Consequently, different models of nursing were explored for example: Theory of Interpersonal Relations, (Peplau, 1997) – focuses on the nurse-patient relationship, but the spiritual aspect does not feature; Human Becoming Theory (Parse, 1997, Masters, 2015) – although highlighting meaning and transcendence, spirituality as a concept remains unstated; Reed (2014) offers a Self-Transcendence Theory – promoting wellbeing in the midst of difficult situations, which is the goal of spirituality and spiritual care in nursing, but in this theory spirituality is only implied. So a number of nursing theories relate to spirituality partially or none at all (Martsolf and Mickley, 1998) and this factor influenced my selection.

Hence, this investigation sits within the theoretical framework of Watson's Theory of Human Caring (Watson, 1988, Watson, 1997, Watson, 2012) which emphasises the importance of spiritual support in a caring environment. This aspect is seen in the Tenth 'Caritive' process , "Allowance for existential-phenomenological spiritual dimension: Opening and attending to spiritual-mysterious, unknown existential dimensions of life-death; attending to soul care for self and one-being-cared-for" (Watson, 2007 p.132). And Masters (2015 p.56) states that: "Watson's philosophy and theory differs from biomedical-based nursing practice ...nursing care is never separated from the context of the unity of the mind-body-spirit-nature of the patient", demonstrating a holistic concept. As a result, the caring work of nurses within such a framework is about a therapeutic interpersonal relationship which supports the mind, body and spirit of individuals during their health/ill-health experiences, and achieving spiritual wellbeing. However, there are suggestions that the theory may be broad and complex (Wehr, n.d.), yet it is extremely applicable to nursing education and practice (George, 2011), and brings caring to the real life setting.

Spiritual wellbeing

Spiritual wellbeing is the ultimate goal of spiritual care in nursing, and is a term that is frequently found in nursing literature, recognizing harmonious interconnectedness with a deity, the self, the community, and the environment (Young and Koopsen, 2005). Furthermore, there is a growing body of evidence supporting the link between the spiritual dimension and patients' wellbeing (Ross, 1995, Swinton and Pattison, 2001, Bekelman et al., 2007, O'Brien, 2008,

Visser et al., 2010, Krentzman, 2013, Ivtzan et al., 2013)². Such positive benefits relate to one's inner life and the relationship with a belief system, others, the environment, and could be considered as a "present state of peace and harmony ... linked to past experiences and future hopes and goals"(Hungelmann et al., 1985 p.151). Consequently, to be spiritually well means a positive engagement with self, ones beliefs, others, and the environment, and nurses are required to be supportive in this aspect of patient care. Indeed, the NMC states that patient wellbeing in nursing care is important, and this is emphasised in the NMC pre-registration education document: "All nurses must support and promote the health, wellbeing, rights and dignity of people, groups, communities and populations" (NMC, 2010a p.13). This statement indicates the responsibility that nurse education has, and Satori (2010b p.25) reinforces this by saying: "incorporating spiritual care into pre and post registration education will enhance nurses' confidence and improve patient wellbeing and satisfaction" . Therefore, it is essential to move towards clearly integrating spirituality in nurse education for the benefit of patients (Bennett and Thompson, 2015), and this investigation seeks to enquire into this matter further.

Spirituality and patient wellbeing

Thus, spirituality in healthcare is important because it affects the wellbeing of patients (Young and Koopsen, 2005), which is the purpose of nursing practice (Swanson, 1993, Ruddick, 2013). But as spirituality tends to be forgotten for the most part (Swinton, 2001), not only in nurse education but also its application in

² Ross (née Waugh)

nursing practice (Narayanasamy, 2006), this juxtaposed position also influenced the need to conduct this investigation.

However, an occurrence manifested in that all the participants for this investigation are female, although three male student nurses signed-up, they did not follow-through for interviews. Accordingly, the issue of gender could be considered as a factor in relation to my investigation. However, there are a number of reasons why I believe gender differences did not have a significant effect on the findings of this investigation, and I will now discuss these.

Gender considerations

Nursing is a female-dominated profession therefore there is a gender imbalance (Oxtoby, 2003, O'Lynn, 2013). But the usual reasons for men choosing a nursing career are similar to women for example, wanting to make a difference in the health and wellbeing of patients, and in relation to this investigation that includes the spiritual dimension. Furthermore, traits such as being caring and empathetic traditionally associated with women also apply to men, and some may choose a nursing career (Murnaghan, 2013). However, gender understandings of nursing care has attracted criticism and debate; allegedly presenting an outdated and sexist message which marginalises men, and is contrary to a more modern contemporary image of the nursing profession (Christensen and Knight 2014).

But the concept of care has proved to be important for identification with nursing for both male and female students (MacWilliamson et al 2013), forming the core of nurse education, so contributing to a student's sense of identity and belonging

to a profession (Brown 2011, Rodes et al 2011). Furthermore, both male and female nursing students demonstrate comparable obligation to the holistic care of patients (Boughn, 2001). Therefore, views and perceptions of spirituality and spiritual care are not expected to be significantly dissimilar.

Research has also identified gender neutral areas within the nursing profession: mental health, accident and emergency, theatre, learning disability, surgical and medical nursing, also nurse education and management (McLaughlin et al., 2010). And a number of these areas are included in adult nursing, which is the context of this investigation, suggesting an equally gender neutral perspective in relation to holistic care (which includes the spiritual). Furthermore, nurse education can accommodate all types of students, those that are psychologically masculine, feminine or androgynous (McLaughlin et al., 2010). In addition, the belief is that as one understands more about nursing, there is a realisation that the job is less gendered (McKay Wilson, 2009). Accordingly, for the reasons discussed above, I do not consider gender differences to be of marked significance in this investigation.

Overview of the thesis

This thesis is contained within ten chapters, and each outlines a particular stage in the process involved in this investigation. Hence, the following details are given of the content and direction taken through the different chapters. In chapter one as presented, I provide a rationale and relevant framework within which this investigation is situated. Following on, chapter two which forms the background to my investigation discusses spirituality in nursing practice, various definitions of

spirituality, and holistic nursing care. This chapter also included discussions of current values and trends in spirituality, and the historical significance of spirituality in nursing care. Several influential policies and statements from an international and national perspective, also the nursing profession within the UK are explored.

Chapter three presents a systematic review of relevant literature to identify the leading themes related to pre-registration spirituality education as well as areas for further research. The themes are: spiritual awareness, spiritual assessment, spiritual competence, and spirituality in pre-registration education. All four themes are discussed in relation to their importance for nurses to acquire competence for spiritual care in their clinical practice. And nursing practice is subsequently underpinned with an account of the theoretical framework of Watson's Theory of Human caring (Watson, 1988).

Within the methodology of chapter four, are debates surrounding spirituality and spiritual care, within the holistic concept. A methodological plan consisting of the philosophies of ontology, epistemology, and research paradigms related to this investigation are discussed. Furthermore the advantages and disadvantages of qualitative and quantitative research, and various related theoretical perspectives are examined to substantiate my choice of a qualitative method using grounded theory. The main tenets of grounded theory are then explained.

Chapter five covers the research methods, where preparation and techniques employed for data collection are laid out, together with details of ethics and

ethical approval. Thus, recruitment, sampling, and interviewing activity are stated also the coding used in this investigation is outlined.

The analysis and findings for Phase 1 of my investigation in chapter six are elaborated and supported by examples from participants' interview excerpts. The main categories identified surrounded perceptions of spirituality and spiritual care, accruing spirituality education, and opportunities to provide spiritual care. Furthermore, the participants' main concerns of: explaining spirituality, remembering spirituality education and the content, and uncertainties surrounding facilitation of spiritual needs, found resolution in the core category of 'Enablement'.

In chapter seven Phase 2 of the investigation is covered, where the analysis and findings examine: post-qualification views on perceptions of spirituality and spiritual care, accruing spirituality education, and ambiguity facilitating fundamental spiritual needs. This exploration resulted in the construction of the main concerns: transient recognition of some aspects of spiritual care, dominance of physical care, the low priority of spiritual care in most clinical areas, and insufficient knowledge about spirituality and spiritual care. The participants progressed to resolve these concerns through 'Efficacy' in supporting the spiritual in patient care.

The findings of Phase 1 and Phase 2 were compared in chapter eight, and both core categories are combined to form the substantive theory of 'Continuing with

Enablement for Efficacy', which is duly explained as the ambition of participants for achieving optimum spiritual care, for the wellbeing of patients.

In chapter nine I present a discussion of the main issues and features of this investigation, together with reference to the relevant literature.

Chapter ten provides an overall summary of addressing the aim and objectives in this investigation. Then the implications of the findings are stated, followed by recommendations for nurse education, nursing practice, nursing's professional body, also suggestions for further research. Finally the limitations and conclusions of this investigation are presented.

CHAPTER TWO: BACKGROUND

Background

Introduction

In this background the significance of spirituality in nursing practice will be discussed to contextualise this investigation. Furthermore, the historical roots of spirituality in nursing with the ensuing debates will be explored to bring this discussion into the 21st century. The debates associated with defining spirituality, occupies a prominent place in this chapter, to reveal its subjective complexities and individual nature. Furthermore, various policies and statements have been issued and serve to inform the healthcare profession in matters relating to spirituality and spiritual care, highlighting the specific importance to nursing practice.

Spiritual roots of nursing

Catanzaro and McMullen (2001) state that the spiritual roots in the history of nursing is significant, and adds that, “A profession cannot progress without knowledge of its own history” (Catanzaro and McMullen, 2001 p.225). So the historical and spiritual roots of nursing will now be briefly discussed to confirm the place of spirituality in the present healthcare context.

Historical context of nursing

Although Florence Nightingale is attributed with integrating defined spiritual values alongside scientific principles of nursing practice (Macrae, 1995), Greenstreet (1999) adds that Nightingale was also influential in secularizing

nursing in the 19th century, when there was a move away from traditional Christian values, towards a new spirit of reason and belief in the human capacity for progress. Similarly sociologists Marx, Durkheim and Weber (Giddens, 2001) suggest that religion becomes less relevant in an increasingly secular society. Therefore, nurses need to be aware of the wide scope that is now included in the concept of spirituality and ultimately spiritual care. Consequently, spiritual care has evolved from a strong Christian religious foundation (Swatzky and Pesut, 2005). And the term evolved is used because, according to Byrne(2002 p.67) “spirituality has an increasingly wide range of interpretations”, as a result spiritual care becomes equally diverse.

But historical accounts catalogue the connection of spirituality with care for the sick and poor of society from the pre-Christian era (Bradshaw, 1994). And nursing for example was a part of early Buddhist and Hindu tradition, as well as the recorded accounts of spiritual and cultural care in ancient Egypt, Greece, Rome and Israel; these support the art and science of modern medicine and nursing (O'Brien, 2008). Indeed it was Hippocrates (460-370 B.C.) the father of Western medicine, who charged those who cared for the sick to be mindful of their patient's spiritual wellbeing (Frank 1959 in O'Brien 2008). Later on, what is particularly noted is that individuals and religious groups with strong spiritual convictions were the forerunners of our modern day nursing profession, and provision of social and hospital care. So the specific involvement of Christianity in nursing will now be discussed.

Christians in a nursing role

Early Christian followers and later Deacons and Deaconesses sought to follow the examples of Jesus, with holistic concerns for the physical, psychosocial and spiritual needs of poor and sick people (O'Brien, 2008). The following biblical passages illustrate this point:

“Then Jesus went about all the cities and villages, teaching in their synagogues, preaching the gospel of the kingdom, and healing every sickness and every disease among the people”(Matthew 9:35).

So Christians desired not only to show their faith as commanded by Jesus, (John 13:34-35), that is “... Love one another; as I have loved you", but also demonstrate compassion and care as exemplified in the parable of the ‘good Samaritan’; here kindness and practical assistance is given to a sick and injured person, and Jesus concludes this parable by saying, “Go and do likewise”,(Luke 10:37). Furthermore, Jesus shows in Matthew 8:2-3 that touch was important, and O'Brien (2008 p.16) refers to this and points out that “loving, empathetic, compassionate touch is perhaps the most vital dimension of a nursing theology of caring”. Moreover, Eriksson (2006) in, ‘The Suffering Human Being’ expounds profoundly that the purpose of caring is the alleviation of another’s suffering by being compassionate.

This trend of religious followers devoting themselves to caring for the poor and needy as an expression of their love for God and fellow-men continued into the 18th and 19th centuries (Ellis, 1980, Swaffield, 1988, Carson, 1989); a view aptly captured and put forward by Narayanasamy (1999a p.387) that, “Nursing is primarily a service to humankind”. Bradshaw compares this concept of care to a

covenant relationship borne out of agape love as there is no separation between the physical and spiritual in relation to total care (Bradshaw, 1994).This is a clear reminder of the holistic ideal of nursing and its unselfish primary vocational purpose of serving the needs of others.

Thus for centuries the religious links with nursing care was widely accepted without question, probably not only as a result of the much needed care given to those who were less well-off and with limited options, but also the fact that many hospitals in Europe were housed in religious institutions (McCavery (1985) in Bradshaw 1994). However, the situation is quite different now as seen in the following opinion:

“the concept of spirituality, as currently understood, is of very recent origin, and is still ‘under construction’, having become separated from its associations with Christian piety and mysticism only since the 1980s”(Paley, 2008a p.175).

So, spiritual care needs to be understood in a different way, as the religious basis for nursing is diminishing. Accordingly, the nursing profession today refers more to spirituality in recognition of a wider understanding within a diverse population. In addition, nurses today are drawn from a similar diverse population having various religious or non-religious beliefs. But this should not affect the individualised care they give (including spiritual) to patients even with the increase of secularisation.

Secularisation of nursing

So secularisation represents a historical process where religion loses its social and cultural significance. Accordingly, the role of religion in modern societies becomes restricted, and encourages a similar debate in nursing, for example

Paley (2008a) believes that the secular expansion of spirituality has contributed to the professionalization quest in nursing. But Waugh (1992 p.33) puts more emphasis on the scientific element within the profession:

“It is clear that the approach of the scientific era ...and its development since then, resulted in a dualistic health care system, the consequence of which was that physiological care increased in importance while the spiritual dimension declined ...”

And the secularisation argument gains further support from Fealy and McNamara (2007) who claim that nursing's religious connections are diminished, and the profession is said to have become largely a secular occupation.

So by the 20th century with developments in medical science and technology, caring for the sick out of a sense of duty, love and compassion began to be marginalized and there was now less tolerance for religion, which resulted in a virtual exodus of the religious orders from nursing in the new modern age (Swaffield, 1988). It is not surprising then that the vacuum left by the retreat of the religious orders was readily occupied by secularism, which soon became popular. So nursing evolved into a more economic activity within a 'culture of cure' (Swaffield, 1988, Hallam, 2002), consequently leading to more task oriented priorities (Davison and Williams, 2009), which to some extent is a legacy that persists today. This so called 'culture of cure' is illustrated when patients are treated more as objects in relation to their health problem or disease instead of being valued as individuals in their own right (Hemingway et al., 2012). Consequently, a sense of vocation in caring is lost to the demands of achieving healthcare targets (Francis, 2013), and such extremes may lead to tragedies similar to those reported to have occurred in the Mid-Staffordshire Hospital.

However, nurses are expected to be perceptive of, and attend to the spiritual care needs of patients, which sits within the art component of the 'art and science of nursing' (Robinson, 2014). But although nursing has moved towards the secular trend in society, which is more marked in the UK (UK Government, 2011b) compared to some other countries for example, Malta, Croatia, and Poland (Religious populations worldwide, 2014), also USA and Mexico, (Religious population worldwide, 2014), the importance of the spiritual dimension in nursing remains relevant. This prevails against secular opposition as the religious/spiritual roots of compassion in nursing still run deep throughout society (Davison and Williams, 2009). Thus a wide perspective of spirituality is now reflected, and must be accommodated throughout healthcare both in the workforce, and the patient population, and which also contextualises this investigation.

Still, some individuals may come into the nursing profession with clear religious beliefs to serve the health needs of people (Prater and McEwen, 2006), but according to Davison and Williams (2009 p.19) "... nursing may mirror cultural changes ... the profession as a calling or vocation is now somewhat outdated". It is also suggested that the increasing scientific basis for healthcare, is responsible for a decline in the original vocational nature of nursing (Salvage, 2004). In addition, career opportunities in nursing (Larsen et al., 2003, Prater and McEwen, 2006) now seem to feature high on a list of priorities, and reflect secularisation trends in nursing (Swaffield, 1988), as a result of its professionalization process (Yam, 2004). So it could be surmised that secularism and recruitment drives have paved the way for others who were not particularly affiliated towards any religious belief, to join the ranks of nursing (Hallam, 2002),

which is welcomed especially with nursing shortages in the 20th and 21st century (Rogers, 1961, Oulton, 2006, Trigg, 2016).

Changing culture

Changing trends concerning the growth of secularism, also cultural values and public opinion have been recognised by International and National bodies who have responded with a series of documents relating to the significance of spirituality in healthcare. For example, The World Health Organisation (WHO) (WHO, 1998) includes the spiritual dimension in its definition, stating the need to respond to each person's spiritual quest; The Department of Health (DH, 2012c) implies spirituality and emphasizes that, patients should expect to be treated with compassion, dignity and respect; International Council of Nurses (ICN) (2012) affirms the respect of the individual's human rights, values, customs and spiritual beliefs; Nursing and Midwifery Council (NMC) (2010a) Standards for Pre-registration Education, highlights holistic care. In addition, the most recent NMC 'The Code' (NMC, 2015) states that people are to be treated as individuals, with dignity, respect and compassion, but stops short by omitting the word spirituality.

Other publications maintaining the importance of spirituality in healthcare are for example: *'Religion or Belief'* (DH, 2009b), *'Spiritual Care & Chaplaincy'* (NHS Scotland, 2009a), *'Standards for Spiritual Care'* (Welsh Assembly Government, 2010a), *'Spiritual Care at the End of Life'* (DH, 2011), and *'Chaplaincy Guidelines'* (NHS England, 2015); these will all be discussed in the next chapter.

The above mentioned documents serve to alert healthcare professionals, including nurses to address spirituality in their practice. Therefore, it is necessary

for pre-registration nurse education programmes to adequately prepare nurses to address spirituality in their professional practice, which is a prime focus in this investigation. However, at this point it is necessary to look at definitions of spirituality in order to gain some understanding of what the concept may mean to different people, and these definitions have informed and shaped this investigation.

Defining spirituality

Although spirituality historically (in a religious sense) has always been a part of nursing practice, there remains ambiguity surrounding its definition (Oldnall, 1995, Van Leeuwen and Cusveller, 2004, Graham, 2008, Barnum, 2011), furthermore, “there is no single authoritative definition of spirituality” (Narayanasamy, 1993 p.196). Another argument is that nursing literature on spirituality needs rigorous analysis of their definitions due to suggestions that they lack adequate critique (Swinton, 2006b, Paley, 2008a, Pesut, 2008b, Clarke, 2009). Also, the many existing definitions of spirituality would seem to indicate insufficient conceptual clarity (Reinert and Koenig, 2013b, Weathers et al., 2015). However, some healthcare academics see these varied definitions positively, because they reflect cultural diversity and personal religious/non-religious beliefs and preferences (Pesut, 2008a, Pike, 2011), furthermore they are representative of the patients and staff in the healthcare system. Most definitions include some common features such as, meaning and purpose in life, relatedness, inner peace/harmony, transcendent/God. Table 2.1 provides examples of definitions of spirituality published within the last thirty years, together with my comments that relate to some key aspects contained in each

one as relevant to the healthcare focus of this investigation. Accordingly, represented here is a potential beneficial quest (wellbeing) for individuals, and especially for people facing the uncertainty that may accompany illness (Swinton and Pattison, 2010). However, as these examples of definitions originate from the USA, UK and Republic of Ireland, they may not be totally applicable across all religions, beliefs and cultures.

Table 2.1 Definitions of spirituality in health care within the past three decades

	Definition of spirituality	Comments
(Stoll, 1989) USA	"...a two-dimensional concept... a continuous interrelationship between and among the inner being of the person, the person's vertical relationship with the transcendent/God or whatever supreme values guide the person's life, and the person's horizontal relationships with self, others, and the environment" (p7).	Spirituality is dynamic, consisting of both vertical and horizontal dimensions that interrelate. This definition is broad enough to accommodate beliefs of religious and non-religious individuals alike; therefore, it is pluralistic in its defining characteristics.
(Heriot, 1992) USA	"... spirituality may be conceived as the umbrella concept under which one finds religion and the needs of the human spirit" (p.23).	A general perspective of spirituality which is all inclusive of religion and everything that concerns the human spirit, with no indication of what some of these may be.
(Narayanasamy, 1999b) UK	"Spirituality is rooted in an awareness which is part of the biological make-up of the human species. Spirituality is present in all individuals and it may manifest as inner peace and strength derived from perceived relationship with a transcendent God or an ultimate reality or whatever an individual values as supreme" (p.123).	The holistic concept of spirituality that includes the physical, psychological, social and spiritual aspects of all individuals is represented in this definition. There is also particular reference to a universal need for peace and strength which could be attained in a variety of ways.
(Catanzaro and McMullen, 2001) USA	"... a way of life, informed by the moral norms of one or more religious traditions, through which the person relates to other persons, the universe, and the transcendent in ways that promote human fulfilment (of self and others) and universal harmony" (p. 222).	Clearly a Judeo-Christian basis for spirituality relating to self and other is presented in this definition. Therefore, this stance excludes those people who are non-religious, and is not particularly useful for health care in a multi-cultural society.
(Tanyi, 2002) USA	"Spirituality is a personal search for meaning and purpose in life, which may not be related to religion. It entails connection to self-chosen and or religious beliefs, values, and practices that give meaning to life, thereby inspiring and motivating individuals to achieve their optimal being. This connection brings faith, hope, peace, and empowerment" (p.506).	The subjective individuality of spirituality is highlighted, and is not specifically related to religion. Meaning to life is highlighted for giving people motivation for optimal achievement and does not seem burdensome, and there is potential for the enhancement of faith, hope, peace and empowerment.

Murray, Zentner & Yakimo, (2009) USA	“... a quality that goes beyond religious affiliation, that strives for inspiration, reverence, awe, meaning and purpose, even in those who do not believe in any god. The spiritual dimension permeates all of life and integrates values and beliefs. It involves harmony with the universe, strives for answers about the infinite, and especially comes into focus as a sustaining power when the person faces emotional stress, physical illness, or death. It goes outside a person’s own power. ” (p182)	This definition engages religious and non-religious individuals, and includes creativeness, worship, and finding meaning in life. A key focus is integration of beliefs and values to achieve harmony with the universe, and efforts to understand the inestimable, which portray a constant struggle. Nevertheless, it suggests that spirituality is a supernatural power that becomes crucial in situations of stress, illness and loss.
(Weathers et al., 2015) Republic of Ireland	“Spirituality is a way of being in the world in which a person feels a sense of connectedness to self, others, and/or a higher power or nature; a sense of meaning in life; a transcendence beyond self, everyday living and suffering” (p.15).	Spirituality provides the opportunity to feel connected not only to self and others, but also to a higher power and the environment. Meaning in life and transcendence is emphasized as being strong enough to be relevant in all circumstances.

Spirituality definition debates

So numerous definitions of spirituality exist and according to Reinert and Koenig (2013b), this may be the reason why the concept is much debated in nursing literature, (Miner-Williams, 2006, Taylor, 2008, O'Brien, 2008, Clarke, 2009, Pike, 2011, Weathers et al., 2015). The construction of multiple definitions surrounding spirituality is said to be the result of its subjective nature, resulting in different meanings for individuals (Narayanasamy, 1993, Ledger, 2005). Furthermore, spirituality is often equated to religious beliefs and practices (McSherry 1998; Narayanasamy & Owens 2001), and nurses tend to use the terms religion and spirituality interchangeably (Carroll, 2001).

However, the concept of spirituality is broad and is not necessarily synonymous with religion, although both religious and non-religious aspects are encompassed in the term (Golberg, 1998). For example, a person may be deeply spiritual without being religious. Therefore, a concept analysis is useful for clarifying spirituality (McBrien, 2006), and researchers such as Weathers et al., (2015) have examined the defining attributes of spirituality in this way and identified three main aspects: 1) connectedness – to oneself, to others, to nature or the world, and a Higher Power, God, or Supreme Being; 2) transcendence – the capacity to change one's outlook on situations in life; 3) meaning in life – appreciating the positive aspects of one's life above other issues. The authors conclude that spirituality is not an artificial concept, and is important and necessary, particularly in times of illness. Thus, spirituality in nursing care should be of prime concern, and as a result of their analysis (Weathers et al., 2015), they presented a conceptual definition (Table 2.1).

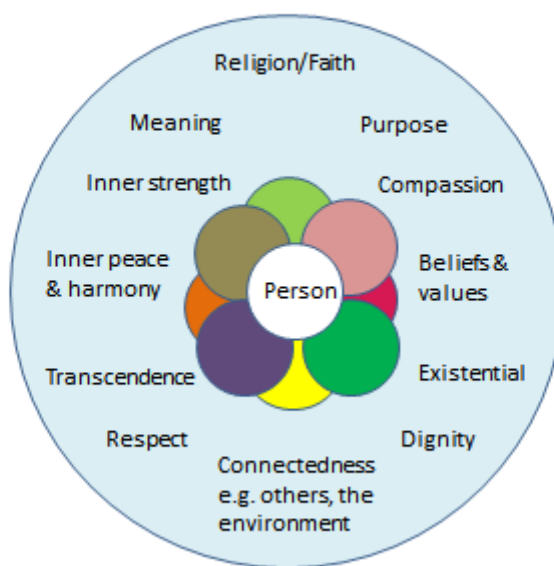
The implications for this investigation is that the core concepts of spirituality as outlined in Table 2.1 offer a coherent and basic underpinning for the personal beliefs and values of patients and participants that contribute to their individual perceptions of spirituality. Hence, there is the potential for all individuals to have a spiritual need (McSherry, 2000a, Wright, 2005). However, this stance attracts debates by academics for example, Swinton (2006b) suggests that claims to accommodate people of all faiths or none is 'amalgamist', while Paley (2008a) sees this as universalizing spirituality to include everyone whether they like it or not, and this latter view seems to allude to notions of increasing secularization.

Consequently, these positions further confirm the non-consensus position for defining spirituality which is constantly borne out within nursing literature (Lemmer, 2002, Swatzky and Pesut, 2005, Ross, 2006, Burkhart and Hogan, 2008, NMC, 2010a, Reinert and Koenig, 2013a, Baldacchino, 2015); which Bradshaw (1994) proposes may be the main contributing factor for spiritual care being marginalized in nursing compared to physical or psychological care. As a result, some patients could be denied the encouragement they require to access their source of spiritual strength for wellbeing, which could in turn affect their ability to cope and recover. So having considered the existing debates, I am in agreement with Reinert and Koenig (2013a), that there is no 'gold standard' for definitions of spirituality. Accordingly, examples of ways spirituality may be viewed in contemporary society will be presented.

Ways of viewing spirituality

Ways of viewing spirituality in Western cultures are affected by its current broad meaning as suggested by Swinton (2001 p.11) that the, “migration of spirituality from the ‘religious’ to the ‘secular’ has led to a change in the meaning of spirituality”. This broad and all-inclusive understanding of spirituality (Figure 2.1) is confirmation that spiritual needs have the potential to be met outside religious structures.

Figure 2.1 Aspects of spirituality



(L. Lewinson, 2014)

Figure 2.1 illustrates some of the components that may be included in the wider concept of spirituality today, which is applicable across both religious and non-religious beliefs. Each person remains at the centre of their own subjective definition of spirituality which is valid, and in the context of this investigation

needs to be respected and accepted, and responded to by all healthcare workers (McSherry and Cash, 2004).

After considering various philosophical arguments connected to the concept of spirituality, McSherry (2004) devised a taxonomy (Table 2.2) with descriptors that are moveable according to the individual's unique definition, as fitting their worldview (McSherry, 2004). This in itself reflects a pluralistic post-modern society (Pesut et al., 2008, Paley, 2008a). However, a person's worldview may change across the lifespan, highlighting that spirituality is not static but dynamic.

Table 2.2 Taxonomy of spirituality – (taken from McSherry 2004)

Theistic	Religious	Language	Cultural, political, Social ideologies	Phenomenological	Existential	Quality of life	Mystical
Belief in a supreme being that could be God or deity.	A religious tradition Believing in God/gods – involvement in religious practices, customs rituals.	People may define spirituality by using such language as inner peace, or inner strength.	The influence of personal political affiliation, or social ideology that directs their attitudes and behaviours.	Learning about life through a variety of experiences and situations, whether positive or negative.	A semantic philosophy of life and being, finding meaning, purpose and fulfilment in the events in life.	Quality of life is implicit in definitions.	Relationship between the transcendent, interpersonal, transpersonal, life after death.

Notes:

- These descriptors are not exhaustive
- This taxonomy represents: The old idea of spirituality – theist and religious, and the post-modern – phenomenological and existential.

Additionally, Swinton (2010) suggests that there should be an awareness of three overlapping and interacting approaches when viewing spirituality, in order for its meaning to emerge:

- 1) Generic approach – a universal understanding which is significant and can be formally identified and assessed as a part of the human experience.
- 2) Biological approach – an assumption that humans have an inherent propensity for religious and spiritual experiences which is naturally relational, and contributes to spiritual wellbeing.
- 3) Religious approach – a traditional understanding of something beyond self which is found in God or transcendence. So a person's religion features strongly in their day-to-day life. However, the sacred which is more general, may be akin to religion, and is also included here.

Consequently, viewing spirituality in this overlapping and interacting way provides a useful basis for nurses to navigate the various definitions of spirituality. Furthermore, Weathers et al., (2015) suggest that the three attributes they identified as a result of their concept analysis (page 25) could be useful in guiding research on spirituality. Nonetheless, nurses need to consider various definitions of spirituality in order to understand their own position on spirituality, as well as relate better to a patient's subjective perception of this concept (Catanzaro and McMullen, 2001, Wallace et al., 2008), which influences wellbeing. But according to Clarke (2013) there remains inherent difficulties when describing the personal and fluid nature of spirituality and spiritual wellbeing. And this in itself is an on-going dilemma that needs to be

accommodated in one's philosophy. So the difficulty people may have in grasping the concept of spirituality is illustrated in this quote by Carson and Stoll (2008) who concede that spirituality is:

"Like the wind, we can see its effects but we can't grasp it in our hands and hold onto it. We recognise when someone is in 'low' or 'high' spirits, but is that spirituality? We believe that a patient's quality of life, health and sense of wholeness are affected by spirituality, yet still we struggle to define it. Why? most likely because spirituality represents 'heart' not 'head' knowledge, and 'heart' knowledge is difficult to encapsulate in words"(Carson and Stoll, 2008 p.4).

Thus, spirituality may be described as a principle, an experience, a sense of God, also the inner person, and this amorphous nature of spirituality leads to a variety of interpretations and definitions, which may originate from a theistic or non-theistic worldview.

However, nursing should acknowledge that the expression and meaning that individuals have about spirituality may differ significantly based on personal values and convictions according to their worldview. So Stoll's (1989) more generic definition is preferred for the purpose of this investigation:

"...a two-dimensional concept... a continuous interrelationship between and among the inner being of the person, the person's vertical relationship with the transcendent/God or whatever supreme values guide the person's life, and the person's horizontal relationships with self, others, and the environment" (p7).

This definition shows inclusivity by leaving space for individuals to fill in their valued and unique understanding of spirituality. It portrays a dynamic engagement with the concept of spirituality, which may or may not be linked to religion. It is important then for nurses and other healthcare workers to be open

and accepting of the various beliefs and practices of individuals, as this contributes to their wellbeing as a whole person.

The whole person

Florence Nightingale recognized spiritual care as an integral part of nursing care (Burkhart and Hogan, 2008), and caring for the whole person, has remained at the heart of nursing (O'Brien, 2008, NHS Scotland, 2009b, Clarke, 2013). There is also recognition that the spiritual dimension influences a patient's physical and mental health, their wellbeing and quality of life (DH, 2009b, Ross, 2009, RCN, 2011b, Baldacchino, 2011b, Draper, 2012, McSherry and Ross, 2015).

Therefore, mental, emotional and physical health is an integral part of spiritual wellbeing; incorporating meaning, hope, love, transcendence, purpose, value connectedness, and sometimes God (Swinton, 2010), which enhances an individual's inner resources for coping during healing and recovery, or dying.

Furthermore, Koenig (2012) carried out extensive review of the literature, examining the connections between religion, spirituality and health. He found that although there were some negative results, the majority of the findings were positive for mental health, (anxiety, depression, schizophrenia), and physical health, (coronary heart disease, hypertension, immune function, pain). These findings strengthen the belief that the medical model of patient care which focuses on medicines and surgery is unsatisfactory (Chan, 2009) .

Therefore, “dealing with spirituality remains an integral part of holistic nursing care” (McBrien, 2006 p.1), which is about the whole person, not just an aspect of their being (Swinton and McSherry, 2006, Ross and McSherry, 2010). And Figure 2.2 is an illustration that shows the integral nature of holistic nursing care with each component having equal status. The connection of each dimension (physical, psychological, social, and spiritual) indicates that holistic nursing care is only achievable when these links are maintained. However, the outer sphere of this diagram also allows movement, so that the uppermost position of priority for attention may be occupied at any time by a different dimension as needs necessitates. For example, a patient who has a cardiac arrest needs immediate physical attention to save their life. However, during the recovery stage their psychological, spiritual or social dimensions of health may require a different level of priority within their overall nursing care.

Figure 2.2 Holistic sphere (Lewinson, 2014)



Figure 2.2 depicts the central position of holistic nursing care, with the integral relationship of the four dimensions of health suspended on an outer moveable connecting circle. Each dimension may potentially rotate so that the top position represents a person's present health priority, while still considering the other dimensions. Therefore, it is necessary for pre-registration nurse education programmes to adequately prepare nurses to provide holistic nursing care, and importantly to address spirituality in their professional practice, which is the prime focus of this investigation.

Spirituality debates in nursing

Subsequently it is seen that the ensuing debates relating to spirituality in nursing care hold fast to strong historical roots of the profession, demonstrating a fundamental desire to deliver nursing care in a holistic way (Ellis, 1980, Brittain and Boozer, 1987, Swaffield, 1988, Allen, 1991, Tjale and Bruce, 2007, Papathanasiou et al., 2013). Furthermore, authors such as Bradshaw (1994) majors from a theological perspective, and O'Brien (2008) explores the links between spirituality and nursing practice from a religious perspective, with reference to the pre-Christian era through post-Reformation. What becomes evident from the historical perspective is that cultural, Christian and non-Christian traditions have had a significant impact in highlighting fundamental values and concepts such as, caring with compassion, respect and dignity, which are expected in all nursing practice. And for nurses to practice with due regard to these principles, their pre-registration programmes should be instrumental in making clear reference to this.

Pre-registration nurse education

Pre-registration nurse education has the responsibility to prepare student nurses to be competent for the various aspects of their role as qualified professionals. However, the medical model of health that is favoured concentrates on the bio-psycho-social aspects of health care, and neglects the spiritual for the most part (WHO, 1998, Swinton, 2001, Chan, 2009, Caldeira et al., 2016) . Individualised holistic nursing care is considered within the nursing profession as a realistic ideal to be embraced, but this cannot be fully achieved when the spiritual dimension of an individual is not addressed, and as Burnard (1988a p.34) asserts “to ignore the spiritual aspects of care is surely a gross omission”. An earlier version of The Nursing and Midwifery Council Code of conduct (NMC, 2010b p.1) for nurses states: “You are personally accountable for actions and omissions in your professional practice and must always be able to justify your decisions”, which puts the onus on nurses to address the spiritual needs of their patients. However, this statement is not present in the new NMC Code (NMC, 2015 p.4), only ” make sure assistance and care for which you are responsible is delivered without undue delay and respect and uphold people’s human rights”, which could be interpreted as including spiritual care. But this document does not explicitly make mention to the spiritual in relation to the professional practice of nurses. Nevertheless, the need for spiritual care within holistic nursing practice is not lessened. Hence, in the light of this, the various policies and statements that make reference to, and give guidance for spirituality in healthcare (to be discussed next) need to be taken into consideration.

Policies and statements

A number of international and UK policies and statements relating to spirituality have had a significant bearing on the need to address the spiritual aspect of holistic nursing care. These policies/statements have had substantial influence for the nursing profession in the way it sees spirituality, and the position this domain has within healthcare practice. Not only should individuals have their rights, wishes and spiritual beliefs acknowledged and respected, but healthcare professionals need to take spirituality into consideration when planning and delivering care in order to facilitate this need for their service users. So in order to illustrate the growing trend for the inclusion of spirituality within healthcare, various documents will be critically reviewed, starting with international, then UK governmental, and finally the nursing profession's regulations.

International perspective

International Council for Nurses

The International Council of Nurses (ICN) is an organisation founded in 1899, and is operated by nurses (ICN, 2012). It plays a leading part in working for quality assurance in nursing care, sound health policies globally, also supporting the expansion of nursing knowledge, and maintaining the integrity of the nursing profession. The ICN code of ethics for nurses was adopted in 1953 and has been revised on a number of occasions (1965, 1989, 2000, 2006 and 2012), in response to changing healthcare needs. However, the core message about spirituality in nursing care has remained: that nurses should promote the, “human rights, values, customs and spiritual beliefs of individuals (ICN, 2012 p.3). This indicates that the ICN considers that spirituality in nursing care is

important and non-negotiable. And this view by the ICN should encourage nurses to demonstrate spirituality in their practice of holistic care.

National Perspective

Although the NHS covers the UK and is funded from national taxation, there is a degree of flexibility in management arrangements for Northern Ireland, Scotland, and Wales. And, although for the most part policies remain similar, I will mainly be focusing on England where this investigation is situated.

Some of the following documents allude to spirituality while others are more explicit: the Human Rights Act (HRA) (DH, 1998) aims to protect civil liberties in Article 9 under 'freedom of thought, conscience and religion'; the *Patient's Charter* (DH, 1992), which was revised in 1995, 1997 and 2001, emphasises meeting whatever spiritual needs patients may have; *Your Guide to the NHS* (DH, 2001 p.29) where it is stated that "NHS staff will respect your privacy and dignity. They will be sensitive to, and respect your religious, spiritual and cultural needs at all times"; *The Mandate* (DH, 2013a p.6) ,focuses on the things people say that matter most, and emphasises "making sure we experience better care, not just better treatment ...expect to be treated with compassion, dignity and respect". And the *Health and Care Standards* in Wales (NHS Wales, 2015), highlight the spiritual within holistic care for dignified and individual care.

The *NHS constitution* (DH, 2009a, DH, 2015c) declares that, the NHS belongs to the people and its prime purpose is to improve health and wellbeing, and reference is made to a comprehensive service available to all irrespective of

gender, race, disability, age, sexual orientation, religion or belief, and must respect their human rights, so recognising service user's rights and experience. Hence, it is important to understand that for some people their spiritual needs are religious in nature, therefore, spiritual care is highly individual (Sartori, 2010a), and on-going improvements to its delivery in the NHS being paramount. Moreover, recently (DH, 2016 p.6) states that "The Government is committed to providing for patients and the public the highest quality, most compassionate health and care service ...". These documents signal a transition or move away from just a focus upon physical care to a more holistic view of the person.

However, *Essence of Care Patient-focused Benchmarking for Clinical Governance* (DH, 2010) was introduced to provide a structured approach for good quality and best practice in the health service. And all twelve sections reiterate that people should feel the care they receive is always delivered in a respectful way with compassion and empathy, taking into consideration diversity and individual needs, religion, belief and culture. But particular attention is drawn to 'wellbeing' which is a significant outcome of attention to spiritual needs and is defined in *Essence of Care* as: "a positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment" (Section 8: Benchmarks for promoting health and well-being, p. 7). Furthermore, the terms respect and dignity have specific links to spiritual needs/care and the document defines both: 1) respect – "regard for the feelings and rights of others", and 2) dignity – "quality of being worthy of respect" (Section 10: Benchmarks for respect and dignity, p.7). However, more guidance was issued to staff in the NHS in, *Religion and belief matter*, also *Religion or Belief*.

Moreover, dignity and spirituality are interconnected, which McSherry (2016) highlights, and suggest that to ignore the spiritual aspects of the person could lead to a violation of their dignity.

Religion and belief matter

This Scottish document (2007), is quite emphatic in stating that meeting the spiritual needs of patients is not an option, but an essential part of care, and the aim of their publication is to raise awareness and provide information regarding the links between religion, spirituality and health (NHS Scotland, 2007). From the 2011 census (Scotland's Census) (UK Government, 2011b), 54% of the Scottish population are Christians, and 37% are non-religious; between these two figures there are small numbers of other faith groups e.g. Muslims, Jewish, Buddhist, Sikh. The multi-cultural population in Scotland, and the rest of the UK (UK Government, 2011a) is recognised, and two years later a similar document *Religion or belief*, was issued for England.

Religion or belief

Religion or belief (DH, 2009b), is a practical guide to the health care profession to facilitate religion or belief in various care contexts, but does not specifically mention spiritual as in the Scottish document above. However, *Religion or belief* indirectly goes some way to remind healthcare professionals about fulfilling their role in relation to the spiritual dimension of health.

Both the above documents as well as the current Welsh Health and Care Standards (NHS Wales, 2015) emphasise that healthcare professionals should respond to the diverse beliefs and values patients hold, thus contributing to quality care. So in relation to this investigation, pre-registration nurse education should reflect such detail in the content of their programmes. Now further statements/guidance, such as for palliative and end of life care will be discussed.

End of life care strategy

End of life care is a national priority that is high on the agenda of the Department of Health, and this is reflected in its fourth annual report (DH, 2012b). One of the main aims is for high quality care which include attention to the spiritual needs for all people approaching the end of life (DH, 2008). However, since April 2013 responsibility for end of life care was transferred to local NHS Commissioning Boards, and *Action for End of Life Care: 2014-2016* is the most up-to-date document (DH, 2014). Likewise, Wales (Welsh Government, 2013), Northern Ireland (Northern Ireland Department of Health Social Services and Public Safety, 2010), and Scotland (Scottish Government, 2015) have produced their own end of life care documents, with similar key features, which represent some standardisation of care in this particular area.

Department of Health: NICE

Another important national body is, The National Institute for Health and Care Excellence (NICE) that informs NHS providers. NICE gives guidance to help both health and social care professionals to provide best quality care based on the best available evidence and value for money. For example, the information on

cancer services, *Improving supportive and palliative care for adults with cancer* (NICE, 2015), is a valuable resource for the provision of spiritual care, and highlights its importance in healthcare services offered to cancer patients. However, a widely used guideline for end of life care, *The Liverpool Care Pathway* received a lot of criticism for being used in a mechanistic way by some health care professionals (DH, 2013b), so changes were made as described below.

One Chance to get it Right

In 2014 the document *One Chance to get it Right: Improving people's experience of care in the last few days and hours of life* (Leadership Alliance for the Care of Dying People, 2014), outlines a new approach to replace the Liverpool Care Pathway. And specific reference is made concerning the delivery and co-ordination of psychological, social and spiritual support with compassion. Furthermore, health and care organisations and staff caring for dying people in England should put these directives into action. Of import, a recent audit for end of life care in hospitals in England recorded by the Royal College of Physicians (2016), reveal that in 89% of cases it was documented that spiritual/cultural/religious needs had been met. However, although this is encouraging, actual documented discussions about such needs with patients who were able to participate or their significant other was quite low (15% and 27% respectively). So clearly there is room for improvements.

In essence, what these various international and national documents seem to be saying explicitly or implicitly, is that spirituality is relevant to the wellbeing of

individuals and this should be taken into consideration in their healthcare.

Therefore, they provide a lead for action by professional bodies and other key stakeholders in the health service. One stakeholder of significance is the hospital chaplaincy service.

Hospital chaplaincy

Religious and spiritual care in the NHS is generally supported by a Hospital Chaplaincy service. The Hospital Chaplaincy within the NHS goes back to when religious spiritual care was a standard part of the care received by in-patients. However, in the 17th Century the Lunacy Act of 1890 formalised this service, and Anglican Chaplains were provided for each psychiatric hospital (Tunbridge (1973) in *Hospital Chaplaincies and Council*, (2006). Today Chaplaincy services are not restricted solely to mental health facilities, but form a part of the general NHS hospital provisions (DH, 2003, DH, 2015). They offer a spiritual care service to patients, family and staff (DH, 2015). And although individual chaplains are mainly affiliated to a particular faith community (but some may be humanist chaplains), they work in a flexible way in response to all NHS individuals religious or non-religious (DH, 2003, South Eastern Health and Social Care Trust, 2007, NHS England, 2015). Hospital chaplaincy therefore, is a potential constant resource of spiritual support for patients, their family/carers, and health care staff.

Hospital chaplaincy in NHS Scotland, and NHS Wales

Although NHS Scotland (Scottish government, 2009) and NHS Wales (Welsh Assembly Government, 2010c) have their respective chaplaincy document, the

overall content is not dissimilar to that of NHS England. Nonetheless, the Scottish document emphasises certain aspects for example, that spirituality integrates mind, body and spirit to help people maintain health, cope with illness, traumas, loss and changes in life. Also that everyone strives for meaning in their life as well as hope during times of illness or injury, (Scottish government, 2009). The Welsh document states that spiritual care is provided when a person is treated with respect, and listened to with due regard to their values and beliefs (Welsh Assembly Government, 2010c), but in addition there is a statement that “Chaplains/spiritual care givers are the specialist spiritual care providers” (p2). So although there is recognition that the responsibility for spiritual care is a team effort, the Welsh document points out that for Chaplains their employment is solely for this purpose; thus potentially a heavy responsibility rests with chaplains in Wales as they are expected to take the lead in spiritual matters. These documents suggest that chaplains are a crucial resource in the provision of religious, spiritual and pastoral care. However, to assume that chaplains can undertake this role in isolation from all other professions involved in the delivery of healthcare including nursing, would be I.

The nursing profession and spirituality

For a number of years there have been discussions and statements for the recognition and inclusion of spirituality in nursing care and the following documents illustrate this: The United Kingdom Council for Nurses, Midwives and Health Visitors (UKCC – predecessor to the NMC), in its 1984 *Code of Professional Conduct*, stated that, nurses, midwives and health visitors should be accountable for their professional practice and should take into account

patients' customs, values and spiritual beliefs (UKCC, 1984). However, a similar paper in 1992 talks about recognising and respecting the uniqueness and dignity of patients, by considering their ethnic origin, religious beliefs and personal attributes when responding to care needs (UKCC, 1992). Nonetheless, it is not clear why spiritual belief has been replaced by religious beliefs, or if spiritual/religious are being used interchangeably, (an example mentioned on page 26). If this is not the case then this later reference only to a patient's religion is decidedly narrow within the broader understanding of spirituality today. But historically explicit reference was made to the 'spiritual' by the professional regulatory body for nursing and midwifery in the UK, and now as the NMC has superseded the UKCC it is necessary to look at the direction it is giving to the nursing profession.

NMC and spirituality

It is worth noticing that two subsequent versions of the professional code of conduct for nurses issued by the NMC does contain specific mention both to religious and spiritual beliefs (NMC, 2002a, NMC, 2004a), which acknowledges a broader concept of spirituality. Furthermore, to some extent the ideal for nurses to practice in a holistic way is upheld. However, it is surprising that, *The Code* (NMC, 2008a) and its up-dated version (NMC, 2010b) has failed to include the words spirituality and religion, so in reality has reneged on previous directives, which sends an ambiguous and confusing message to the nursing and midwifery professions. The rationale for this change is unclear, but in an effort to compensate, both these versions of the NMC Code makes reference to respect and dignity, which are a part of spiritual care, and an integral aspect of a nurse's

role (White, 2012). So now, attention to the spiritual needs of patients is more implied than explicit in both these NMC publications, which fails to give clear direction to the nursing and midwifery professions as a whole.

Furthermore, to compound this situation, the most recent NMC Code (NMC, 2015) does not mention the word spiritual at all, and only gives reference to compassion (a component of spirituality) which is about, “how care is given through relationships based on empathy, respect and dignity” (DH, 2012a p.13). Subsequently, the omission of ‘spiritual’ from the NMC code started a lively debate among nurses and other health care workers. This followed an article, *A spiritual shortfall?* (McSherry and Ross, 2015), in a widely read nursing journal, in an attempt to have ‘spiritual’ reinstated in *The Code*. As well as a number of on-line responses, these are some examples of published comments: ‘The NMC should know spiritual care is as important as ever’ (Rideout, 2015); ‘Spirituality’ should be cited in the NMC code of conduct, nurses say’ (Well, 2015); ‘Omitting spirituality from NMC Code disadvantages our patients’ (Swift, 2015); ‘It’s time to stop equating the spiritual to the religious’ (Middleton-Green, 2015).

The above responses are an indication of the strength of feeling among nurses and others to the omission of spirituality in the NMC Code. Therefore, it is left to nurses at this time to interpret and fill in the spirituality gap found in this document. And, with the uncertainty about spirituality that many nurses have, it is unhelpful for their professional Code not to give a lead on the spiritual dimension of healthcare by not overtly attributing recognition to it. So, contrary to the many international and national policy documents discussed earlier, the current NMC

Code may raise questions about the importance of spirituality in holistic nursing practice.

So what is evident is that the NMC has a loose engagement with religion and spirituality, with no clear guidance, direction or explanation of what these concepts mean. As a result, and most importantly, there is no indication of how religion/spirituality should be addressed within nurse education and by practicing nurses. Consequently, it is necessary for NMC documents to explain and promote spirituality in a clear way so that those within the nursing profession are in no doubt concerning their role and responsibility in this area. This now leads me to briefly focus on nurse education.

Spirituality in nurse education

Changes over time

When attention is turned to nurse education it is seen that from the Royal Charter in the 1930's to changes in the 1980's when nurse education moved from hospital schools of nursing to higher education establishments, the UKCC and its successor the NMC have set out specific requirements for pre-registration nursing programmes in a series of publications to improve and guide training (UKCC, 1986, NMC, 2002b, NMC, 2004a, NMC, 2010a). But although there is acceptance that nursing is a practice-based profession, a new direction in nurse education for the 1990's and beyond was launched with Project 2000 (UKCC, 1986). One prominent feature was ending the apprenticeship model where students were counted as part of the workforce, to them having supernumerary status and gaining an academic qualification at a higher education diploma level.

In addition, this academic shift to Project 2000 contained competencies for registered nurses which included the ability to recognise the physical, psychological, social and spiritual needs of patients/clients (UKCC, 1986). There was also reference to health needs models and the holistic approach to care, reinforcing equal consideration for spirituality among the other dimensions of health. Furthermore, the current document, *Standards for pre-registration nursing education* (NMC, 2010a) unlike *The Code* (NMC, 2015) clearly includes attention to spirituality, which highlights incongruence between the two standards. Thus, in an effort to counteract uncertainty and any negativity that may exist as a result of this incongruence, nurse educators should emphasise the spiritual within holistic care. However, nurse competence is an undisputed outcome of all nurse educational programmes, and this will now be addressed.

Nurse competence

Subsequent documents relating to requirements for pre-registration nursing programmes (NMC, 2002b, NMC, 2004a) place competence as one of the key essential requirement for registration, emphasising that “it [competence] is a holistic concept” (NMC, 2010a p. 11). Furthermore, the NMC states: “A holistic approach to nursing considers physical, social, economic, psychological, spiritual and other factors when assessing, planning and delivering care” (NMC, 2010a p. 148). Although *The Code*, and *Standards for pre-registration nursing education* are issued by the same body, the detail relating to spiritual care is inconsistent, and this oscillating between inclusion and non-inclusion of spirituality sends a mixed message to the nursing profession. Yet clearly it is seen that the NMC expects competences and holistic care to go hand-in-hand, as well as the

responsibility to practice in a way that is person-centred, upholding the dignity and human rights of patients (NMC, 2010a, NMC, 2015). And at this point I will briefly discuss more issues relating to spirituality in the nursing profession, patient care and the role of nurses, as this has a bearing in my overall argument in support of the importance of spirituality in nursing and my investigation.

Influences on the nursing profession

In time, nursing began the campaign to be recognised as a profession in its own right apart from medicine, spearheaded by leading figures such as Florence Nightingale, Virginia Henderson (Mason et al., 2011) and Mrs Bedford Fenwick (Hector, 1973). Yet, although there is a stronger secular influence within the nursing profession today, it is recognised that spirituality remains a fundamental dimension (Lewinson et al., 2015) and could exist without religion. Nevertheless, for some people spirituality often finds expression in a religious framework to 'make sense' of health and illness situations, so providing a means of coping with various health issues and challenges (Simsen, 1988). Thus total patient care is the goal of holistic nursing.

Total patient care

Leading theorists in the nursing profession such as Peplau (1952), Orem (1985) and Henderson (1966) all believe it is not enough to focus on the disease episode in an individual's illness experience, but to promote the delivery of total patient care without neglecting the spiritual dimension. Moreover, Martsolf and Mickley (1998) present two worldviews of spirituality that are relevant to the ideas of nurse theorists: 1) reciprocal interaction – people are

made up of various dimensions, as the person interacts with their environment, on-going change may take place, or alternatively as a response to threats to survival; and 2) simultaneous action – people are distinguished by patterns that interchange with the environment and change is continuous. Accordingly, these worldviews influence the way spirituality is perceived within a conceptual model or theory.

Therefore, those models that adopt the reciprocal interaction worldview see the spiritual dimension interacting in a holistic way, whereas with simultaneous action, spirituality is seen within the presenting patterns of a person's life (Martsof and Mickley, 1998). The former reciprocal model which promotes holistic care is the basis of my theorising, and synchronises with the holistic concept of Watson's (1988) theory of human caring (discussed on page 7), within which nurses facilitate the spiritual needs of patients.

Nurse facilitation

However, apart from the historical discourse, earlier research sought to identify certain interventions by the nurse that might facilitate spirituality when a person is ill such as, arranging a visit with clergy, talking with patients, time for personal prayer, meditation or reading, as well as help if needed to attend the hospital chapel (Reed, 1991), which concur with other findings (Dickinson, 1975, Purdie et al., 2008, Baldacchino, 2010). From such studies it is clear that spirituality was still mainly viewed within the context of religion, but Dickinson (1975) did include broader aspects such as hope, will, and purpose; Reed (1991) included the facilitation of the search for meaning in illness. Here it is seen that the intangible

wider aspects of spirituality are recognised in a way that warrants more attention by the nurse in order to address such like needs of patients.

Given the integral nature of the spiritual dimension within holistic care, I am more aware that nurses need to acquire spiritual care education in their training (Lewinson et al., 2015), an opinion previously offered by Highfield and Cason (1983);Simsen, (1988); Abbasi et al (2014). In spite of such compelling arguments, and a swell of interest over the past three decades to support a move for nurses to be adequately prepared to meet patients' spiritual needs, this has not been realised, therefore, there is a need for spirituality in nurse education to gain recognition (Waugh, 1992).However, this is changing with attention being drawn to the matter by a number of nurse researchers, (Ross, 1996, Bradshaw, 1997, McSherry and Draper, 1997, Bush, 1999, Maddox, 2001, Narayanasamy, 2006, Baldacchino, 2008a, Lemmer, 2010, Cone and Giske, 2013, Bennett and Thompson, 2015).

Nurses express importance of spiritual care

Emerging evidence would suggest that nurses themselves have expressed that spirituality is an important part of their caring activity for patients, so resulting in an on-going desire to be better equipped ,(Ross, 1996, Baldacchino, 2008a, McSherry and Jamieson, 2011). However, it should be acknowledged that some progress has been made to address the needs of nurses for spirituality education (Ross, 1996, Bradshaw, 1997, Narayanasamy, 1999b, Bush, 1999, Maddox, 2001, Shih et al., 2001, Lemmer, 2002, McSherry et al., 2008, Baldacchino, 2011b, Attard et al., 2014); but further research evidence into the effectiveness

of spirituality education in nurse programmes is needed for the nursing profession to effectively address these issues.

Nurses need to adequately support the spiritual dimension within holistic care, to enhance patient wellbeing. Adequate spirituality education in pre-registration nursing programmes would increase nurses' understanding and provision of spiritual care (Chan et al., 2006). Thus, including spirituality in pre-registration nurse education should not be an optional extra, but a legitimate, unambiguous and standard content. Such an advance would help to remove some of the uncertainties nurses feel surrounding the assessment and delivery of spiritual care for patients (Ross, 1996, Blesch, 2013).

Summary

This chapter has traced historically the religious significance of spirituality in healthcare to the present wider post-modern understanding, reflected in various definitions and debates. Having examined a number of relevant international, national and professional statements, guidance and policies, it is clear that spirituality is a central theme and relevant in matters concerning healthcare provision, both past and present. However, despite this evidence, there seems to be a lack of adequate attention to its inclusion in nurse education and practice. Therefore, as a result of the limitations discussed in this chapter, I will explore why spirituality may not be being adequately addressed in practice, and more specifically whether this has anything to do with how nurses are educated and prepared. Accordingly, the first place to explore is to identify what research has already been done, by carrying out a systematic review of the literature.

CHAPTER THREE: LITERATURE REVIEW

Literature review

Introduction

It is important that a literature review is comprehensive, rigorous and systematic, presenting details of the searching process. This literature search serves to source relevant empirical publications, to identify the significance and practicalities of spirituality in nurse education and practice. Such an undertaking is necessary to demonstrate thoroughness and transparency. Selected studies will be presented and appraised in a critical way (O'Rourke in Bowling (2009) so affording reliability to the results and conclusions of the review (Aveyard, 2010). Furthermore, as a result of this review it was discovered that no research as yet addressed the transferability and sustainability of pre-registration spirituality education, and this evidence provides the main rationale for my investigation.³

The search

In order to identify relevant literature for this review, a computer search of relevant databases useful to healthcare professionals was chosen and the details are as follows:

1) British Nursing Index (BNI) – a UK nursing and midwifery database which also includes some international nursing and Midwifery journals as well as allied health material. The BNI database was accessed through the Royal College of Nursing library and is one of the most up-to-date resources available for nursing and midwifery.

³ Aspects of this chapter were published in the journal 'Nurse Education Today' (Appendix 1)

2) Cumulative Index to Nursing and Allied Health Literature (CINAHL) – is considered a most useful database for nurses, covering material from 1992 to date. CINAHL also enables access to ‘grey’ literature which falls outside the mainstream of journal publications for example, nursing dissertations, and conference proceedings which could provide additional useful evidence.

3) Medical Literature On-Line (MEDLINE) – an American bibliographic database containing more than 19 million references, many of the journals on this site are of relevance to health professionals.

Search terms

Having identified the most appropriate databases and before searching the various sites in turn, I proceeded to generate the keywords/phrases that were central to in my research question (Polit and Beck, 2010). The word list was drawn from the main search terms which are: ‘spirituality in nurse education’, ‘competence’ and ‘holistic nursing care’ (Appendix 2). The advanced search option for the databases was chosen as it allows the search to be refined within certain parameters.

Inclusion criteria

The first was for primary research literature using any method of investigation relating to spirituality in pre-registration nurse education; secondly was for studies dating from 1992 when a seminal piece of work was carried out in the UK (Waugh, 1992), through to 2013 (subsequently updated to 2015) ; and thirdly, only English language papers with abstract, and peer reviewed were sourced.

Exclusion criteria

These were post-registration nurse education; editorials and discussion papers; books and book chapters; and lastly, reviews and conference papers.

The search process

During the process of the search the time saving device of Truncation was employed, which is denoted by an asterisk (*) or a dollar sign (\$) and is added to the root or stem of a word in order to find different endings. In addition, Boolean operators were used which are 'and' 'or' 'not' to include or exclude specific terms. However, the 'not' was unnecessary in this search (appendix 2).

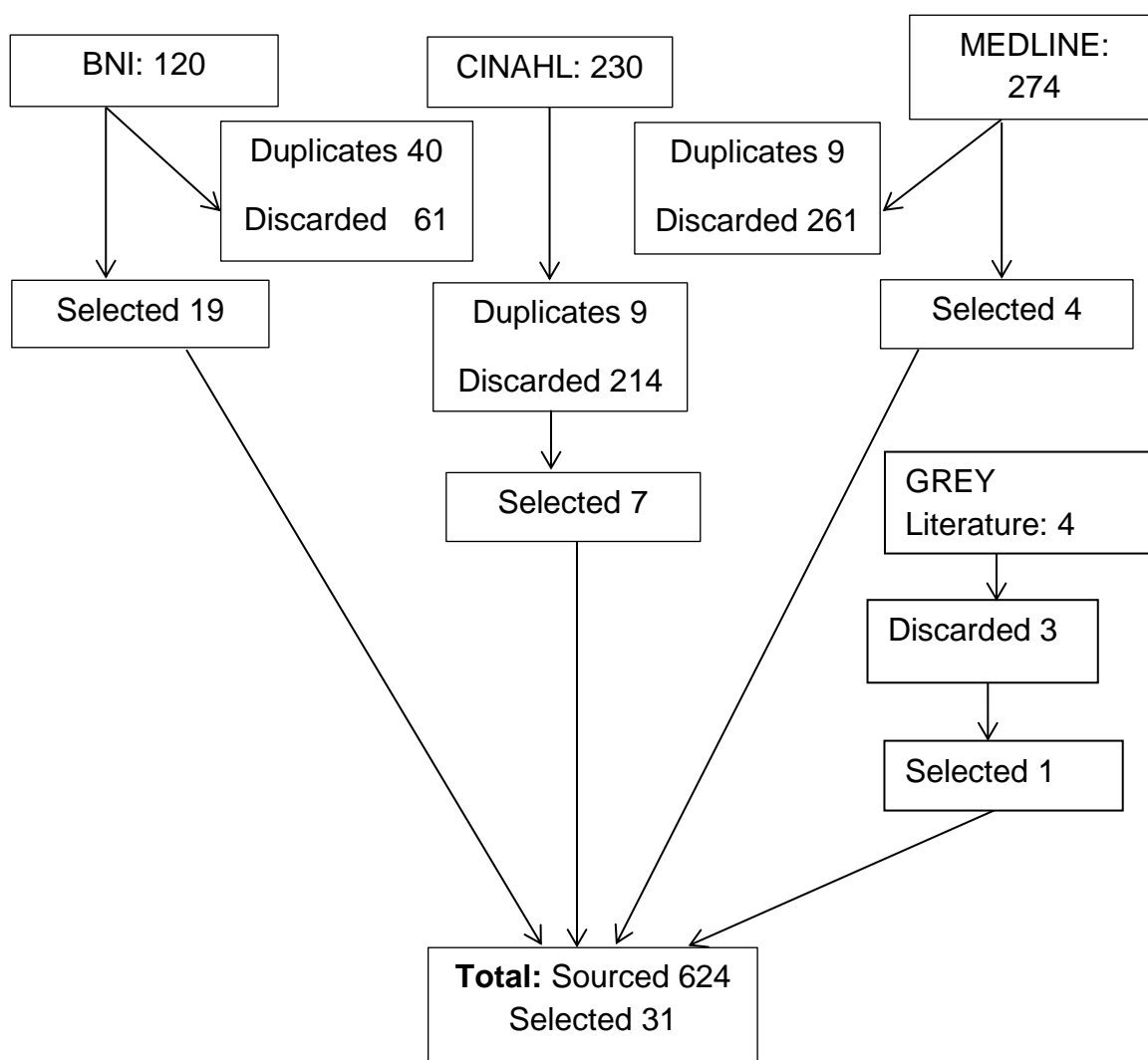
During the search a number of articles were duplicated on the various databases, so these were removed from the final list. Furthermore, other authors may have used obscure/novel titles for their work, which inevitably were not identified within the search criteria. After refining the search, titles were selected that seemed to relate best to my research question, so the abstracts were read to confirm suitability of information for inclusion in the review. However, some titles appeared promising but after reading the abstract they were unsuitable (Aveyard, 2010). Additionally, through a follow-up of references one unpublished study of relevance was found in the grey literature.

Search summary

The search however, only returned a small number of studies (31) from the electronic databases that met the criteria concerning spirituality education in pre-

registration nursing courses. There were: 29 relating to adult nursing, 1 to children nursing and 1 to midwifery. Of the 31 studies 12 were quantitative, 15 qualitative and 4 of mixed methods. A manual search for other relevant studies did not reveal any further papers that were not already retrieved recently or in the past. The following Figure 3.1 shows the results from the data bases searched, and the final number of studied found that met the inclusion criteria and were therefore selected for review.

Figure 3.1 Summary of selected studies



The majority of studies found related to the adult branch of nursing, and this dominance was also acknowledged by research from the child branch (O'Shea et al., 2011). Adult nursing being the largest of the four branches of nursing could explain the volume of research from this sector.

The numbers of qualitative and quantitative studies found suggest an equivalent effort by researchers to gather in-depth understanding of the 'behaviour' as well as the narrower focus of larger systematic empirical investigations that measure outcomes. The mixed methods studies bring triangulation to research in order to enhance confidence in the findings. It is surprising that only 4 published and 1 unpublished study meeting the search criteria was carried out in the UK. Most of the studies originated from North America (13) and follows a prevalent trend for other research in the area of spirituality. Other papers were from: Malta (2), Netherlands (2), Norway (2), Singapore (2), South Africa (2), Europe (1), Iran (1), and Republic of Ireland (1) – (see Figure 3.2)

Figure 3.2 Thirty one literature review studies

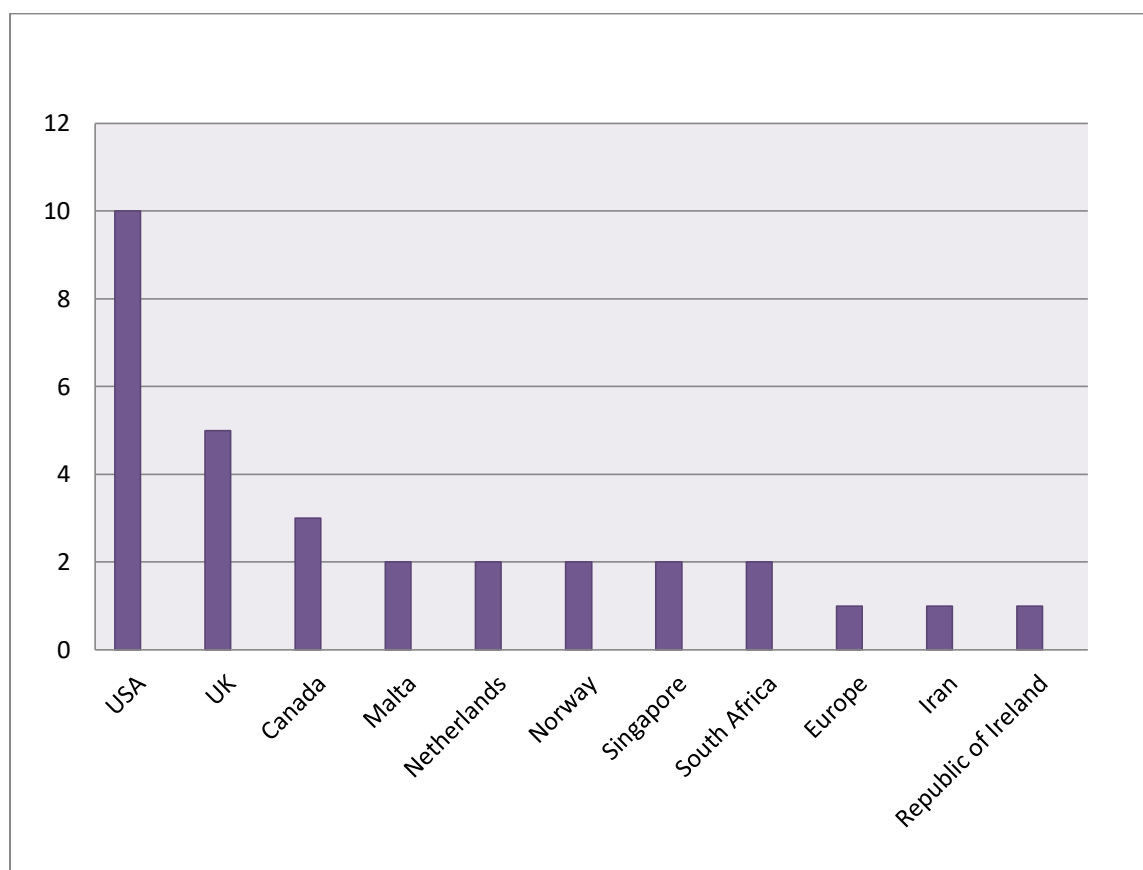


Figure 3.2 chart the number of all the relevant studies found (31) from various countries/location that met the inclusion criteria. And the above figure contain studies from 2002 – 2015.

Assessment of papers

The search conducted located specific primary research material surrounding the concept of spirituality in pre-registration nurse education. The papers were assessed for quality and scope using NICE guidance (NICE, 2012) : 14 checklist items (example: Appendix 3a) of broadly accepted principles that typify qualitative research, and may affect validity, and 19 checklist items (example: Appendix 3b) for quantitative research with factors that could affect reliability. Accordingly, the recent debates about the subject matter were examined, to

bring together what is known, thus providing a rationale for further research and analysis (Aveyard, 2010).

Overview of search

This literature search would suggest that the momentum of interest reflected by published papers relating to spirituality has increased, since 1992 when the first substantive study into spiritual care in the UK was carried out (Waugh, 1992). However, in relation to empirical studies of spirituality, and specifically relating to this literature search and adult branch pre-registration nurse education, it is observed that none came to light before 2002 with a more gradual increase over the ensuing years before a cluster of 7 in 2008 (Table 3.1). The increasing momentum observed could be the result of an increased number of researchers and educationalist with an interest in spirituality who wish to see more inclusion of this subject in nurse education programmes.

Table 3.1 Selected spirituality in nursing care papers

Year	Studies	Country	Type	Sample size	Sample	Area of focus
2002	Pesut, B.	Canada	Mixed (survey & open questions)	53	Student nurses	Students' perceived well-being and spirituality, as well as their perceptions of spiritual nursing care and how these changed during 4 years of nurse education.
2002	Lemmer, C.	USA	Quantitative (survey)	250	Baccalaureate nursing programmes	How the spiritual dimension of nursing care is taught in baccalaureate nursing programmes.
2003	Olson, J.K., Paul, P., Douglass, L., Clark, M. B., Simington, J., & Goddard, N.	Canada	Qualitative (questionnaire)	18	Schools of nursing	The extent to which the spiritual dimension is addressed in Canadian undergraduate nursing curricula.
2003	Meyer, C. L.	USA	Quantitative (survey)	280	Student nurses	Impact of student's personal and environmental factors in nursing education on their perceived ability to provide spiritual care.
2005	Kenny, G., & Ashley, M.	UK	Qualitative	21	Children's nursing students	Children's nursing students' perspective on educational practice concerning spirituality in the nursing curriculum.

2006	Seymour, B.	UK Unpublished Theses	Qualitative (case study)	54	Student nurses	Evaluation of students' learning about spirituality in the classroom.
2007	Mitchell, M., & Hall, J.	UK	Qualitative	16	Student midwives	A retrospective exploratory study, using a creative approach to teach spirituality to student midwives.
2007	Lovanio, K., & Wallace, M.	USA	Quantitative (pre-test/post- test *SSCRS scale)	10	Undergraduate nursing students	Student nurse education course to enhance knowledge and understanding of spiritual care.
2007	Hoffert, D., Henshaw, C., & Mvududu, N.	USA	Quantitative (survey)	38	Baccalaureate nursing students	Enhancing the ability of Nursing students to carry out spiritual assessment.
2007	Mooney, B., &Timmins, F.	Republic of Ireland	Qualitative	100	Student nurses	Learning about spirituality through the medium of art.
2008	Graham, P. E.	USA unpublished Theses	Mixed (*SAS Survey & interviews)	24	Senior nursing students	The preparedness of nursing students to assess their patients' spiritual needs after a four hour spirituality seminar.
2008	McSherry, W., Gretton, M., Draper, P., & Watson, R.	UK	Quantitative (questionnaire)	135	Pre-registration nursing students	Ethical basis of teaching spirituality and the impact on students' perceptions and understanding of spirituality.
2008	Purdie, A., Sheward, L., & Gifford, E.	UK	Qualitative (focus groups)	6	Student nurses	Developing holistic caring skills particularly in relation to spiritual care.

2008	Wallace, M., Campbell, S., Grossman, S. C., Shea, J. M., Lange, J. W., & Quell, T. T.	USA	Mixed (*SSCRS pre-test/post-test & questions)	67	Undergraduate nurses	Evaluate students' spiritual knowledge and attitudes following integration of spirituality in the nursing curriculum.
2008	Taylor Johnston, E., Mamier, I., Bahjri, K., Anton, T., & Petersen, F.	USA	Quantitative (*DSE pre-test/post-test)	201	Baccalaureate nursing students	Efficacy of a self-study programme to teach nurses how to talk with patients about spirituality and identify learning factors.
2008	Van Leeuwen, R., Tiesinga, L. J., Middel, B., Post, D., & Jochemsen, H.	The Netherlands	Quantitative (quasi-experimental)	97	Student nurses	Evaluate the effectiveness of an educational course to develop competence in spiritual care.
2009	Van Leeuwen, R., Tiesinga, L. J., Jochemsen, H., & Post, D.	The Netherlands	Qualitative (peer-review groups)	39	Student nurses	Effects of peer-review discussion groups on developing competence in providing spiritual care.
2010	Baldacchino, D.	Malta	Qualitative (focus groups)	7	Undergraduate nursing students	Experiential learning for the delivery of spiritual care to clients in Lourdes.
2011	Nardi, D., & Rooda, L.	USA	Mixed (survey & questionnaire)	86	Baccalaureate nursing studies	The nature of spirituality in senior baccalaureate nursing students.

2011	O'shea, R., Wallace, M., Fitzpatric, J.J.	USA	Quantitative (Survey)	41	Student nurses	The effects of a spiritual education session on paediatric nurses' perspectives towards providing spiritual care.
2012	Tiew, L. H., & Drury, V.	Singapore	Qualitative (interviews)	16	Student nurses	Student nurses' perceptions and attitudes relating to spirituality and spiritual care in practice.
2012	Giske, T., & Cone, P.	Norway	Qualitative (grounded theory)	42	Student nurses	To determine undergraduate nursing students' perspective on spiritual care and how they learn to assess and provide spiritual care to patients.
2012	Barss, K. S.	Canada	Qualitative (phenomenology)	4	Nurse teachers	Using the T.R.U.S.T. Model to support caregivers in nurturing their own spirituality and offering patients opportunity to nurture theirs to promote well-being.
2012	Burkhart, L., & Schmidt, W.	USA	Quantitative (survey)	59	Student nurses	To determine the effectiveness of a spiritual care educational and reflective programme on students' ability to provide spiritual care.
2012	Costello, M., Atinaja-Faller, J., & Hedberg, M.	USA	Quantitative (quasi- experimental)	52	Student nurses	A pilot study to determine if simulation is an effective method for instructing nursing students in the provision of spiritual care.
2013	Tiew, L. H., Creedy, D. K., & Chan, M. F.	Singapore	Quantitative (survey)	745	Student nurses	Exploration of final-year undergraduate students in Singapore in relation to their perspectives of spirituality and spiritual care-giving.

2013	Cone, P. H., & Giske, T.	Norway	Qualitative (grounded theory)	19	Nurse teachers	Exploring teachers' understanding of spirituality and how they prepare undergraduate nursing students to recognise spiritual cues and learn to assess and provide spiritual care.
2013	du Plessis, E., Koen, M. P., & Bester, P.	South Africa	Qualitative (phenomenology)	18	Mental health nursing students	Students gained confidence implementing psychiatric nursing skills in home visits within a faith community, and spiritual care was provided indirectly.
2014	Ross, L., van Leeuwen, R., Baldacchino, D., Giske, T., McSherry, W., Narayanasamy, A., Downes, C., Jarvis, P., & Schep-Akkerman, A.	Europe	Quantitative (survey – pilot study)	618	Student nurses/midwives	A description of undergraduate nurses'/midwives' perceptions of spirituality/spiritual care, and their perceived competence in delivering spiritual care.
2015	Frouzandeh, N Aein, F., & Noorian, C.	Iran	Quantitative	30	Student nurses	A spiritual care training course to determine its effectiveness for Self-efficacy of nursing students in providing spiritual care to patients.
2015	Linda, N.S Klopper, H.C., & Phetlhu, D.R.	South Africa	Qualitative (Explorative)	90	Student nurses	The opinions of student nurses on the teaching-learning of spiritual care in their undergraduate nursing programme.

* **SSCRS** – Spirituality and Spiritual Care Rating Scale; * **SAS** – Spirituality Assessment Scale; * **DSE** – Daily Spiritual Experience Scale

Selected studies

After thorough reading and quality appraisal of all the selected studies, the key features in each paper were identified, and subsequently grouped into four main themes:

- 1) Spiritual awareness
- 2) Spiritual assessment
- 3) Competence for spiritual care
- 4) Spirituality education in pre-registration programmes

In Table 3.2 the various studies have been grouped in the themes as listed above, and it is noticed that the largest amount of studies (17) concerned 'spirituality education in the pre-registration programme. This strongly reflects the debates to improve spirituality education in pre-registration nurse curricular,(Brittain and Boozer, 1987, Bradshaw, 1997, Bush, 1999, Grosvenor, 2000, Callister et al., 2004, McSherry et al., 2008, Costello et al., 2012, Blesch, 2013, Cone and Giske, 2013, Bennett and Thompson, 2015). Inversely, a small group of studies (2) which could not be ignored, was in the area of spiritual assessment, which currently in nursing practice is mainly carried out in an informal way (Ross and McSherry, 2010). The above four themes identified will now be examined and analysed in turn.

Table 3.2 Four Themes

Theme	Study	Country of origin	Method	Sample size	Participants	Focus
Spiritual awareness	Pesut, B. (2002)	Canada	Mixed	53	Student nurses	Students' perceived well-being and spirituality, as well as their perceptions of spiritual nursing care and how these changed during 4 years of nurse education.
Spiritual awareness	Baldacchino, D. R. (2008)	Malta	Qualitative	65	Student nurses	Increasing students' awareness about the spiritual dimension in nursing care, to enable them to implement holistic care.
Spiritual awareness	Tiew, L. H., & Drury, V. (2012)	Singapore	Qualitative	16	Student nurses	Perceptions relating to spirituality and spiritual care in practice.
Spiritual awareness	Tiew, L. H., Creedy, D, K., & Chan, M, F. (2013)	Singapore	Quantitative	745	Student nurses	A survey of final year nursing students to ascertain their perspectives of spirituality and spiritual care-giving.
Spiritual awareness	du Plessis, E., Koen, M. P., & Bester, P. (2013)	South Africa	Qualitative	18	Student nurses	Students gained confidence implementing psychiatric nursing skills in home visits within a faith community, and spiritual care was provided indirectly.
Spiritual awareness	Meyer, C. L. (2003)	USA	Quantitative	280	Student nurses	Impact of student's personal and environmental factors in nursing education on their perceived ability to provide spiritual care.

Spiritual assessment	Hoffert, D., Henshaw, C., & Mvududu, N. (2007)	USA	Quantitative	38	Baccalaureate nursing students	Enhancing the ability of Nursing students to carry out spiritual assessment.
Spiritual assessment	Graham, P. E., (2008)	USA Unpublished Thesis	Mixed (*SAS Survey & interviews)	24	Senior nursing students	The preparedness of nursing students to assess their patients' spiritual needs after a four hour spirituality seminar.
Spiritual competence	Van Leeuwen, R., Tiesinga, L. J., Middel, B., Post, D., & Jochemsen, H. (2008)	Netherlands	Quantitative	97	Student nurses	Evaluate the effectiveness of an educational course to develop competence in spiritual care.
Spiritual competence	Purdie, A., Sheward, L., & Gifford, E. (2008)	UK	Qualitative	6	Student nurses	Developing holistic caring skills particularly in relation to spiritual care.
Spiritual competence	Van Leeuwen, R., Tiesinga, L. J., Jochemsen, H., & Post, D. (2009)	Netherlands	Qualitative	39	Student nurses	Effects of peer-review discussion groups on developing competence in providing spiritual care.
Spiritual competence	Baldacchino, D. (2010)	Malta	Qualitative	7	Undergraduate nursing students	Experiential learning for the delivery of spiritual care to clients in Lourdes.
Spiritual competence	Ross, L., van Leeuwen, R., Baldacchino, D., Giske, T., McSherry, W., Narayanasamy, A., Downes, C., Jarvis, P., & Schep-Akkerman, A. (2014)	Europe	Quantitative (Survey) Pilot study	618	Student nurses/midwives	A description of undergraduate nurses'/midwives' perceptions of spirituality/spiritual care, and their perceived competence in delivering spiritual care.

Spiritual competence	Frouzandeh, N., Aein, F., & Noorian, C. (2015)	Iran	Quantitative	30	Student nurses	A spiritual care training course to determine its effectiveness for Self-efficacy of nursing students in providing spiritual care to patients.
Spirituality in pre-registration programmes	Lemmer, C. (2002)	USA	Quantitative	250	Baccalaureate nursing programmes	How the spiritual dimension of nursing care is taught in baccalaureate nursing programmes.
Spirituality in pre-registration programmes	Olson, J.K., Paul, P., Douglass, L., Clark, M. B., Simington, J., & Goddard, N. (2003)	Canada	Qualitative	18	Schools of nursing	The extent to which the spiritual dimension is addressed in Canadian undergraduate nursing curricula.
Spirituality in pre-registration programmes	Kenny, G., & Ashley, M. (2005)	UK	Qualitative	21	Children's nursing students	Children nursing students' perspective on educational practice concerning spirituality in the nursing curriculum.
Spirituality in pre-registration programmes	Seymour, B. (2006)	UK (Unpublished Theses)	Qualitative	54	Student nurses	Evaluation of students' learning about spirituality in the classroom.
Spirituality in pre-registration programmes	Mooney, B., & Timmins, F. (2007)	Republic of Ireland	Qualitative	100	Student nurses	Learning about spirituality through the medium of art.
Spirituality in	Lovanio, K., &	USA	Quantitative	10	Undergraduate	Student nurse education course to

pre-registration programmes	Wallace, M. (2007)				nurses	enhance knowledge and understanding of spiritual care.
Spirituality in pre-registration programmes	McSherry, W., Gretton, M., Draper, P., & Watson, R. (2008)	UK	Quantitative	135	Pre-registration nursing students	Ethical basis of teaching spirituality and the impact on students' perceptions and understanding of spirituality.
Spirituality in pre-registration programmes	Wallace, M., Campbell, S., Grossman, S. C., Shea, J. M., Lange, J, W. & Quell, T. T. (2008)	USA	Mixed	67	Undergraduate nurses	Evaluate students' spiritual knowledge and attitudes following integration of spirituality in the nursing curriculum.
Spirituality in pre-registration programmes	Taylor Johnston, E., Mamier, I., Bahjri, K., Anton, T., & Petersen, F. (2008)	USA	Quantitative	201	Baccalaureate nursing students	Efficacy of a self-study programme to teach nurses how to talk with patients about spirituality and identify learning factors.
Spirituality in pre-registration programmes	Nardi, D., & Rooda, L. (2011)	USA	Mixed	86	Baccalaureate nursing studies	The nature of spirituality in senior baccalaureate nursing students.
Spirituality in pre-registration programmes	Barss, K. S. (2012)	Canada	Qualitative	4	Nurse teachers	Using the T.R.U.S.T. Model to support caregivers in nurturing their own spirituality and offering patients opportunity to nurture theirs to promote well-being.

Spirituality in pre-registration programmes	Cone, P. H., & Giske, T. (2013)	Norway	Qualitative	19	Nurse teachers	Exploring teachers' understanding of spirituality and how they prepare undergraduate nursing students to recognise spiritual cues and learn to assess and provide spiritual care.
Spirituality in pre-registration programmes	Costello, M., Atinaja-Faller, J., & Hedberg, M. (2012)	USA	Quantitative (quasi-experimental)	52	Student nurses	A pilot study to determine if simulation is an effective method for instructing nursing students in the provision of spiritual care.
Spirituality in pre-registration programmes	Giske, T., & Cone, P. (2012)	Norway	Qualitative	42	Student nurses	To determine undergraduate nursing students' perspective on spiritual care and how they learn to assess and provide spiritual care to patients.
Spirituality in pre-registration programmes	Burkhart, L., & Schmidt, W. (2012)	USA	Quantitative (survey)	59	Student nurses	To determine the effectiveness of a spiritual care educational and reflective programme on students' ability to provide spiritual care.
Spirituality in pre-registration programmes	Mitchell, M., & Hall, J., (2007)	UK	Qualitative	16	Student midwives	A retrospective exploratory study, using a creative approach to teach spirituality to student midwives.
Spirituality in pre-registration programmes	Linda, N.S., Klopper, H.C., & Phetlhu, D.R. (2015)	South Africa	Qualitative (Explorative)	90	Student nurses	The opinions of student nurses on the teaching-learning of spiritual care in their undergraduate nursing programme.

Four themes

1) Spiritual awareness

Spiritual awareness indicates sensitivity (Lemmer, 2002, McEwen, 2005), for example towards a patient's religious background, attention to religious/spiritual conversations, also recognition of spiritual cues in a variety of health care settings (Narayanasamy et al., 2004, Giske and Cone, 2012). Spiritual awareness may be attained through personal perception as well as various sources of information. This implies being cognizant towards spirituality, but also there is a suggestion of a tacit understanding which seems fitting for matters of spirituality, including learning in this area.

A number of authors concur that one of the reasons why nurses find it difficult to routinely provide spiritual care is not only due to a lack of awareness, but also some uncertainty or discomfort with their own spirituality (Catanzaro and McMullen, 2001, Lemmer, 2002, McEwen, 2005), which could also influence their confidence to carry out spiritual assessment (to be discussed later). However, Catanzaro and McMullen (2001), McEwan (2005), also Bennett and Thompson (2015) confirm the suggestion by Piles (1990) that the ability to provide spiritual care can be learned, which would increase nurses' spiritual awareness. Therefore, there is a strong possibility that the hesitancy some nurses experience around meeting the spiritual need of patients originate from a lack of knowledge and experience in this area(Callister et al., 2004). So there is good reason for nurse education to be pre-emptive in making positive strides to include strategies for increasing the development of spiritual awareness among

pre-registration nursing students. In addition, this move would make a significant contribution to increasing attention to the spiritual needs of patients and give real meaning to the concept of holistic care.

In a Canadian study using mixed methods, Pesut (2002) investigated the perception (awareness) of nursing students regarding their own spirituality and the development of spiritual care giving as a result of educational experience. All possible first year (n=35) and fourth year (n=18) student nurses in a Christian university were recruited for the study. The varying class sizes accounted for the small number of participants, and the factor of attrition between the first and fourth year. The researcher acknowledged the reluctance of some students to decline participation in the research project, so it was emphasised that responses were voluntary and anonymous (Pesut 2002), thus removing the pressure from students to conform, and any preconception of what may be expected of them. However, the researcher admits that many students chose this private Christian university because they desired to develop spiritually. So there is a high probability that all students were well motivated and inclined towards exploring spiritual interventions for the benefit of patients and their own personal growth.

Learning activities took place both in the classroom and the clinical setting thus emphasising the necessary theory-practice link which fosters integration of knowledge (Attard et al., 2014), and is a crucial feature in nurse education (NMC, 2010a). All the participants were required to complete a spiritual well-being scale developed by Paloutzian and Ellison (1982a), designed to measure the quality

of their spiritual health from both a religious and existential perspective, similar to that described on page 21 in a definition of spirituality by Stoll (1989).

Furthermore, there is an opinion that everyone is spiritual in some way (Ross, 1997, Sartori, 2010a), which adds credence to the idea that the term spirituality has 'public ownership' (Clarke, 2013). Thus, for some people it is to do with the function spirituality has for them or society, whereas for others spirituality is substantial, with the person holding certain views, experiences and traditions for example, a particular religion or belief. However, the findings of the spiritual well-being scale in the Pesut (2002) investigation showed that students rated themselves highly for both individual spirituality and spiritual care-giving, which is consistent with findings by Hoover (2002), also they were aware that spirituality did not necessarily equate to religion, and that people should feel free to believe what they want. But what was also discovered, is that although students entered their nursing programme with a strong sense of personal spirituality, which Taylor et al., (1999) found has a positive correlation with how comfortable they felt in providing spiritual care, specific education on spirituality in nursing care broadened this view. In addition, consideration of diverse beliefs enabled them to grow in terms of sensitivity in their personal spiritual agendas.

The fact that this study is small as well as the participants only being recruited from a Christian university, limits its generalizability for application to other groups and settings in a population (Holloway and Wheeler, 2000).

Nevertheless, the study contributes valuable insight into the development of spiritual awareness among nursing students, which is believed to be a key prerequisite for meeting the spiritual needs of patients.

The aim of a Maltese study unit (Baldacchino, 2008a), *Teaching on the spiritual dimension in care: The perceived impact on undergraduate nursing students*, was intended to increase students' spiritual awareness so that they would become more sensitive to patients' needs and the practice of holistic care. This qualitative study used a cohort of 65 students in the fourth year of a Diploma Health Sciences nursing course. The participants were all Christians, and representative of the strong Roman Catholic affiliation (95%) of the Maltese population (Baldacchino, 2008a). The course consisted of theory and clinical experience over 14 weeks. To achieve the overall aim to implement holistic care, five objectives were set: 1) define the term spirituality and spiritual care; 2) become aware of spiritual distress in illness; 3) identify the possible spiritual needs of patients during illness; 4) list the spiritual coping strategies used by patients in illness; and 5) reflect on their own spirituality (Baldacchino, 2008a). The tool, Actioning Spirituality and Spiritual care Education and Training (ASSET) (Narayanasamy, 1999c) was used for identifying the impact of the study unit. This model purports certain outcomes as a result of spirituality teaching: value clarification, sensitivity and tolerance, knowledgeable practitioner in the spiritual dimensions of nursing, competence in assessing spiritual needs, evaluating the effectiveness of spiritual care, and positive nurse-patient spiritual integrity. The results showed impact in three areas: personal – self-awareness of spirituality and health, academic – increased knowledge of the terms spirituality and spiritual care, and professional – awareness of holistic care including spiritual needs.

A possible limitation of this study was that all students were Christians and it was thought that this probably made them more aware of their own spirituality and therefore not representative of the general nurse population elsewhere.

Furthermore, some literature suggests that when nurses prioritise spirituality in their lives they also tend to do so in the care of patients (Hoover, 2002). In the end students confirmed that facilitating patients' spiritual needs was central to holistic care.

In contrast the following quantitative study conducted in the USA by Meyer (2003), used students from both religious and non-religious institutions, and looked into the effectiveness of nurse educators to prepare students to provide spiritual care. Both student and environmental aspects in nurse education were explored in order to determine any contributory factors towards the perception of students' ability to provide spiritual care. Unlike the Pesut (2002) study, this was much larger consisting of 280 participants drawn from twelve mid-western nursing schools, six of which were private institutions with a religious affiliation. Questionnaires used, Howden's (1992) Spirituality Assessment Scale (SAS) to measure student's spirituality. The findings revealed that the participants in private religious institutions showed more religious commitment, which bears similarities to the findings of Pesut (2002). Furthermore, a higher rating was given to the emphasis on spirituality in their educational programmes. However, there was no significant difference in relation to the didactic content or what was offered in the clinical setting of the different types of programmes (Meyer 2003). This suggests that there may be some difference in the delivery adopted by the educational staff involved, and/or the spiritual conviction of staff, as well as

students. Catanzaro and McMullen (2001) are of the opinion that if teaching staff are comfortable with the language of religion and spirituality they are more effective in communicating the importance of the same to their students, a view also supported in a study by Van Leeuwen et al (2008). Nonetheless, the emphasis on spirituality in the programmes seemed to be the key factor in relation to students' perceived ability to deliver spiritual care. So in terms of spiritual awareness, whether students were from a religious or non-religious institution does not seem to make a huge difference.

Spiritual awareness and spiritual care in practice were the focus of a qualitative study in Singapore (Tiew and Drury, 2012). Sixteen final year student nurses of religious and non-religious persuasions from three educational institutions formed the research sample. In-depth face-to-face interviews were conducted concerning perceptions and attitudes about spirituality and spiritual care in practice. The data when analysed identified three themes: 1) students' perceptions of spirituality – spiritual care was perceived to be universal, innate, uniquely individual, and individually defined, an integral and vital part of one's being. An association of spirituality with holism was made with the thought that without it we are not considered whole. 2) Spiritual care – attending to spiritual needs called for an understanding of the patient's spiritual perspectives, and possessing that awareness leads to spiritual assessment, which initiates spiritual care, an opinion supported by Swatzky and Pesut (2005). Also, the students' view of spiritual care was considered to be ambivalent, which echo the complexity of this topic. 3) Factors influencing spiritual care in practice – there were suggestion that students who lacked spiritual awareness were unable to

appreciate the importance of spiritual care. However, as indicated in a study by Baldacchino (2006), some participants expressed concerns and discomfort about providing spiritual care to patients whose spiritual beliefs were different to their own. There was also concern that they may be misconstrued as taking advantage of the patient's vulnerability to promote their personal spiritual or religious beliefs. But other participants did not see these differences as affecting their efforts to provide spiritual care. Another important finding was that all participants thought that spirituality education in their nurse programme was inadequate, low in priority, and dispensable. Furthermore, as Ross (1997) asserted, the ward culture could either encourage or discourage spiritual care.

However, this was a small study and a year later Tiew et al (2013) conducted a large quantitative survey involving 745 final year student nurses in Singapore, to investigate perceptions of spirituality and spiritual care, using a Spiritual Care-Giving Scale (SCGS) (Tiew and Creedy, 2012). The SCGS was devised to be culturally relevant, and look at factors such as: attributes for spiritual care, spiritual perspectives, defining spiritual care, spiritual care attitudes, and spiritual care values. The findings affirmed the importance of spiritual awareness as a prerequisite for nurses to facilitate patients' spiritual needs (McSherry et al., 2004, Pesut and Reimer-Kirkham, 2010). What was also evident was a heightened sense of awareness, but strangely the research respondents did not recognise spiritual assessment as an aspect of spiritual care. The overall results suggest that for spirituality education to be more effective there should be a varied teaching approach for example, individual reflection, experiential activities

and small group discussions in the clinical setting. Furthermore, this could involve learning in the community.

In a South African qualitative phenomenological study, du Plessis et al (2013) explored the experience of 18 final year student nurses on family placement within a faith community. The purpose was to gain practical experience in psychiatric community nursing and to promote the mental health of the families. Preparation for this placement consisted of a theoretical module and a two week psychiatric nursing skills course. All the study participants and the families were of the Christian faith. The data consisted of comprehensive reflective reporting after the visits, and the themes were clustered into three groups: 1) initial challenge of the home visits before experiencing competence, 2) an awareness of both religious and cultural factors, and 3) specific perception for their role in providing spiritual care. It was also reported that the nursing students did not explicitly assess the spiritual dimension or the culture of the family. However, it was recognised that spiritual care occurred indirectly as a part of their role in caring with respect, active listening and empathy, similar to that suggested by Clarke (2013). Nevertheless, the researchers concluded that the notion of such indirect response could result in some spiritual needs being overlooked. So it is a necessity for some form of spiritual assessment in order to have a better idea of the patient's spiritual needs, and then respond appropriately with spiritual care.

2) Spiritual assessment

Spiritual assessment provides information about any interventions that would help a patient to cope with the healthcare issues they may be facing (Muncy,

1996, Young and Koopsen, 2005, McSherry and Ross, 2010), providing a deeper understanding within holistic care (Young and Koopsen, 2005). However, Ross (1997 p.39) informs that sensitivity is crucial:

“Having carers sensitive to the cues patients display is, perhaps, of paramount importance. If cues remain undetected the underlying spiritual needs cannot be met. This raises the issue of spiritual assessment”.

Therefore, before attempting to address patients’ spiritual needs, some form of spiritual assessment is useful. But this activity may be challenging because of the ambiguous nature of spirituality (Boutell and Bozett, 1990b, Narayanasamy, 1991), in that it is very subjective and means different things to different people. Nevertheless, a number of nurses do engage in some form of spiritual assessment (Boutell and Bozett, 1990b). However, over time, a number of nurse researchers have focused on spiritual assessment in nursing care (Rumbold, 2007, McSherry and Ross, 2010, Bennett and Thompson, 2015). Aspects identified as most frequently assessed were fears, sources of strength, and feelings of hope; whereas the unifying force in self and transcendence which are more abstract concepts and difficult to capture were less frequently assessed. Interestingly, nurses aged 50 to 59 were more likely to carry out spiritual assessment, although there seems to be no definite reason for this (Boutell and Bozett, 1990b). But psychiatric nurses tended to exceed the performance of nurses in the general areas, and this may be attributed to them being able to spend time in quality interaction with their patients. It could be that nurses were more likely to consider spiritual matters in less acute areas compared to critical care units where time and demanding physiological needs take priority (Boutell and Bozett, 1990b).

Yet Govier (2000) recommends adopting a systematic approach to assessing spiritual well-being, even though Brush and Daly (2000) acknowledged the fact that some nurses felt uncomfortable or unprepared to discuss topics of a religious or spiritual nature, thus confirming the view by McSherry (2010) relating to evidential uncertainties about the quality, governance and provision of spiritual assessment. Even so, Callister et al (2004) suggests that it is necessary to learn how to assess spiritual needs in order to plan appropriate care interventions. But as already mentioned by Ross (1997) it is the nurse's sensitivity to cues displayed by patients, not the assessment procedure itself that is important. Therefore, informal assessment is desirable (Bennett and Thompson, 2015), as well as learning skill to formally assess spiritual wellbeing.

Hoffert et al (2007) in the USA undertook a quantitative research project looking into 'Enhancing the ability of nursing students to perform a spiritual assessment', so that they would recognise, respect, and facilitate the spiritual needs of clients. The premise was to address 4 barriers believed to affect provision of spiritual care: 1) Nurses' uncertainty of their spiritual role as a result of inadequate spirituality education in their nursing programme, 2) lack of awareness, uncertainty or discomfort with personal spirituality, 3) confusion about religion and spirituality, and 4) discomfort in using spiritual assessment tools. Accordingly, based on the concept that spiritual growth is a 2-directional (horizontal and vertical) process, the researchers designed a 'Client Spiritual Assessment Tool' which was easy to use, and adaptable to individual needs. Additionally, questions and observations were included for in-depth spiritual assessment.

A convenience sample of 38 first year students of various spiritual beliefs and ethnicity from a religious-affiliated institution completed a pre-test and post-test survey. This survey followed a seminar about spirituality in nursing which included: opportunity to discuss the importance of assessing and providing spiritual care in nursing, and differentiating between religion and spirituality. The findings were that the educational programme made a difference in students' knowledge and comfort with performing spiritual assessment, and this positive outcome was not reliant on the students' previous educational experience, religious affiliation or ethnicity. Thus the conclusion was drawn that spirituality is complex and perhaps intimidating, therefore specific education and experience is required to build competence and confidence, a view supported by Greenstreet (1999) and Narayanasamy (1999c). However, there was no indication that the knowledge gained for spiritual assessment was sustained in practice.

Furthermore, another USA study was carried out by Graham (2008) to explore the preparedness of nursing students to assess patients' spiritual needs. This mixed method study in a Midwestern Christian Bachelor of Science in Nursing Programme, involved 24 senior student nurses. This study was similar in some ways to that carried out by Hoffert et al (2007), but this time involved the completion of a Spirituality Assessment Scale (O'Brien, 2008), before and after a four hour spirituality seminar. The seminar covered religion and spirituality, assessing patient's spiritual needs, and providing spiritual care.

In addition, the qualitative component in this study took the form of an interview questionnaire.

The results showed that some positive effects on the students' nursing care were gained from their personal beliefs, as well as affirmation from colleagues. They were now able to recognise that, simple actions such as, 'presence', constitutes spiritual care (Jackson, 2004). But although the participants felt that there was insufficient emphasis on spirituality in nursing education and clinical practice, which concurs with conclusions by Callister et al (2004), McSherry and Jamieson (2011), they recognised the necessity of assessing patients' spiritual needs (McSherry and Watson, 2002, Cavendish et al., 2004), and the importance of learning spiritual competence for spiritual care (Van Leeuwen and Cusveller, 2004). Again there was no evidence that the knowledge gained was sustained throughout their practice. However, an exploration of spiritual competence follows.

3) Spiritual Competence

Nurses need to acquire relevant competences to practice as registered practitioners, (Nursing and Board, 1997, DH, 1999, ICN, 2012, NMC, 2008b, NMC, 2010a, NMC, 2015). Moreover, Van Leeuwen and Cusveller (2004) suggesting that spiritual care is related to all facets of a nurse's competence, and that it is not a stand-alone activity but an integral part of regular nursing care. Research relating to spiritual competencies in nursing and holistic care is sparse. However, Meyer (2003) is in agreement with Harrington (1995), that the strongest predictor of perceived capacity to provide spiritual care results from a student's own personal spirituality; yet from studies by Baldacchino (2008a), and Attard et al (2014), it would appear that students as a result of knowledge and skills from their targeted course gained competence to deliver spiritual care.

The concept of clinical competence in general originated in North America (Calman et al., 2002), and the literature reveals that competence is an important factor in student learning and assessment in the UK, United States and Australia; with clinical competence assessment forming a large part of students' assessment within pre-registration nurse education programmes (Farrell and Timmins, 2008). However, student assessment for competence in spiritual care is not apparent. The NMC (2010a) defines competence as a combination of skills, knowledge and attitudes, values and technical abilities necessary for safe and effective nursing care, and thus is a necessary requirement for entry to the NMC register. So research relating to spiritual competencies in nursing is of great relevance.

To ascertain the effectiveness of nurse education for competence development, Van Leeuwen et al (2008) carried out two studies in the Netherlands. Firstly a quasi-experimental longitudinal study involving 97 Christian student nurses from two Christian nursing schools. Half the participants formed the intervention group and were assigned to clinical placement; while the control group followed a six week educational programme on spiritual care (based on a nursing competency profile for spiritual care). After six weeks the groups swapped over. A questionnaire with items from the Spiritual Care Competence Scale (SCCS) (Van Leeuwen et al., 2007), covering all the main nursing competencies, was completed by all participants on three occasions; at baseline, six weeks from commencement of the research and again at the end of the research after the cross over period.

At the beginning of the study there were no statistically significant differences in the students' self-assessed competencies, but after six weeks students in the control group differed in their perceived competencies in relation to three aspects: professionalisation and improving spiritual care, referral to professionals and attitude towards the patient's spirituality. However, at the conclusion of the study and after four months the intervention group perceived themselves to be more competent and the researchers attributed this to the time they had to internalise spiritual care needs. But the researchers also raise the question as to whether students are really competent if they perceive themselves as competent (Van Leeuwen et al., 2008). It is possible that this perceived competence could be an indication of increased self-confidence, and raises the question of how best to measure spiritual competences, but this may not be realistic as according to Van Leeuwen and Cusveller (2004) this aspect is a part of other nursing competences.

However, the findings do not totally agree with other research, revealing that spiritual competence development could also result from undertaking a standard educational programme, and not directly as a result of a course in spiritual care (Pesut, 2002). What was also discovered in the Van Leeuwen et al (2008) study was that the students' own personal beliefs were strong enough to lead them to interpret religious aspects of spirituality that were not specifically spelt out in the course. This draws attention also to the relevance of possible differences in spiritual values, attitude and motivation that may exist among teaching staff which could affect teaching delivery. In addition, there was the spiritual disposition of students, and the importance of recognising these values (Shih et

al., 2001). The study further reinforces the suggestion that a nurse's own spirituality influences their awareness and competence to provide spiritual care, which was suggested by (Meyer, 2003).

It is likely that the results of this study could be limited by the strong Christian background of the students. Additionally, students probably chose to attend either of these two faith based institutions in line with their spiritual beliefs and aspirations; a factor which could also positively influence the research results. The overall conclusion is that education has an impact on students' development of perceived competencies for spiritual care, but spirituality and spiritual care is mainly presented as theory and does not have an established place in the clinical component of the nursing curriculum.

A qualitative study conducted a year later by Van Leeuwen et al (2009a), also looked at developing student nurses' competence in providing spiritual care, by analysing students' reflective peer-review journals. Reflection according to Gibbs (1988) is an everyday process of events and experiences, but this can be structured when formally adopted for educational learning purposes. Thus, reflective journals to provide qualitative document analysis for peer-review were completed by 39 3rd year nursing students from two Christian nursing schools in the Netherlands. The journal entries revealed that their personal experience served as a reference point for reflection on spirituality in nursing practice, and the following dimensions were identified: 1) handling one's own spirituality - students showed insecurity, especially their own Christian identity. Some students with strong Christian beliefs felt supported by their faith and would like

their patients to have this experience, but were aware that evangelism was not part of the nurses' role; 2) Coping with feelings of uncertainty - at times they were afraid of saying the wrong thing when communicating with patients, and were aware that they should not impose their opinions on patients, so they suppressed their own faith when supporting patients with different beliefs. This raises issues of conflict between personal convictions and professional practice, similar to findings by McSherry and Jamieson (2011).

Spirituality may present as a difficult concept for reflective thinking not only because of its subjectivity, but it is thought that education in spiritual care creates very personal questions and ethical dilemmas (Van Leeuwen et al., 2009a), which may affect nurses' provision of spiritual care. Accordingly, the researchers consider that nursing education in spiritual care need to focus on raising awareness of the nurse concerning motives, objectives and expectations. Once more this study although useful should be viewed with some caution, as all participants were enrolled at Christian universities, so they probably have a particular interest to further develop their own spiritual beliefs and capabilities.

In contrast, and for the first time, an innovative learning opportunity was offered to six 3rd year adult branch students from a UK University, involving participation in a two-week placement with seriously ill and disabled people in Lourdes (Purdie et al., 2008). The overall aim was to increase their holistic caring skills. Lourdes is a famous town in the foothills of the Pyrenees that is a major place of pilgrimage for Roman Catholics.

This research project involved experiential learning which focuses on the role experience has in the learning process. Students kept a diary throughout this placement to record relevant issues, incidents and activities, in order to provide a reflective reference during focus groups. According to Holloway and Wheeler (2000), focus groups consist of people coming together with a commonality of experience to extract ideas, thoughts and perceptions on a particular issue.

As a result of the focus groups it seemed that students' insight into the nature of caring was developed, their listening skills improved, and spirituality and trust increased. This development was assisted by the high ratio of 'support staff' to pilgrims (14/10) which included registered nurses, helpers (the student nurses replaced two helpers), a doctor and a chaplain, as well as more time with the pilgrims. They interacted with Pilgrims on a regular basis, and the students emphasised that they had time to develop trusting meaningful relationships, improve their listening skills, understanding of compassion, and holistic care.

Two years later in a similar study from the University of Malta, Baldacchino (2010) involved a group of 7 undergraduate students who took up the offer of a placement in Lourdes. Although there were 31 students in total following a particular study unit, the other 24 did not form part of this research, and had alternative ward placements. The placement in Lourdes was intended to promote the delivery of spiritual care while assisting sick pilgrims. Similar to the Purdie et al., (2008) study, students were given theoretical input, as well as reflective diaries to complete for use later during focus group interviews.

The four themes that emerged were: 1) Team work - students engaged in team building and developed a sense of belonging; 2) holistic care - they met clients' physical and spiritual needs as well as participating in religious services; 3) trustful nurse-client relationships - which developed as a result of cooperating with time schedules as well as clients' being able to share their personal problems and life achievements; and 4) personal spirituality was strengthened - with the opportunity to give and receive in terms of care and learning (Baldacchino, 2010). Again the high carer to client ratio, having more time, and dedicated role models contributed significantly to the learning experience. The conclusion drawn was that this experiential learning experience concurred with the above findings from Purdie et al (2008). However, although these studies were very small, they suggest that students' competence to deliver spiritual care does not rest predominantly on classroom education, which is supported by Tiew et al (2013), but should be put together with particular focus in the clinical setting, and the opportunity to reflect on spiritual care activities to achieve a total learning experience.

Nonetheless, these two studies have a number of significant limitations for nurse education and could not be replicated on a wide scale for the following reasons: 1) the high ratio of nurse to patient, 2) the impossibility to offer such an experience to a large group of students, 3) some students would not wish to be involved in such a strong religious activity, 4) the religious bias, 5) the huge amount of time afforded to one patient/group of patients. So the majority of spirituality education for student nurses may still lie within the confines of their local academic establishments.

More recently, a European quantitative pilot study by (Ross et al., 2014) aimed at developing spirituality teaching, looked into undergraduate nurses'/midwives' understanding of spirituality/spiritual care, and their acquisition of competence to deliver the same. This study involved 4 countries (Wales, Netherlands, Malta, and Norway) and 531 students from both religious and non-religious universities. Questionnaires were used to collect data on: spiritual well-being (JAREL, Hungelman et al., 1996); spiritual attitude and involvement (Meezenbroek et al., 2008); perceptions of spirituality (SSCRS, McSherry et al., 2002); and spiritual competence (SCCS, Van Leeuwen et al., 2009). The results revealed that the majority of respondents rated themselves highly on spiritual well-being (71.9%), just over half indicated high spiritual attitude/involvement (53.9%), spirituality/spiritual care were considered important and were perceived in broad terms, and 74.4% of respondents thought they were competent in delivering spiritual care. However, respondents felt less competent about spiritual assessment. The researchers commented that if nurse/midwifery education programmes addressed these areas then competency may be enhanced, thus confirming other early findings (Narayanasamy, 1993).

More findings from the same study were published later (Ross et al., 2016), and identified the factors contributing to undergraduate nurses'/midwives' perceived competence in giving spiritual care. It was found that perceived spiritual care competence was connected to the students' broad perception of spirituality and spiritual care, also students who were actively religious perceived themselves more competent in spiritual care. However, learning from nursing text together

with clinical practice for developing competence formed the basis of the following study.

In Iran Frouzandeh et al (2015) conducted a study using a pre-post interventional quantitative method, highlighting competence for spiritual care in the light of patients' perception and culture. A spiritual care training course was undertaken by 30 senior nursing students to determine self-efficacy in providing spiritual care for patients. The research was in three stages: 1) four two hour sessions in the classroom focussing on books covering topics such as: understanding spirituality and spiritual care, being aware of spiritual tension during illness, identifying the spiritual needs of patients, designing holistic caring programs; 2) clinical experience assessing the spiritual health of the patients, and then preparing the nursing process to provide spiritual care; 3) small group discussions about the care plans students had prepared, followed by completion of a questionnaire. Analysis was by Statistical Package for the Social Sciences (SPSS), as well as descriptive statistics (mean and standard deviation), and inferential statistics (paired *t*-test). The results showed a high level (21.1) of self-efficacy post-test, compared to lower level (13.74) pre-test. The findings showed that having completed the spiritual care training course, the self-efficacy of the nursing students increased in providing spiritual care for patients, which confirms similar positive results from a study by Van Leeuwen et al (2008). The conclusion is that nursing students can develop further efficacy for providing spiritual care to patients as a result of spirituality education both in the classroom and the clinical areas.

Nevertheless, if nursing is considered a spiritual activity, everything a nurse or midwife does could potentially be spiritual (Clarke, 2013). Furthermore, there is no benchmark for competence in spiritual care, so it is not clear what is meant to be understood when one perceives themselves as being more competent, a question raised in the Van Leeuwen et al (2008) study. Clearly, more investigation in this area is needed to inform a better understanding.

4) Spirituality in pre-registration programmes

Nurses are educated to deliver effective, efficient and safe evidence-based care, which necessitates the acquisition of relevant competences to practice as a registered practitioner (DH, 1999, McSherry, 2000a, NMC, 2008b, NMC, 2010a). Furthermore, Van Leeuwen and Cusveller (2004) as noted earlier, believe that spiritual care is related to all facets of a nurse's competence, therefore it becomes an integral part of everyday nursing (Clarke, 2013). However, the question of how best to introduce spiritual aspects into nurse education programmes remains mainly unanswered (Narayanasamy, 1993, Greenstreet, 1999, McSherry, 2000a, Mitchell et al., 2006, Pesut, 2008b, O'Shea et al., 2011). Given that spirituality is included in holistic care and nurses are required to practice in this way, tensions arise from a secularization point of view. Paley (2008b) argues that nurses should not be obliged to undertake spirituality education because it may increase their discomfort about the topic. Furthermore, he suggests that nurses may benefit more from, "education in the psychology of false, but resolutely optimistic beliefs, would be both more edifying and more evidence-based" (Paley, 2008b p.11). Nevertheless, this view seems narrow, as studies have shown that nurses are in favour of receiving spirituality education

to equip them to meet the spiritual needs of patients in a better way (Ross, 1996, Baldacchino, 2008b, McSherry and Jamieson, 2011).

A UK investigation into the ethical basis for teaching spirituality was the focus of the first year of a three year survey conducted by McSherry et al (2008). The rationale for this investigation was based on the professional requirements for student nurses to deliver competent spiritual care, so students across all branches of nursing (adult, mental health, learning disability and children) were included. The 143 first year students nurses completed a questionnaire which included the Spirituality and Spiritual Care Rating Scale previously developed by McSherry et al (2002). However, in order to gather information relating to the ethics of teaching spirituality other randomly placed questions were incorporated into the questionnaire.

The results showed that in relation to perceptions of spirituality - most students (male and female) made links between spirituality and existentialism (meaning, purpose and fulfilment in life), they also felt that spirituality was relevant to everyone. However, there was a negative difference of opinion for students who had more qualifications. Perhaps the intangible nature of spirituality was overshadowed by the more tangible and scientific aspects of nursing. But studies have shown that senior students are more able to embrace the concept of spirituality and spiritual care (Boutell and Bozett, 1990b). Overall the students considered that spirituality was relevant to religious and non-religious people. Additionally, students felt that they had a right to form their own views about spirituality and lecturers should not pass judgement on that. Having said this,

students thought they should be taught about spirituality. The conclusion seem to be that spirituality education is welcomed by students as long as they are free to hold their own views, which is quite positive. However, Swinton (2006b p.921) draws attention to a suggestion by Walter (2002) that spirituality education could be a form of indoctrination if educators with their own agenda confine the topic within narrowly defined parameters. So moves to integrate spirituality education into undergraduate curricula, with the intention of improving knowledge and attitudes is considered challenging (Baldacchino and Draper, 2001, Pesut, 2002, Linda et al., 2015).

But this was the aim of a mixed methods investigation in the USA by Wallace et al., (2008). Sixty seven participants were involved in this one-time sample of 33 junior and 34 senior students, on a spirituality course which included both classroom and clinical placement. The study revealed some significant differences in pre and post-test scores of spirituality and spiritual care knowledge and attitudes for junior and senior nursing students following integration of spirituality into the undergraduate nursing curricula. This finding may be an indication of the time needed to assimilate and internalise the various aspects of spirituality as previously alluded to by Van Leewen et al., (2008).

On the evidence of pre-test and post-test scores using the SSCRS (McSherry, 2000b) to measure students' knowledge of spirituality and spiritual care there, was an increase in agreement that spirituality is not just about a belief and faith in God or a Supreme Being. This was attributed to the students' awareness of different ways of addressing spiritual issues, representing a broad view as

indicated in the study conducted by Pesut (2002). However, less agreement existed among junior students' perception that, arranging for the hospital chaplain to visit or the patient's own religious leader constitutes provision of spiritual care. Nevertheless, spending time with a patient giving support and reassurance, enabling them to find meaning and purpose in their illness, listening to and allowing patients to discuss and explore their fears, anxieties and troubles, also respect for privacy, dignity and patients' religious/cultural beliefs, were all perceived within this broad context as providing spiritual care. In addition, the students thought spirituality did apply to individuals who were atheists or agnostics. But on the other-hand, they did not think art, creativity and self-expression had anything to do with spirituality, which is an interesting comment and runs contrary to a study by Mooney and Timmins (2007).

When Olson et al., (2003) decided to look closely into the extent to which the spiritual dimension is addressed in Canadian university undergraduate programmes, they adopted a qualitative exploratory descriptive design, involving 18 schools and 39 members of staff. Questionnaires were completed with the flexibility to determine how to gather information from their teaching colleagues in the same year programme.

As a result, 26 respondents stated that the term spiritual dimension was not defined in their education programme, and only 4 reported that students and lecturers were encouraged to define this term. However, some confusion existed about the relationship between religion and spirituality, consequently the spiritual dimension was often hidden under concepts of culture, healing or psychological

dimension. Nevertheless, 13 respondents had a definition of the spiritual dimension, but opinions did vary on the importance of addressing this in their programme, which does not encourage promotion of a culture of holistic nursing care. For the majority of schools (11) there were course objectives addressing the spiritual dimension for example, identifying mutual assumptions about spirituality, description of common spiritual struggles of dying persons, and outlining the elements of spiritual assessment. However, the integration of theoretical and clinical teaching was considered by the researchers to be haphazard, which may have practice implication for students.

This investigation was small in terms of a national study for Canada, but revealed that some institutions are aware that spirituality needs to be included in their curricula. Overall it would appear that the inclusion of spirituality in nurse education programmes has not progressed to any significant degree internationally.

With the aim of exploring how spirituality was being taught, Lemmer (2002) undertook a survey involving 250 randomly selected respondents from baccalaureate nursing programmes in America. As well as demographic data which asked for region of the country, and whether the institution is public or private, religious or non-religious, faculty members (lecturers) completed the survey for a 25 items Likert scale covering teaching on spiritual care. There was also a 13 item checklist of teaching methods, a 14 item Likert scale relating to attitudes that may influence teaching spirituality content, plus two open-ended questions to supplement information gained from the scales.

The majority of programmes (81.5%) included the spiritual dimension which was integrated throughout the curriculum, and the most frequently used methods for teaching were classroom based. And there was no significant difference among the programmes in relation to the amount of time assigned to teaching spirituality. Twenty-one (15.9%) programmes offered an elective spiritual care course.

Even though religion and spirituality were not thought to be synonymous, it is surprising that only 5 programmes offered a definition of spiritual care, even though many of the programmes included the spiritual dimension. In terms of attitudes, most programmes believed that spiritual care was a part of nursing care and more significantly, that it can be taught. However, the conclusion drawn was that teaching staff have an important part to play in nurses' understanding of their role to deliver spiritual care. This concurs with the opinions of Catanzaro and McMullen (2001), and Van Leeuwen et al (2008). However, this study only took into consideration the views of the teaching staff, and feedback from students enrolled in the nursing courses at these institutions may have made a useful contribution to the survey.

When considering the nature of spirituality in senior baccalaureate nursing students, Nardi and Rooda (2011) chose a mixed-methods study involving 86 senior nursing students from two American programmes, one public and the other a private faith-based university. Seventy nine percent of all participants were Christians, being either Catholic or Protestant.

The research instrument consisted of a spirituality scale questionnaire devised by the researchers, to determine the degree to which the participants were aware of spirituality and their use of nursing strategies to address patients' spiritual needs. Furthermore, it is noted that the curriculum of the faith-based university did include a course which focused on spirituality and spiritual caring in the first year of the programme, but this factor did not seem to affect the outcome of the investigation.

Most participants agreed that spiritual care was a basic part of nursing and that caring for the spirit is equally important as meeting other needs. Additionally, awareness of one's spirituality was an asset for supporting patients' spiritual needs as indicated previously by Baldacchino (2008a). Overall 5 aspects of spirituality-based nursing practice were found: Valuing and supporting others, the use of spirituality-based nursing process, use of the metaphysical self, individual spirituality-based actions, and spirituality-based outcomes. The overall findings suggest that correct awareness of the spiritual needs of patients will result in effective spirituality-based nursing care for example, presence, assessment, facilitation (Nardi and Rooda, 2011). But the notion of efficacy was the basis for the following investigation.

Efficacy of a self-study programme to teach spiritual care was the attention of Taylor et al., (2008) to enable nurses to talk with patients in a spiritually healing way, as well as investigate how such learning develops. Quantitative data were gathered over 7 months from the 201 participants enrolled at both a religious and a non-religious institution. In this pre-test/ post-test pre-experimental design,

students were issued with an interactive workbook which gave them the opportunity to practice skills, test understanding or gain personal insight. In addition, an optional DVD to summarise the main points in the workbook was available.

The results showed an increase in attention by students to spiritual care, and the ability to create an empathetic response to patients' spiritual experience or spiritual pain. The indications seem to emphasise that spiritual care is more to be taught, rather than caught as suggested by Bradshaw (1997), where a nurse learns from the example of a teacher/mentor/role model. The researchers concede that as this study was not longitudinal, it is unknown how well the students would retain the attitudes, skills, and knowledge from this programme of study.

Burkhardt and Nagai-Jacobson (2002) suggest that there is room for a person's spirituality to be expressed through the creative arts. So in adult nursing, learning spirituality through the medium of art was an innovative investigation in the Republic of Ireland that engaged Mooney and Timmins (2007). Given that there is no concrete definition for spirituality and the difficulties of teaching large groups of undergraduate student nurses, a course was devised to enhance students' engagement with the concept of spirituality by exposing them to art work in a gallery.

Spiritual themes given to the students served as prompts for the selection of a piece of art work that they perceived to be spiritual in nature, which they then

had to write the reason/s for their choice and discuss in a focus group at a later stage. As a result of this exercise 5 themes emerged: Recognising spiritual dimensions of everyday life for example, love, hope, happiness and suffering; a snapshot of spirituality through others' impressions of art - the varied interpretations of their colleagues' choice; developing a deeper awareness of the meaning of spirituality - thinking about spirituality in new ways; spirituality transcends traditional religions - separating religion from spirituality; and spirituality-enhancing the nurses' role - the course served to increase these skills.

So this teaching course offered students the opportunity to reflect on their own understanding of spirituality and develop a deeper awareness of its meaning. It also allowed them to understand how spirituality goes beyond religion and gave them the opportunity to express their feelings of spirituality. It would appear that this experience of spirituality through art was liberating for the students involved, as they were given the freedom to interpret and express their impressions, which bears similarities to some of the findings in the Mitchell and Hall's (2007) study with midwives to be looked at next.

Although the care needed by service users may be administered by particular sections of the NHS as appropriate, yet the general values, principles and guidelines for care apply right across the board. Equally, the same can be said for all nurses to practice in a holistic way in all branches (NMC, 2004, NMC, 2010a). Thus a UK research project by Mitchell and Hall (2007) concerning teaching spirituality to student midwives adds to the debate in this area. The

researchers acknowledged that a philosophy of holistic care for women should underpin education of student midwives, and that midwives should understand the concept of spirituality and how it impacts on pregnancy and childbirth.

Mitchell and Hall (2007) acknowledge that spirituality has received minimal attention in midwifery discourse, education, and research. Consequently the researchers developed a creative educational approach utilising, video, music, aroma, and storytelling, together with the opportunity for students to express themselves through art. The researchers believed that the students as well as being intellectual should be encouraged to explore creative aspects to broaden their thinking.

Thus Mitchell and Hall (2007) used a purposive sample of 16 student midwives in a retrospective exploratory investigation, where they completed a questionnaire after the classroom session with the components as stated above. They also reflected on and wrote about their views and experiences on: spirituality and birth, the creation of birth art, also the teaching and group sessions.

From the findings, student midwives recognised that it was important to learn about spirituality in relation to birth, also that increased awareness of the spiritual dimension of birth could impact on and improve their practice. Students found that using creativity to explore the concept of spirituality was beneficial in raising issues of spirituality surrounding birth. In conclusion the researchers commented that traditional approaches adopted by educators in the academic culture are not necessarily the best. Moreover, this comment may be a useful encouragement

for further innovative teaching and learning strategies for spirituality education in nursing programmes.

Another innovation but this time in the USA was a pilot study, '*The use of simulation to instruct students on the provision of spiritual care*' (Costello et al., 2012). A convenience sample of 52 students participated in this quantitative study, using a pre-test/post-test design to determine whether simulation would increase the participants' perceived competence in providing spiritual care. After written information and discussion of case study examples of providing spiritual care, the participants were given a scenario and engaged in a 2 hour session in the simulation laboratory. The students were assessed before and after the intervention using the SCCS (Van Leeuwen et al., 2009b), which measured attitude toward patient spirituality, communication, assessment and implementation of spiritual care, referral, personal support and patient counselling, professionalization, and improving the quality of care.

The findings revealed a statistically significant increase in the participants' perceived spiritual care competency after the simulation session. The students were more aware that spirituality was a part of the patient's experience in a variety of situations, and they felt more able to discuss spiritual matters. The researchers suggest that the inclusion of spiritual care in simulation scenarios is a useful and easy way of incorporating this concept into nurse education programmes.

Nevertheless, traditional classroom teaching which forms a substantial proportion of nurse education programmes, was the environment for the Seymour (2006) Scottish project investigating nursing students' experiences of spiritual education. This is an unpublished thesis in which the researcher focused on the value of classroom teaching and whether students thought this environment developed their understanding of spirituality and spiritual care. Two questions which reflected a shortfall in nurse education were being asked in this project: 1) was it possible to learn about spirituality and spiritual care in the classroom? And 2) what understandings, if any, did students have of spirituality? Accordingly, the aims of this qualitative case study involving 54 students were: 1) to design a spirituality course suitable for the stages of their educational and professional development; 2) explore students' understanding of spirituality and spiritual care as a result of the course; 3) scrutinise student nurses' personal and professional interpretation of spirituality; and 4) examine what personal abilities students thought they needed to provide spiritual care. The investigation consisted of the following components: Nominal group technique, evaluation of questionnaire, journal writing, reflective group interviews and lectures.

The course gave students the opportunity to discuss and explore the meaning of spirituality and spiritual care which they did not have in clinical practice. In addition, they learned from the spiritual care experiences of their colleagues which helped them to reflect on how they had met spiritual needs in the past. The main conclusions of this study are, a) that spirituality and spiritual care can be learnt in a classroom environment, b) students appreciated that the teaching increased their understanding of spirituality and spiritual care, c) understanding

about spiritual needs and their importance, and d) the challenge of providing spiritual care.

Likewise, the enhancement of knowledge and understanding among student nurses of spiritual care was the aim of a spirituality-focused project undertaken by Lovanio and Wallace (2007). The researchers used a pilot program which had the potential to be implemented in the curriculum. They selected 10 nursing students in their first clinical experience who had an interest in spirituality to participate in the study which involved a pre-test/post-test evaluation. In addition, 10 residents in a faith-based long-term care home were paired with the 10 students. A 3-hour presentation about spirituality in nursing was given to the students, and they attended a weekly clinical conference which gave them opportunity to discuss for example, definition of religion and spirituality, holistic nursing, and interventions they had implemented. Pre-test and post-test evaluations were done using the SSCRS (McSherry et al., 2002).

The results showed that students were emboldened to put into practice a number of interventions with their residents such as, prayer, music meditation, walking outdoors, and they also kept a reflective journal for the duration of the project. Overall the project was effective and served to broaden the students' concept of the individual nature of spirituality. There was also an increased awareness for spiritual care. Hence, the researchers initiated plans to integrate the same course in future programs. Although this pilot project yielded positive results, it is limited by the small non-random sample of participants linked to a faith-based clinical setting. However, these findings are relevant as to the importance of

further studies to examine spirituality education in a variety of non-faith based settings.

One such non-faith based institution research '*Measuring effectiveness of a spiritual care pedagogy in nursing education*', was carried out in the USA (Burkhart and Schmidt, 2012). This was a quantitative investigation in which 59 student nurses were randomly assigned to a control or intervention group. All students would be involved in a 6 week practical placement, but the intervention group would also complete the spiritual care educational and reflective programme (SCERP), consisting of face-to-face and an on-line components. In addition a pre/post-test survey would be carried out for the clinical placement. Data were collected using four survey instruments: a demographic data sheet, the Spiritual Care Inventory, the Spiritual Care in Practice survey, and the Spiritual Well-Being Scale (Paloutzian and Ellison, 1982b). The initial analysis comparing the control and intervention pre-test survey scores did not show statistically significant differences in spiritual, religious or existential wellbeing. However, in the intervention group there was a statistically significant increase in providing spiritual care, thus supporting the effectiveness of a spiritual care educational and reflective programme, as part of a clinical placement. The intervention also increased spiritual awareness of patients' spiritual need in everyday practice. This is yet another example of positive outcomes from not only academic spirituality education, but the added benefits when linked to practice.

The perceptions of how student nurses learn to assess and provide spiritual care was the attention of a Norwegian investigation by Giske and Cone (2012) using grounded theory. Focus group Interviews were conducted with 42 student nurses from three Norwegian universities in all three years of the course, to share their thoughts about three questions: what is spiritual care? How do you learn to assess and provide spiritual care? and, Tell us about your experiences related to spiritual care?

What transpired as the participants' main concern was "how to create a professional relationship with patients and maintain rapport when spiritual concerns were recognised"; they resolved this by the theory "opening up to learning spiritual care" (Giske and Cone, 2012 p.2006). This theory consisted of an interactive spiralling process of spiritual care involving, a) preparing for connection - life experience was recognised as playing a valuable part in students' learning, together with teaching and discussions with other students on the course; b) connecting with and supporting - students were aware of their own vulnerability and that of their patients, and they realised that patients may have certain conditions that could influence the urgency of spiritual concerns. Consequently it was important to support patients respectfully; c) reflecting on experiences - thinking through various actions of spiritual care and being able to share this with their colleagues and teaching staff. It is seen that as the profile of spirituality is raised in the learning opportunities given to nurses, with the assistance of appropriate tools, then both nurse and patient benefit.

What helps nurse educators feel more prepared to meet the challenge of educating nurses to provide evidence-based, non-intrusive spiritual care was the focus of a small Canadian investigation by Barss (2012). An interpretive phenomenology approach was used to inform and inspire pedagogy by reviewing expressions of lived experience to find their meaning. In addition, this study sought to shed more light on what helps nursing professionals feel better about providing spiritual care. In order to do this Bass (2012) developed a model for inclusive spiritual care named T.R.U.S.T., to explore five domains: 1) Traditions - spiritual/religious practices, individually or in community; 2) Reconciliation - unresolved issues and exploration of how/if these might be reconciled; 3) Understandings - personal beliefs and how they influence well-being positively/negatively; 4) Searching - existential/faith questions prompted by current challenges; and 5) Teachers - spiritual/religious mentors and internal/external resources the individual trusts to help sort through relevant issues (Barss, 2012). The intention of this model is to teach nursing students how to integrate spiritual care into holistic nursing practice.

Only 4 members of the teaching staff where the researcher was employed participated in the study, but she explained that this sample size is typical of phenomenological research which focuses on in-depth inquiry of the lived experience of a small number of individuals. Most of the data were collected through individual interviews and observation, but there was also a 90 minute digital recording of a group session.

What transpired from the investigation was that the participants felt the T.R.U.S.T. model made it easier for students to build rapport with patients about spiritual matters, even with those of a different belief. The model fostered confidence and consistency for student nurses to deliver spiritual care, which to some extent may be the missing link even if students deem themselves competent. So given that in the past nurses tend to be hesitant to address spiritual needs, (McSherry, 1998, Narayanasamy and Owens, 2001, Ross, 2006, McSherry and Jamieson, 2011) the above findings are encouraging.

The task of teaching staff to enable student nurses to realise holistic care was the aim of a Norwegian study using grounded theory, where Cone and Giske (2013) explored teachers' understanding of spirituality and how they prepare undergraduate nursing students to recognise spiritual cues and learn to provide spiritual care. Data were collected from the 19 participants, most of whom were Christians, during five semi-structured focus group interviews. Open ended questions used were: what is spiritual care? How did you learn to give it? How do you teach students spiritual care? And finally, tell us of your experience with spiritual care. The teacher participants' main concern was 'how to help students recognise cues and ways of providing spiritual care'.

The findings revealed that 'Journeying with Students through Maturation' resolved their main concern. This involved: a) raising student awareness of the essence of spirituality - by providing a variety of reading material to do with spiritual care, questioning to recognise spiritual cues, role modelling spiritual care to students in the clinical area, reflection in group discussions and journal

writing; b) assisting students to overcome personal barriers - emboldening students to develop an attitude of openness, respect and tolerance, discussing ways of balancing professional boundaries and personal being, group reflection on ways to handle patients' existential pain, support to stay firm in challenging situations; and c) mentoring students' spiritual care competency – maintaining focus on spiritual care throughout the nursing programme, understanding how to prepare for spiritual encounters, preparing written care plans for spiritual care in the clinical area, supporting collaboration for spiritual care with other professionals, encouraging written reflections and group discussions on spiritual care events, and clinical evaluations that examined spirituality and spiritual care. The conclusion drawn was that it is necessary to be explicit with a continuous input throughout nursing programmes to prepare students to recognise and act on spiritual cues, and this last point was identified some years earlier by Ross (1997).

The following South African qualitative, explorative, descriptive and contextual study was conducted by Linda et al (2015), to examine students' opinions of teaching and learning of spiritual care in the undergraduate nursing programme. Data were collected from 90 students using focus group interviews for the first to final year students. The findings revealed the students' experiences about teaching and learning of spiritual care to be about: 1) Personal inferences about learning spiritual care – spiritual care being addressed mainly in the first year, not in depth and consisted of pieces of information related to loss and grieving, and the religious requirement of various faiths. Another related finding was that final year students could not remember what, when, and how they learned

spiritual care, and this was assumed to be the lack of spiritual care content in the overall nursing programme, which focused on nursing skills competence; 2) Perceived challenges in learning of spiritual care - the students suggested various ways for teaching and learning, but felt that simulation laboratory was unsuitable for acquiring competence in spiritual care, which is contrary to what Costello et al (2012) found in their research. Students commented that very few nursing models dealt with spiritual care, and teachers overlooked the need for caring competences and how students would provide holistic nursing. Furthermore, students requested more support in clinical placements to become more confident, as some areas were 'toxic' and demotivating, because qualified staff appeared at times to have become desensitised to patients' needs; 3) Perceived conflicting nursing perspectives – interference by nursing staff to their practice of spiritual care, perceived professional boundaries conflicting with 'spiritual values'; and 4) students' spiritual and emotional needs - a feeling of reward and self-satisfaction at being able to care for a patient holistically.

The researchers believe that spiritual care completes the essence of caring in the nursing profession. They recommend that efforts should be made to improve nursing practice through application of spiritual care, as this is a missing aspect of holistic nursing.

Although this literature review primarily concerns adult nursing, it is possible that contributions to the debate on spirituality and spiritual care from the other branches of nursing could be useful. There was no relevant spirituality study

from the learning disability branch, but one was found from midwifery (as previously discussed), and one from children nursing now to be examined.

Some insight was given into the spiritual domain in relation to children nursing by Kenny and Ashley (2005). They conducted a UK study into spirituality education of child branch nursing students, acknowledging the paucity of literature in children nursing on this particular concept. As a result, in this quantitative study they used main themes from the adult nursing literature on spirituality, which included: no clear agreement on the definition of spirituality, the search for conceptual clarity, lack of skills for holistic care due to inadequate educational preparation, shortage of staff, shorter hospital stays, lack of privacy and no assessment tools. They thought that all these inhibit the practice of spiritual care in clinical settings.

Twenty one child branch lecturers completed a questionnaire and the answers were compared with conclusions from the adult literature. Certain similarities were found: 1) that spirituality and religion were interchangeable, but spirituality could be expressed through religion; 2) those with a strong religious belief were more likely to engage in religious practices, also 75 percent thought that spirituality was often recognised through emotional care, and in particular death and dying circumstances. Furthermore, emphasis was made that in children nursing the family were considered the 'main drivers' for recognising spiritual needs and realising spiritual care; 3) knowledge of child development, and self-awareness was thought to be important for recognising spiritual care; 4) communication skills and self-awareness was seen as important for spiritual

assessment; 5) spirituality was learnt through seminars, lectures and directed reading, children and families, and private study. Evidently, knowledge and understanding needs are the same regardless of the branch of nursing, and the benefits of spirituality education is similar as revealed in a study by O'Shea et al (2011), however appropriate differences in translation to the various client/patient groups is inevitable.

Summary of main findings

Having reviewed the relevant literature presented in this section, it becomes clear that it is important for nurses to be aware of, understand and acquire competence in matters of spirituality and spiritual care for the wellbeing of patients. The studies included in this review focused on four significant themes relating to spirituality in nurse education: spiritual awareness, spiritual assessment, spiritual competence, and spirituality in pre-registration programmes. In Table 3.3 I have given a synopsis of the main findings on all four Themes.

Table 3.3 Synopsis of main findings

Theme	Studies	Main findings
Spiritual awareness	6	<p>Spiritual awareness is recognising and being sensitive to the spiritual needs of patients.</p> <ul style="list-style-type: none"> - Awareness by students that spirituality is broad and does not always equate to religion, and consideration was given to the diverse beliefs of people. - There was an awareness that spiritual care sometimes occurred indirectly as part of their caring role. - Spirituality education increased their spiritual awareness, which was a prerequisite for facilitating the spiritual needs of patients within holistic care.
Spiritual assessment	2	<p>Spiritual assessment concerns gathering of information for spiritual interventions that would help a patient cope with the healthcare issues they face.</p> <ul style="list-style-type: none"> - Recognising the necessity of assessing patients' spiritual needs, whether by formal or informal means (more often informally). - Spirituality education was shown to contribute to students' knowledge and comfort with performing spiritual assessment.
Spiritual competence	6	<p>Spiritual competence entails a combination of skills, knowledge, attitudes, and values which are necessary for effective spiritual nursing care.</p> <ul style="list-style-type: none"> - Includes an understanding of compassion and holistic caring skills. - Opportunities to reflect on and discuss thoughts and feelings on the topic of spirituality and spiritual care, enhanced competence. - Increased spiritual care responses is a result of competence.

Contd.		<ul style="list-style-type: none"> - Some students who were religious perceived themselves to be more competent. - Some students' perception of competence could be self-confidence. - Competence for spiritual care was not solely dependent on academic input. - Experiential as well as academic input, served to develop positive attitudes towards patients' spirituality.
Spirituality in pre-registration courses	17	<p>Spirituality education is intended to improve knowledge and understanding for facilitating spiritual care in the clinical setting. The seventeen studies for this theme investigated nursing students and a number of teaching staff.</p> <ul style="list-style-type: none"> - Students accepted that spirituality was not just about religion, but included numerous individual beliefs, values and preferences. Different ways of addressing spiritual issues for example, respect for privacy, dignity and religious/cultural beliefs, were highlighted. - Spirituality and spiritual care was taught in a variety of ways for example, classroom sessions, community placements, experiential learning, simulation, art work; each one contributing to the enhancement of the students' learning experience. - There was an increased awareness that patients' spiritual needs was in everyday nursing care. - Students thought that they should be taught about spirituality, and teaching staff have an important part to play in nurses' understanding or their role to deliver spiritual care. However, there were marked differences in the structure, content and time allocated for spirituality education in various pre-registration programmes. - Linking academic and clinical learning of spirituality and spiritual care was more effective. - There was a suggestion that spirituality and spiritual care should be taught through all years of the pre-registration nursing programme.

It is quite evident that nurse education plays a significant part in preparing pre-registration students for the spiritual dimension of their role as the preceding studies have shown. And shortly before submitting this thesis a recent Australian study (Cooper and Chang, 2016) was identified, showing that student nurses' perceived themselves more prepared to provide spiritual care within holistic nursing. This occurred after completing the 13 week 'spiritual care subject' in the 1st year of their undergraduate programme. However, although a number of these studies report enhanced knowledge, understanding and skills to facilitate spiritual care in the short term as a result of mainly targeted courses, there remains a gap in the literature concerning the long term effects of such learning in clinical practice. It is therefore necessary to ascertain the transferability and sustaining impact of pre-registration spirituality education for on-going holistic nursing care. Consequently, the literature review reveals the need for a longitudinal study to investigate the above. Accordingly, this is the aim and objectives for this investigation:

Aim - Explore the impact of pre-registration nurses' spirituality education, and its transferability, and sustainability in the clinical setting.

Objectives - 1) gather subjective information from final year pre-registration nurses/and when newly qualified about their perceptions, knowledge and understanding of spirituality and spiritual care; 2) gain insight concerning participants' personal application of spirituality and spiritual care in clinical areas. In order to proceed logically, in the methodology chapter which is next, I begin to outline the steps and processes for this investigation.

CHAPTER FOUR: METHODOLOGY

Methodology

Introduction

In this chapter I will discuss the significance of methodology and how it has shaped this investigation, by elucidating the philosophical significance of ontology (truth or reality) and epistemology (how truth is knowable). Discussions of the research paradigms that have influenced this investigation will take place as well as underpinning theoretical perspectives. The research strategy involved in achieving the aim and objectives for this investigation are pivotal, so theoretical perspectives, and features of various research methods and their relevance will be detailed to justify my choice in this area. Moreover, the tenets of grounded theory are expounded, also substantive and formal theory is explained. The significance of reflexivity and the importance of memo writing will also be discussed.

The assumptions of methodology

Methodology concerns philosophical approaches to be considered by a researcher in the study of a particular phenomenon (Saks and Allsop, 2007), and involves a logical study of the principles governing an enquiry. Furthermore, Sapsford (2006 p.176) defines methodology as “The philosophical stance or worldview that underlies and informs a style of research”. Therefore, methodology consists of assumptions, rules and methods, and acts as a blueprint or roadmap that researchers follow to make their work more open to for example, analysis and critique, and to choose appropriate research methods. The terms research design, research methods, and research methodology are

sometimes used interchangeably, but this could be misleading as there are distinguishing features related to each term. For example, research design denotes what kind of study is being planned with details of how, when and where data are collected and analysed (Parahoo, 2014); research methods are the tools or techniques that researchers employ to collect data (Denscombe, 2014); and research methodology provides the overall framework for the research process and procedure that guide the investigation (Dawson, 2013). Although methodology would seem to be used loosely at times by some people, researchers should be knowledgeable about the precise meaning of the terms mentioned, and apply the same to the research investigation to build rigor, validity and thoroughness. So in essence research methodology is concerned with ideas and principles on which procedures are based to answer the questions being studied.

A methodological plan

The methodological plan for this investigation includes the following philosophical stances: 1) Ontology – establishing what will be explored; 2) epistemology – the rules of truth for justifying validity; 3) the research paradigm - beliefs and practices shared by researchers within various disciplines to regulate their inquiry. So the aim of the philosophical stances is to demonstrate their influences on the researcher's choice of method for this investigation. Such cognizance governs the purpose of the investigation, to reduce bias that may wittingly or unwittingly be introduced by the researcher. The former aspects will now be discussed in further detail.

Ontology

Ontology, concerns ways of constructing reality, in other words, “how things really are” and “how things really work” ... (Denzin and Lincoln, 1998 p.201), therefore, it is the beliefs and attitudes about the world we live in (Corbin and Strauss, 2008). Furthermore, Dawson (2013) adds that ontology is the structure and representation of how our social world is expressed. Consequently, this study is about participants’ knowledge and understanding of spirituality and spiritual care, and its application in their healthcare practice.

There are two basic positions: Realist and constructionist, and philosophically spirituality can be considered from these two contrasting perspectives. The realist belief is that there are aspects of our reality that are ontologically independent of our concepts and perceptions or beliefs, and furthermore, what we presently believe is a guesstimate of reality, and subsequent new observations draw us nearer to understanding reality (Denscombe, 2010); therefore, reality exists independent of the human mind. On the other hand, the constructionist appreciates reality subjectively, as mentally constructed through peoples’ perceptions and interactions with others; so our ideas are the only true reality that are worth knowing. Social reality is seen as something that is constantly being created, and multiple realities comprise our social world (Denscombe, 2010).

When it comes to matters of spirituality and health, it is the participants’ constructed understanding, and their attitude to this domain that is sought in my investigation, as it may affect their response to the spiritual needs of patients. Accordingly, ontology in this investigation focuses on the philosophy that

promotes the spiritual domain in relation to the experience of student nurses, and when they become newly qualified Registered Nurses.

Epistemology

Epistemology is a branch of philosophy which relates to the possibilities of knowing and learning about the social world (Richie and Lewis, 2003). Thus there are philosophical arguments of how people acquire knowledge about the social world (Denscombe, 2010). Therefore, in relation to this investigation, it is how knowledge concerning spirituality and spiritual care is acquired.

There are three principle perspectives related to epistemology: Objectivism, subjectivism, and constructivism. Objectivism recognises an external universal reality that can be studied. The researcher adopts a detached stance from the source of knowledge to arrive at an objective reality, whereas subjectivism is about knowledge that is internally constructed and therefore subjective within a specific context. There is also a holistic character attached to subjectivism, and in this investigation concerning spirituality, the art of nursing is appreciated and promoted, whereby the individual's spiritual nature and needs share equal focus with cognitive and physiological needs (O'Brien, 2008).

Finally, constructivism is socially constructed and sits between the previous two perspectives. It introduces another dimension that distinguishes between knowledge of the human world and that of the physical world within a particular context (Gray, 2013). Therefore, for the purpose of this investigation, and as spirituality is a constructed concept, the author will take the constructivism

approach as it relates with the fundamental tenets of Grounded Theory (discussed later in the chapter), which will be employed for data collection and analysis of findings.

Research Paradigms

Research paradigms are a series of philosophical ideas and practices shared by researchers within various disciplines and regulate their inquiry. They influence the practice of research. Figure 4.1 presents a design framework of procedures with interconnecting philosophical paradigms, strategies of inquiry, and particular research methods (Creswell, 2009). These are identified in this chapter to explain the reason for choosing a particular method for this investigation.

Paradigms in nursing research needs clarification according to Weaver and Olson (2006), due to issues of semantic confusion related to the terms 'research tradition', 'worldview' and 'paradigm'. So while Bowling (2009), describes paradigms as a set of theoretical perspectives, Creswell (2009) says it is a worldview of beliefs, values and methods within which research takes place. However, Kuhn (1970) suggests that research traditions are similar to paradigms, having an impact on how the research is conducted. Therefore, the terms research tradition, worldview or paradigm seems to be a matter of individual choice by researchers within various disciplines, but essentially have the same meaning. For the purpose of this investigation I have chosen to use the term paradigm, and will discuss the following: Positivist, Interpretivist, and Pragmatic paradigms.

Figure 4.1 Framework of design (adapted from Creswell 2009)

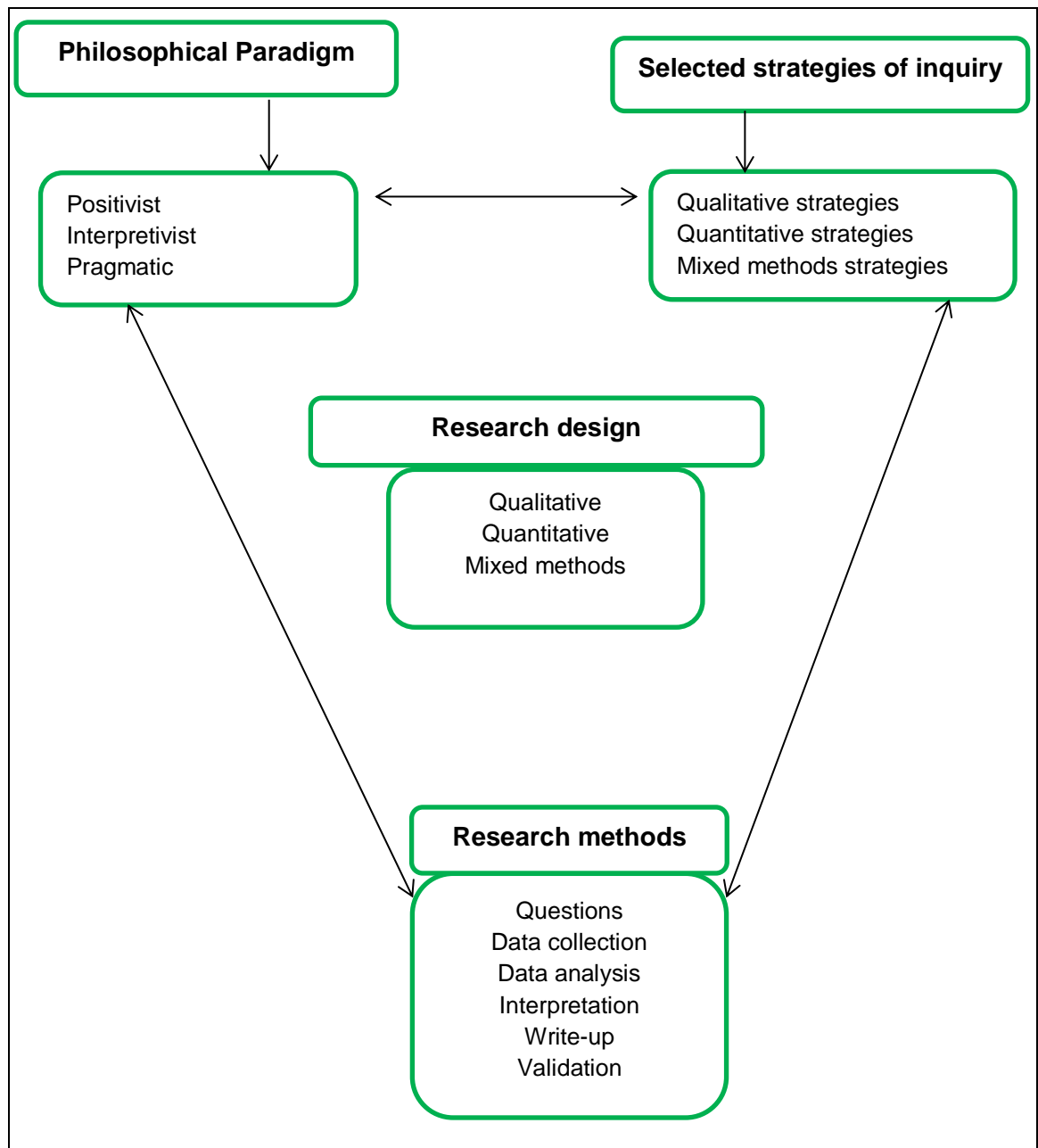


Figure 4.1 shows a framework that is useful for planning research. The framework explains the interaction of three components: philosophical worldviews, strategies of inquiry, and research methods. Both the philosophical worldview assumptions that relate to the investigation and the strategy of inquiry related to this worldview are considered, before the methods of research are actioned.

Positivist paradigm

The positivist assumption perceives a single reality that people are aware of, also statistical information can be collected about this reality. This kind of deductive reasoning using for example, surveys, randomised control trial or quasi-experimental methods to generate and test hypothesis, requires a quantitative method (Figure 4.1).

Quantitative research is regarded as classical, traditional and scientific (Polit and Beck, 2004). Hence, positivism has an established and dominant philosophy underlying scientific methodology (Bowling, 2009). Medical research and evidence-based nursing favour a positivist stance and they both grant it a higher status in the range of scientific quantitative research, using samples that give more possibilities of being generalised (Polit and Beck, 2010). Postpositivist hold to a deterministic philosophy of cause and effect such as found in experiments. These research activities commence with a theory before collecting data which supports or refutes the theory (Creswell, 2009). Thus, as mentioned by researchers such as Charmaz (2006), and Bowling (2009), the term positivist holds a dominant and established sway for scientific methods. Quantitative studies feature objectivity, as opposed to the individual's subjective experience, and this method has been used for a number of studies about spirituality which require statistical measurements (Bonelli et al., 2012). However, in my investigation, the individuals' subjective perception, knowledge, experience and practice concerned with the spiritual domain in nursing is sought, which lie within the metaphysical (valuing, intuition, personal beliefs and interpretations), therefore does not fit within a positivist paradigm.

Interpretivist paradigm

The Interpretivist seeks to understand the reality of a particular situation or context through interaction. Consequently, there is no single reality across social and cultural groups therefore the kind of research required is a qualitative approach (Figure 4.1) to describe the subjective reality of individuals (Seymour, 2006). The interpretivist paradigm emphasises that the values of the researcher is inherent in all phases of the research process. Therefore, truth is established by a negotiated dialogue with people, by talking to them or observing situation/s (Figure 4.2). Accordingly, my investigation does the same by a series of in-depth interviews to explore understandings and knowledge of spirituality and spiritual care from the participants' perspective. Fostering such dialogue between researcher and participants is vital to gain a sophisticated understanding; also there is room for re-interpretation and negotiation in a pragmatic way.

Pragmatic paradigm

Pragmatism features actions, situations, and consequences relating to problem solving, and what works. Therefore, a pragmatic approach involves using the method which appears best suited to the research problem (Denscombe, 2008). There is recognition of the complementary possibilities of different research approaches hence this paradigm favours triangulation for a mixed methods approach (figure 4.2). What can be seen is the appropriate links between various factors, examples are: application - nursing; strategies - interviews; approaches - grounded theory; disciplinary base – sociology.

Figure 4.2 The major interpretive approaches (Holloway 2010)

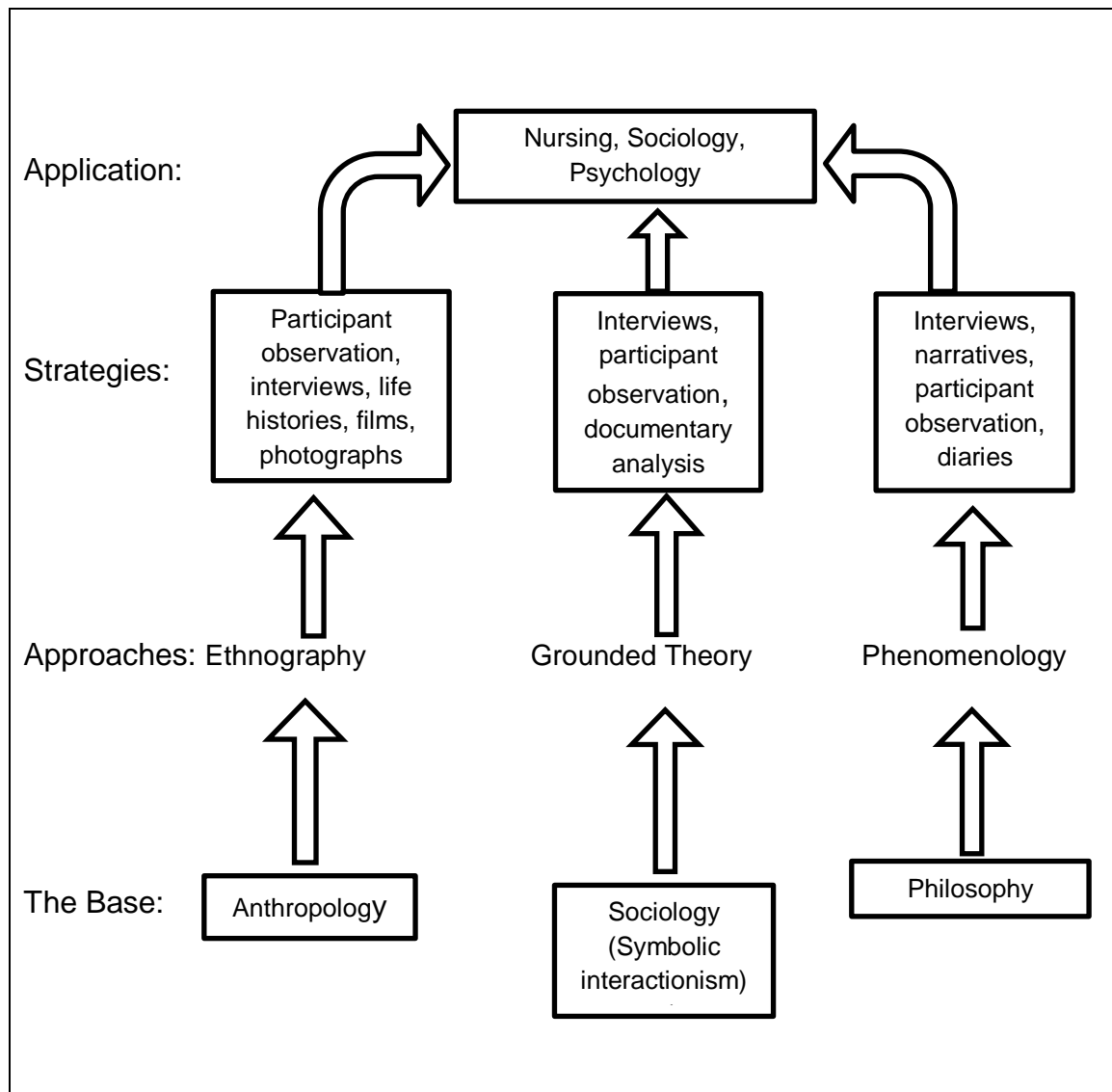


Figure 4.2 presents the link between the disciplinary bases, their corresponding research approaches, strategies and application. In relation to this nursing investigation it is seen that symbolic interactionism forms the basis for a grounded theory approach, and in this instance interviews was the strategy used to collect data. However, the essential differences between qualitative and quantitative methods of enquiry will be discussed next.

Qualitative Vs Quantitative

Although the primary purpose of both qualitative and quantitative research is similar in that they aim to contribute knowledge about a particular subject, they have essential differences (Table 4.1). The positivist scientific method associated with quantitative research is reductionist, in that it reduces human experience to the predefined issues being investigated, and emphasises control, rigour and measurements. Conversely, qualitative methods are concerned with the in-depth study of human phenomena from the individuals' subjective perspective.

Table 4.1 Quantitative and Qualitative features in relation to this investigation

Quantitative	Qualitative	Qualitative relevance for this research
Objective	Subjective	The subjective perspective of spirituality and spiritual care
One reality	Multiple realities	The realities of each participant
Reduction, control, prediction	Discovery, description, understanding	Discovery of new insight into the spirituality education related to practice
Parts equal to the whole	Whole is greater than the parts	Holistic perspective of the phenomenon
Statistical measurements	Interpretive results	Researchers' interpretation of the data
Deductive theory testing/verification	Inductive meaning/theory development	New insights/generating new theory by induction
Generalisation	Uniqueness	The unique reality of each participant is reflected

Table 4.1 displays the main differences between the features of quantitative and qualitative research traditions, which should be considered before selecting either or both methods for an investigation.

From the review of the literature concerning spirituality and spiritual care in nursing, it is seen that quantitative, qualitative and a triangulation of both these methods have been used to study spirituality and spiritual care. Furthermore, it was necessary to appreciate some fundamental characteristics of qualitative research to provide further justification when considering the selection of the stance most appropriate for answering the research question of this investigation; Table 4.2 summarises these characteristics.

Table 4.2 Summary & characteristics of qualitative research (from Key 1997)

Purpose - Understanding	Endeavours to understand people's interpretations
Reality - Dynamic	Reality changes with changes in people's perceptions.
Viewpoint - Insider	Reality is what people perceive it to be.
Values - Value bound	Values will have an impact and should be understood and taken into consideration when conducting and reporting research.
Focus - Holistic	A total or complete picture is sought.
Orientation - Discovery or Constructed	Theories and hypotheses evolve or are constructed from the data collected respectively.
Data - Subjective	Data are perceptions of the people in the environment.
Instrumentation - Human	The human person is the primary collection instrument.
Conditions - Naturalistic	Investigations are conducted under natural conditions.
Results - Valid	The focus is on design and procedures to gain in-depth data that is real and rich.

Table 4.2 charts pertinent features that are associated with qualitative research for example, appreciating people's views and values to gain an in-depth holistic impression, natural conditions for carrying out the investigation, formation of theories/hypotheses from the collected data. Such features add further clarification for my selection. Accordingly, for the purpose of my research, a quantitative method was subsequently rejected in favour of qualitative, which offers the scope to gather the unique subjective experience of the participants. In

addition, this investigation of spirituality requires a holistic perspective to develop an understanding of participants' human experiences, which is important for health professionals who focus on caring, communication and interaction (Holloway and Wheeler, 2000). This aspect may be complex, but necessary for understanding the impact of spirituality education in the care setting. The next step was to formulate a research strategy, which is set out later in this chapter. In addition, it was useful to consider various paradigms for a planned approach to my investigation, and a summary of the same is shown in Table 4.3.

Table 4.3 Summary linking philosophical paradigms & research methods

Paradigm	Ontology	Epistemology	Question	Method
Positivist	A single reality exists	Focus on reliable and valid tools to uncover reality	What works?	Quantitative
Interpretivist	Reality is in a set context through interactions	Discover the underlying meaning of the situation	Why do individuals act in a certain way?	Qualitative
Pragmatic	The truth is what matters	Relies on pertinent ways to understand reality	Will this intervention improve learning?	Mixed methods

Table 4.3 lists various paradigms together with a summary of the relating ontology and epistemology stance. Pertinent to this investigation is the interpretivist paradigm which corresponds with reality in context, discovering meaning of the situation, and reason for participants' actions. This is seen to be appropriate for this investigation, and in particular, the constructivist grounded theory (p136) method, favoured for representing the subjective meaning of each participant. Consequently, the qualitative method chosen for this investigation is further justified.

Naturalistic methods

Naturalistic inquiries concern complex human issues and require direct exploration (Polit and Beck, 2010). The emphasis is on understanding the lived human experience, by gathering qualitative data which is subjective. The research takes place through direct contact with participants in the 'real-world' or 'natural' setting, and the researcher does not attempt to manipulate the phenomenon of interest in a predetermined way, but allows this phenomenon to naturally unfold. This is in contrast to what occurs in a quantitative controlled setting. Clearly a naturalistic method suits my investigation to gain insight about spirituality and spiritual care within the context of the participants' learning environment, and it is useful to look at the theoretical perspectives which are relevant to qualitative research traditions.

Theoretical perspective

Theoretical perspectives, according to Crotty (1998) relate to underpinning beliefs concerning research. These beliefs should be congruent with the researcher's epistemology to demonstrate the research methodologies that emerge from them (Richie and Lewis, 2003). Table 4.4 below outlines various qualitative research traditions, their corresponding disciplinary origin, and the aims of the research in each particular sphere. But I although there are a few traditions that are partially relevant to this investigation for example, ethnography, critical theory, and phenomenology, I will only discuss constructionism, symbolic interactionism and grounded theory that have direct bearing.

Table 4.4 Traditions of Qualitative Research (Richie and Lewis 2003)

Research Tradition	Disciplinary origins	Aims
Ethnography	Anthropology/ Sociology	Understanding the social world of people being studied through immersion in their community to produce detailed description of people, their culture and beliefs.
Critical theory	Sociology	Identifying ways in which material conditions (economic, political, gender, ethnic) influence beliefs, behaviour and experiences
Phenomenology/ ethnomethodology	Philosophy/ Sociology	Understanding the 'constructs' people use in everyday life to make sense of their world. Uncovering meanings contained within conversation or text
<i>Leading to Conversation analysis</i>	Sociology/ Linguistics	Analysing the way different conversations are structured and the meanings they contain
<i>Discourse analysis</i>	Sociology	Examining the way knowledge is produced within different discourses and the performances, linguistic styles and rhetorical devices used in particular accounts
<i>Protocol analysis</i>	Psychology	Examining and drawing inference about the cognitive processes that underlie the performance of tasks
Constructivism	Sociology	Displaying 'multiple constructed realities' through the shared investigation (by researchers and participants) of meanings and explanations
Hermeneutics	Philosophy	Deals with interpretation, often with reference to biblical or other literary texts, but it also includes verbal and nonverbal communication
Symbolic Interactionism	Sociology/social Psychology	Exploring behaviour and social roles to understand how people interpret and react to their environment
<i>Leading to Grounded theory</i>	Sociology	Developing 'emergent' theories of social action through the identification of analytical categories and the relationships between them
<i>Ethogenics</i>	Social psychology	Exploring the underlying structure of behavioural acts by investigating the meaning people attach to them

Table 4.4 illustrate the various research traditions, origins and aims, associated with qualitative research. These traditions were duly considered in order to justify the most appropriate one for my investigation.

Constructionism

Silverman (2010) suggests that knowledge is constructed as opposed to being discovered, and that people make their own reality by actively creating meaning. Although constructionism appreciates that participants' actions are constructed, unlike constructivism, it discounts the researchers' involvement in the construction and interpretation of data, (Morse et al., 2009). However, Charmaz (2009) concedes that with the passage of time constructionism has evolved to bear a close resemblance to constructivism, which could explain why the two terms at times are used interchangeably. However, spirituality is a concept constructed by the individual, so constructivism is in line with this investigation.

Symbolic interactionism

Symbolic interactionism emphasises the individual's point of view, and their actions in society are a result of their interpretation of the meaning of their world. The framework of symbolic interactionism is derived from the work of the American philosopher George Herbert Mead in the 1920s (Giddens, 2001), but it was Herbert Blumer (1900 – 1987) who actually coined the term symbolic interactionism (Chambliss, 2014). It is said that, the meaning we give to things is not permanent as this can change as a result of our social interaction, which includes perceptions of spirituality and spiritual care. Therefore, the world of reality exists only as it is interpreted and comprehended by the individual.

Accordingly, this investigation is underpinned by symbolic interactionism, with the empirical starting point of the subjective meaning that individual participants attach to the spiritual dimension in their academic and clinical environments. Hence, their knowledge, perceptions and actions will be shaped by the experiences in their respected environments. Therefore, these positions conceptualise how the participants relate within the context in which they are studied (Flick, 2009). As a result, symbolic interactionism, featuring Grounded Theory was found to be most suited to answer my research question. Accordingly, the actions, interactions and an emergent theory will be grounded in the views of participants. Grounded Theory will now be discussed in detail.

Grounded theory

Grounded theory has roots in symbolic interactionism, and was developed in the 1960s by two sociologists Glaser and Strauss (1967). It is one of the major qualitative approaches being used by health professionals since the 1960s (Holloway and Wheeler, 2010), and allows the researcher to focus on generating comprehensive explanations from people about their social world that are grounded in reality (Glaser and Strauss, 1967). It is characterised by openness (Gibson and Hartman, 2014), and has become an important research method for the study of nursing phenomena, contributing to theory development such as, 'Opening up to learning spiritual care' (Giske and Cone, 2012), 'Carrying hope' (Wigley, 2013) 'Journeying with Students through Maturation' (Cone and Giske, 2013); these respective theories are 'grounded' in the perspectives of the individuals who function in the areas studied, as they deal with and resolve challenging problems (Gibson and Hartman, 2014). Essentially, the purpose is to

explain 'what is going on'. Thus, grounded theory is useful where little is already known about a topic, so provides a new perspective on existing knowledge, in other words a 'reality-fit'. And Glaser and Strauss maintained that building new theories was more important than verifying existing ones as social reality is constantly changing (Glaser and Strauss, 1967). However, only two studies in my literature review used grounded theory, one explored teachers' understanding of their preparation of undergraduate nursing students to assess and provide spiritual care (Giske and Cone, 2012), and the other investigated assessment and provision of spiritual care from the student nurses' perspective (Cone and Giske, 2013).

But this investigation seeks to build new theory, as little is known about the transferability and sustained impact that spirituality education has in clinical practice within holistic nursing care. The process of developing grounded theory for my investigation is presented below in Figure 4.3.

Figure 4.3 The process in developing grounded theory

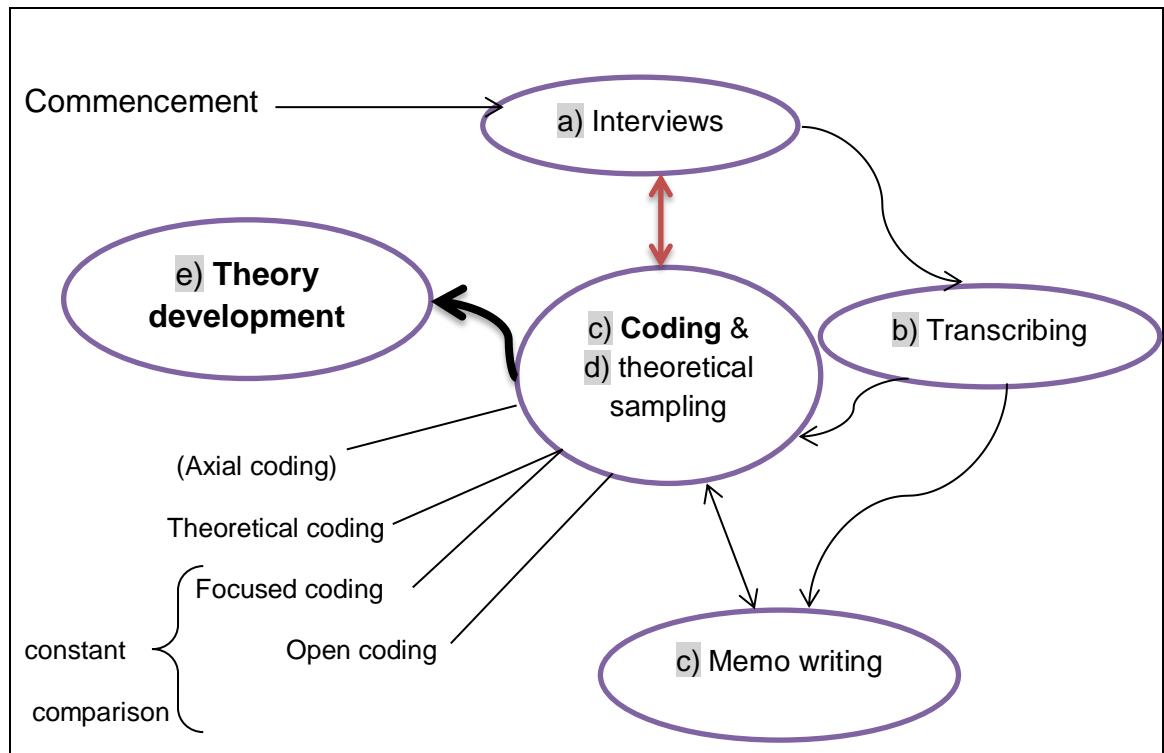


Figure 4.3 illustrates the process of data collection and analysis occurring in a cyclical pattern: a) first interview, b) transcribing, c) coding & memo writing, d) theoretical sampling for further interviews & constant comparison, e) theory development.

Developments in grounded theory

Over the years grounded theory methodology has developed so that a number of aspects originally proposed by Glaser and Strauss in 1967 are no longer followed for example, avoiding existing literature about the subject matter at the beginning of the research (Flick, 2009), in other words, to start the research with a 'Tabula rasa' state of mind (a blank slate). Glaser (1992) was concerned that the literature might contaminate and hamper the researcher's effort to generate categories. The blank slate concept is a controversial notion and is criticised for

being unacademic because it suggests ignoring the literature at this point. However, this seems to be a myth because according to Urquhart (2013) it is possible to do a literature review before one starts the research, providing this does not influence the coding process. Nevertheless, most researchers will have read something about the phenomena, and this was my experience, as I found it necessary to review the literature around spirituality and spiritual care in nursing, in order to: 1) identify gaps in the literature which is necessary to justify further research, 2) formulate relevant questions to be answered, 3) write a research proposal for the university ethics committee. In addition, for ethics approval it was necessary to state an approximate number of participants that would be involved in the investigation, which is not in keeping with the constructs of grounded theory, as this particular factor is determined by theoretical saturation (Charmaz, 2006). The fact remains that any researcher is likely to have a number of ideas before going into an investigation; the challenge is to recognise these and detach them from what the participants disclose (De Chesney, 2015).

Versions of grounded theory

Since the work of the original founders Glaser and Strauss (1967), different versions of grounded theory have developed (De Chesney, 2015), therefore, it is necessary to be acquainted with variant methods for example, classical - Glaser (Glaser, 1978, Glaser, 1992a), Straussian - (Strauss and Corbin, 1990, Strauss and Corbin, 1998) , and constructivist - Charmaz (Charmaz, 2000, Charmaz, 2006, Charmaz, 2014, Clarke, 2005) before deciding which one to use in an investigation. Denscombe (2014) asserts that Glaser's (classical) version deems that meaning exists in the data, and grounded theory allows the researcher to

extract that meaning and develop it into a more abstract theory. In contrast the versions of Strauss and Corbin (1990), and Charmaz (2006) sees the researcher introducing some shape and sense into the data, acknowledging that researchers are not likely to be totally impartial. Therefore, the meaning attached to any data involves some kind of interpretation by the researcher. However, Glaser disagrees with this stance and argues that there is a potential to 'force' the data to fit the researchers' categories rather than let the data speak for themselves (Glaser, 1992). However, Charmaz (2014) agrees to some extent with Glaser and Strauss (1967), but emphasise the role of the researcher as interpreter, and so favours a constructivist grounded theory. This relies on the researcher's view and consider that data and data analysis are social constructions (Charmaz, 2006), rather than a process of discovering reality.

Key components of Grounded Theory

Regardless of the version of grounded theory, according to (Engward, 2013) there are certain key features that a grounded theory must demonstrate:

- 1) Openness/theoretical sensitivity
- 2) Immediate analysis
- 3) Coding and continuous comparison
- 4) Memo writing
- 5) Theoretical sampling
- 6) Theoretical saturation
- 7) The use of the literature as data
- 8) Integration of theory
- 9) Production of a substantive theory

However, the procedure of grounded theory does not operate in stages, but instead takes on an interconnected cyclical pattern throughout. This necessitates a procedural framework for data collection, analysis, and theory development, which is the intention of this investigation.

Main tenets of grounded theory

Whether the theory to be developed is substantive and/or formal theory (page 143), the three main tenets of grounded theory apply: theoretical sensitivity, constant comparison, and theoretical sampling. However, these and some of the other components listed above will now be discussed and their relevance to this investigation outlined.

Openness/theoretical sensitivity

According to Glaser and Strauss (1967) theoretical sensitivity is about being open to conceptualise and formulate theory as it emerges from the data, which will account for the substantive grounded categories. Theoretical sensitivity involves the researcher's personal and variable views, as well as a theoretical insight into the area being researched (Glaser and Strauss, 1967). And my views and insight into pre-registration education (adult branch) resulted from previous involvement as a lecturer in this area.

Immediate analysis

Immediate analysis means that as each new piece of data is analysed soon after collection, for similarities and differences, that will inform further data collection

(Engward, 2013). However, unlike a number of empirical research, analysis in grounded theory does not follow a linear, step-by-step process of data collection before commencing the data analysis (Engward, 2013, Parahoo, 2014). Rather it is cyclical, in order to inform the next part of data collection in a reciprocal relationship (Bowling, 2009). Thus, the grounded theorist employs an on-going iterative (repetition of a sequence) technique to develop categories that are closely related to the data and each other, leading to an interrelated theory (Gibson and Hartman, 2014). This technique was followed throughout my investigation (example in chapter Five) to arrive at a theory closely related to the data.

Coding and Constant comparison

Coding - is a link between data collection and the development of an emergent theory (Charmaz, 2006), and involves a process of breaking the data into smaller components and labelling these. These codes are combined and related to each other to form categories or concepts (Engward, 2013).

Charmaz (2006, p.42) explains that coding is about “naming segments of data with a label that simultaneously categorizes, summarizes, and accounts for each piece of data.” So it was necessary in this process to consider carefully the information given by the participants to discover patterns and contrasts (chapter Five, p.166). In qualitative studies the researcher will undertake some comparison of the data (Silverman, 2010), but the term constant comparison is usually associated with grounded theory (Flick, 2009).

Constant comparison - this is a crucial feature in the cyclical process of grounded theory studies. The process of comparing like with like for similarities and differences in the data, to identify emerging themes and patterns, assisting theoretical sampling for further data collection. Thus, there is a comparison of incidents and categories to generate concepts. Constant comparison forms part of the iterative process for analysis, during which the properties and their relationship to each category are defined. Eventually the core category is arrived at, which accounts for a difference in the behaviour pattern/s that is relevant and problematic for the perceptions involved (Glaser, 2005).

Memo writing

Memo writing is essential to grounded theory, and constitutes a vital process for building theory, and according to Charmaz (2014) they are imperative, as they encourage analysis of the data for developing codes and categories in the investigation. Although memos may slow down the pace of analysis (Glaser and Strauss, 1967), it obliges the researcher to think through and confirm categories for 'fit', relevance and 'work' in the emerging theory. Memos are further described by Lempert (2007 p.245) as:

“the distillation process through which the researcher transforms data into theory”.

Corbin and Strauss (2008) assert that the activity of writing memos forces the analyst to think about the data, and this is more important than the actual kind of memo. Nevertheless, it should be spontaneous, and allow the researcher space to converse with themselves and analyse ideas about codes and emerging categories in whatever way that occur to them (Charmaz, 2014). Memos also

serve to “keep you involved in the analysis and helps you to increase the level of abstraction of your ideas” (Charmaz, 2014 p.162). Therefore, memo writing offers the opportunity to think theoretically (Gibson and Hartman, 2014), but early memos may be rather descriptive, and according to Lempert (2007 p.249):

“often messy and incomplete, with undigested theories and nascent opinions that may be represented in fragmented phrases, weird diagrams, half sentences or long treatises. Whatever works is just fine in a memo: a memo need only be the account of a researcher talking to him/herself. Clarity and integration comes with the expanding analysis”.

These statements about early memo writing were for me reassuring, as my thoughts and opinions to do with the research process, and ideas that were coming out of the data were not always connected and coherent. Despite my early uncertainties, it was encouraging to know that the grounded theory method would ultimately generate theory. So, even as the analysis develops, the content of memos will improve in depth and quality conceptualization, and ultimately integration. Therefore, memos are a fundamental link between data and emergent theory (Lempert, 2007). Subsequently, the writing of memos throughout this investigation contributed to my reflexivity (discussed later in this chapter), and some of these will be included from time-to-time as relevant examples, to support various aspects being discussed.

Theoretical sampling

Theoretical sampling differentiates grounded theory from other qualitative inquiries (Charmaz, 2014), and Gibson and Hartman (2014 p.123) affirm that:

“Theoretical sampling follows on from theoretical sensitivity...”

Thus the main purpose of the process is to inform what data to collect next and where to find them (Glaser and Strauss, 1967), in order to further develop the theory. So in this investigation there was joint collecting, coding and analysing of data, while remaining open to further theory building. This was appropriate in relation to the development of a substantive theory (Glaser and Strauss, 1967). However, as seen in Table 4.5, theoretical sampling also allows variations in sampling opportunities, which was needed in this investigation using a constructivist grounded theory (demonstrated in chapter 5).

Variations on theoretical sampling

Before acquiring the information in Table 4.5 I was perplexed about opportunities for theoretical sampling, due to my convenience sample (discussed on page 156), also the limited purposeful sampling across two campuses. In addition, I found it necessary to return to some of my data for inclusion of relevant concepts. Therefore, it was reassuring to know that my theoretical sampling which mainly resembled type B, but at times included type C and D would not be disqualified.

Table 4.5 Variations on theoretical sampling (from Corbin & Strauss 2008)

Type	Related Detail
A	A researcher may look for persons, sites or events where he or she purposefully can gather data related to categories, their properties, and dimensions.
B	A researcher may gather data very systematically (going from one person or place to another on a list) or by sampling on the basis of convenience (whoever walks through a door or whoever agrees to participate).
C	A researcher may find that differences often emerge quite fortuitously.
D	A researcher may return to the data themselves, reorganizing them according to theoretically relevant concepts.

Table 4.5 displays variations on theoretical sampling, as put forward by Corbin & Strauss, affording some flexibility. This precludes notions and doubts of theoretical sampling not being carried out solely as in type A, and this flexibility was deemed necessary in this investigation.

Theoretical saturation

Theoretical saturation is said to be the arrival at a point where similar instances are repeatedly seen, and no additional data will develop the properties further (Glaser and Strauss, 1967). Theoretical saturation is not about the sample size or the number of participants required for a study, therefore, adding further data makes no difference, so the emphasis is about the density of categorization and not its parsimony (Dey, 2007). In this investigation the known differences in the participant group, for example, cohort, campus, religious/non-religious beliefs, was utilised through theoretical sampling, in an effort to increase the variety of properties within categories towards a point of saturation.

Theoretical saturation or theoretical sufficiency

Over time theoretical saturation has become a contentious term, and according to Wiener (2007), theoretical saturation is a judgement, which may take into account research factors such as insufficient time and money. My time to complete this investigation was limited, therefore, one needed to be cautious in claiming theoretical saturation, and a considered judgement was valid (Wiener, 2007). Furthermore, Dey (1999) believes the term 'saturation' to be unclear, as not all data is coded, and there is a reliance on the researcher's inference that the properties of the category are saturated. Accordingly, claims of saturation

should not be made, but instead 'theoretical sufficiency' (Dey, 1999). With the above in mind, only data relevant to answering the research question continued to be analysed during focused coding, so as a result in this investigation my claim to 'theoretical sufficiency' is stronger. Consequently, this theoretical sufficiency led to the construction of a substantive theory.

Substantive theory

The production of a substantive theory is the purpose of grounded theory, which Engward (2013) describes as concepts that relate to each other in a cohesive manner. Hence, substantive theory connects to the particular phenomena being researched and therefore in contrast to formal theory, cannot be generalised (Urquhart, 2013). Substantive theory may be an end in itself, or may be developed further to arrive at a formal theory. The intention of this investigation is to arrive at a substantive theory about the impact of spirituality education in nursing practice, but formal theory will be discussed briefly to explain the essential difference.

Formal theory

Formal theory is a generic issue (non-specific and relating to a class or group of things) spanning several substantive areas of study (Charmaz, 2006). The process involves constant comparative analysis to check for similarities in other substantive fields. Accordingly, the core category will be extended in a general way (Glaser, 2007). This theoretical interpretation of a generic issue or process is conceptual and not descriptive, becoming abstract of time, place and people

(Strauss and Corbin, 1990). As indicated above, the production of a formal theory was not relevant for my investigation.

Basic Social Process (BSP)

In grounded theory a core category is always present, but this is not necessarily the case for a BSP. However, BSPs are a type of core category that are processural, having two or more clear emergent stages which distinguishes and explains the variations in the main concern/s of the study population (Glaser, 2005). Therefore, the main concern of participants in the study population becomes the Basic Social Problem, which is resolved by the explanation offered by the (BSP) (Polit and Beck, 2010). BSPs are abstract and independent in the sense that they are free from time, place and the perspective of participants therefore, they are generalizable (Glaser, 2005). However, BSP has been criticised for being reductionist and positivist in its quest to clump together the experiences of a variety of participants in an all-encompassing theme (Rimmer, 2014). Furthermore, questions are raised about:

“an idealised picture wrapped up in public relations rhetoric rather than one reflecting the realities people struggle with” (Charmaz, 2014 p.35).

As this investigation is based on the personal views of the participants, it is clear that BSP is not pertinent.

Rationale for selecting constructivist grounded theory

The debates and developments of grounded theory were duly considered (pp.132 -143) before the constructivist version was chosen. Constructivist grounded theory resists mechanical applications and favours flexibility (Charmaz,

2014). So the rationale is to allow participants to put shape to their understanding of spirituality and spiritual care, and its translation and practical application in holistic nursing. Hence, the defining elements which include, the interaction of the researcher and participants in interpreting meanings of the phenomenon is suited to answer the questions posed in this investigation, and therefore defends my selection of an appropriate version of grounded theory (Denzin and Lincoln, 2007). Furthermore, viewing the research as constructed, removes neutrality, and value-free notions of the researcher, so promoting reflexivity.

Reflexivity

Reflexivity is a feature of qualitative research that uses a continuous process of reflection by the researcher on his/her values, preconceptions, behaviour or presence, and those of the respondents, which can affect responses (Parahoo 1997). So nothing speaks for itself (Denzin and Lincoln, 2000), therefore, the aim is to guard against personal bias in making judgements (Polit and Beck, 2010). Although reflexivity examines how the researcher's interests, positions, and assumptions may influence his/her inquiry, it is not an opportunity to 'bare one's soul'. Nevertheless, as a fairly private person the unease of 'exposure' was a sobering reality for this reflective account. Therefore, careful consideration was given about the purpose of what to include and what not to include of a personal nature for reflexivity. Accordingly, it was necessary for me to have time and space for reflective self-awareness in order to recognise my thoughts and feelings which could potentially introduce bias in this investigation. As a result,

the reflexivity presented in this document should enable the reader to assess the extent to which certain factors may influence the inquiry (Charmaz, 2009).

Familial influences

I am the daughter of immigrant parents who came to the UK from the West Indies in the early 1950s, in response to invitations by the then government. My father was a shop owner and my mother a seamstress back home in Jamaica, and their life was considered fairly comfortable, owning their own home and employing at least two domestic workers. Both my parents were Christians of a Protestant denomination, and I was brought up in Sunday school and church life as far back as I can remember. But, as I grew older my religiosity came from my personal decisions and not the practices my parents exemplified although these were good. I am still an active member of a faith community.

My parents' intention to spend five years in the UK and then return home to Jamaica did not happen. They recounted difficult times for a variety of reasons for the West Indian immigrants in those days, particularly in terms of renting accommodation. They bemoaned their situation in the UK in those early days as it was not what they had anticipated. But my parents were hard working, and the accommodation pressures impelled them to purchase their own property after two years, to have some semblance of the decent family life they were used to; even though for financial reasons it was necessary to rent out some of the rooms and occupy the basement.

Consequently, all my education was in this country, and later my nursing career path. I always wanted to be a nurse, although my father for some time strongly objected to my career choice, considering that I should choose something 'better'. But my mother was more supportive, and encouraged me to keep learning and achieve more throughout my career. Sad to say, my mother died just before I started this phase of my degree, and this was a great sorrow to me. However, I still have my father who is now 94 years old, but strong, well and independent. By this familial account I bring to the fore some important occurrences that have ingrained my life, and contribute to who I am as a private individual. I am aware that these familial influences will inevitably accompany me in this research undertaking, and I acknowledge their reflexive significance.

Career influences and Christian beliefs

My background as a Registered General Nurse, Registered Midwife, Health Visitor, and Registered Nurse Tutor (in adult branch nursing), define who I am as a professional person. And being, as some would term, 'a religious person', has influenced my lifestyle to a certain extent. I believe spirituality to be: God centered with a sense of meaning and purpose in life, which gives me assurance and peace. Spirituality also relates to a capacity to appreciate the natural world, as well as meaningful association with others. So in relation to this investigation, I am able to appreciate the religious and non-religious aspects of spirituality, akin to the Stoll (1989) definition (p.32). Although my Christian beliefs remained personal, the participants were aware of both my keen interest in the topic being investigated, and my professional background, as a result of my recruitment presentation. However, my Christian beliefs were not the only motivating factor

that led me to undertake this investigation. I was also concerned with how spirituality in nursing was regarded by some of my fellow academics, and the place spirituality currently holds within nurse education and practice. The following memos from my research diary (Table 4.6) during 2007 and 2009 reveal some of my early concerns and frustrations:

Table 4.6 Early general memos of my research journey

- | |
|---|
| <p>(a) ... I was also alarmed at the negative opinions of some colleagues in relation to the value of spirituality in nursing care. I want to study this dimension of health in depth and make some contribution to my profession and the existing literature (2007).</p> <p>(b) I feel a little lost, and tired of defending and justifying the worth of researching spirituality. I do not feel confident with the level of supervision at present, but perhaps this will change when ... an external supervisor with expertise in researching the spiritual dimension in healthcare is involved (2009).</p> <p>(c) I have also contacted... (<i>name omitted for confidentiality</i>) at Staffordshire university - they have a research department for spirituality in nursing - I may consider transferring there if things do not improve (2009).</p> |
|---|

The main points are that a reflexive stance will inform how I as a researcher will conduct my investigation, relate to the participants, and represent them in written accounts (Charmaz 2014). The subjectivity of the researcher and of those being studied then becomes part of the research process (Flick, 2009).

However, there is no standard meaning for reflexivity, but in constructivist grounded theory the researcher is intentional in including him/herself in terms of the research process, and outcome, which Etherington (2004) suggests should be a means to an end and not an end in itself. So it was important to be aware of

how my own thoughts, feelings, culture, social, personal, and professional history, could influence the dialogue with participants. Additionally, the accurate transcription of their conversations and written representations of the data will contribute to the rigour that is required of good qualitative research (Etherington, 2004), which is the intention of this investigation.

Summary

Assumptions of methodology covered worldviews that inform different styles of research, and these assumptions, rules and methods are like a roadmap that assists the researcher. Methodological plans included the philosophical stance of ontology, epistemology, and research paradigms to demonstrate their influence on the researcher's choice of method. Furthermore, the underpinning theoretical perspectives related to research, were discussed. The advantages and disadvantages of quantitative and qualitative research methods were elaborated to consider the choice deemed suitable for this investigation, in order to gather the subjective experience of participants concerning spirituality and spiritual care within holistic nursing. Grounded theory, its features, and developments with comparisons of various schools were discussed, and my reasons for selecting a constructivist version were presented. Finally, the function of substantive and formal theory and the relevance of BSP were discussed, as well as the significance of reflexivity and its influence on the researcher and the research process. The methods used in this investigation will now be described.

CHAPTER FIVE: METHODS

Methods

Introduction

Research methods relate to the techniques used to collect data (Jones, 2007), and because each method has its own strengths and weaknesses, it is important to choose the one that is most appropriate for this investigation of spirituality and spiritual care. Before starting this process it was necessary to obtain ethical approval from the university's Faculty of Health sciences Ethics Panel, as well as local NHS trusts that the participants would potentially be working for. The recruitment process will be detailed, followed by, in this instance, individual in-depth interviews. This was the tool for the data collection in this grounded theory method, to gather information concerning the perception and activities of the participants. Although an account of the developments in grounded theory was previously explained in chapter 3, the constructivist version chosen by the researcher will be deliberated in this chapter to contextualise the coding and analytical process to be followed.

Ethical considerations

Ethics in qualitative health care research can be complex especially if patients are involved, which is not the case in this investigation. Bowling (2009) explicates ethical concerns relating to participants in the following quote:

“People who agree to take part in research studies need protection in relation to their privacy and protection from manipulation by the researcher. ...The general ethical principle governing research is that respondents should not be harmed as

a result of participating in the research, and they should give their informed consent to participate” (Bowling, 2009 p.176).

Spirituality may be a sensitive topic for some people (Ross, 2006) and the researcher should take into consideration the four primary ethical principles (Beauchamp and Childress, 2001): 1) Autonomy – respect the right of an individual to make his or her own choice; 2) Beneficence – acting in the best interest of the person; 3) Non-maleficence – the principle of avoiding the causation of harm; 4) Justice – fairness and equality among individuals.

Ethical principles and this investigation

The most significant ethical principle in relation to this investigation is autonomy; accepting the participants’ freedom to participate or not participate. There are no real concerning elements that would call for assurance of beneficence or non-maleficence, to prevent participants coming to any harm. However, debriefing with the researcher at the end of every interview will take place, but in the event of a participant becoming troubled or upset as a result of the subject matter, the university’s student counselling service is available. Each participant was treated fairly and equally in the arrangements and conduct of the interviews.

Accordingly, the researcher was mindful of the following:

- (1) Participants’ inner feelings and thoughts as spiritual matters are explored, as they could become emotional.
- (2) Complete informed consent would be difficult at the very beginning because of the tentative and exploratory nature of qualitative research.

(3) The possibility of the participants' anonymity being breached by descriptions of the research process, as well as excerpts from the data. Therefore, caution is required, as well as adherence to the Data Protection Act (UK Government, 1998). The interviews would be planned and conducted with due regard to the ethical issues. So the next step was to gain ethical approval from the university to carry out the investigation.

Ethical approval

This research would involve student nurses and later when they are qualified as Registered nurses. Hospitals, universities and other institutions where research is carried out have in place formal committees and protocols for reviewing research plans (Polit et al., 2006). Therefore, in order to gain this approval for my investigation, it was necessary to satisfy the ethics committees in the form of a research proposal and other documentation, that all issues relating to the participants and the data collection procedures were addressed. All the potential participants were registered on a pre-registration nursing programme at the university, so approval was granted in due course by the university's Faculty of Health Sciences Ethics Panel (Appendix 4). Later on I also gained approval from the local NHS trust (Appendix 5), where the participants would find employment as newly qualified Registered nurses. Finally approval from the university's pre-registration programme manager (Appendix 6) allowed me to begin the recruitment process.

Recruitment

For this, a number of items were prepared:

- 1) PowerPoint presentation for the recruitment sessions – this provided background information about myself and the rationale for the proposed investigation (Appendix 7)
- 2) An introductory letter – inviting students to participate (Appendix 8)
- 3) Participant information sheet – giving details of the procedures of the investigation (Appendix 9)
- 4) Consent form – details of what the students were signing up for and their right to opt out at any point (Appendix 10).

Accordingly, recruitment from four cohorts of adult branch nursing students necessitating four presentations, took place over 22 months, between January 2012 and November 2013. Subsequently, the initial sample population would be a non-probability one of convenience (Bowling, 2009), being students at a university in the West Midlands; so recruitment was easier. Sampling aspects will now be explained.

Sampling

“A sample is defined as a subset of the target population” (Parahoo, 1997 p.221), which in this case are adult branch student nurses. Although all the adult branch student nurses were eligible, only those present at the various recruitment sessions were invited to participate in this investigation. However, not everyone was willing or able to take part.

Qualitative researchers often favour non-probability samples for its potential to contribute to the understanding a phenomenon which is culture specific as a result of the interaction between the researcher and the participants (Parahoo, 2006). Consequently, my investigation sought information from adult branch nursing students concerning their subjective understanding, and application of spirituality and spiritual care in nurse education and practice, and when they are newly Registered nurses. Conversely, quantitative researchers may choose probability in order to select a representative sample, to produce data that can be generalised to a larger population (Parahoo, 2006), but this was not the aim for my investigation.

Non-probability sample

There are five types of non-probability sample as shown in Table 5.1.

Table 5.1 Types of non-probability samples

Sample Type	Description
Convenience	Selection is made from individuals who happen to be available
Purposive	The researcher chooses who to include in order to provide required data
Quota	Different groups in the sample are adequately represented
Snowball	A respondent refers someone they know
Volunteer	The researcher relies individuals to self-select to participate

Table 5.1 displays the various types of non-probability samples and the reasons a researcher would consider when making a selection for a research study. For my investigation the initial sample was one of convenience, but soon after became more purposive through theoretical sampling.

However, only convenience and purposive will be discussed as they have relevance for this investigation:

a) Convenience sample: Participants are near at hand, most likely to respond, also should have the relevant information for the investigation. Therefore, the adult branch student nurses that were present on the recruitment days were invited to be a part of the sample. The drawback is that a convenience sample may be biased, and some potential participants may be missed as they were not available at the time of recruitment.

b) Purposive sample: This is a deliberate non-random method of sampling for a group or setting with a particular characteristic (Bowling, 2009 p.208). Glaser and Strauss (1967) assert that 'purposeful' sampling is commonly used where informants are selected who have specific knowledge about the research question. Consequently, my potential participants would have some knowledge of the research subject relating to spirituality and spiritual care as a result of their nursing programme. Furthermore, only adult branch student nurses who would subsequently work locally as newly qualified Registered nurses for Phase 2 of my investigation were required. Therefore, the initial convenient sample begins to be more purposive. Most qualitative research eventually evolve to purposive sampling (Polit et al., 2001), and my grounded theory investigation will go on to use theoretical sampling in response to emerging information from earlier findings in the data analysis process.

Sample size

In relation to sample size in qualitative research, there are no fixed rules, so sample size is mainly a function of purpose of the inquiry (Polit et al., 2006).

Furthermore, Patton (1990 p.184) confirms:

“Sample size depends on what you want to know, the purpose of the inquiry, what’s at stake, what will be useful, what will have credibility, and what can be done with available time and resources”.

Clearly factors relating to the aims of the research should dictate the sample size, therefore this issue may be outside the control of the researcher (Cormack, 2000). Furthermore, in grounded theory studies the sample size is dictated by theoretical sampling to the point of theoretical saturation/sufficiency, which was the case in this investigation. Consequently, following my initial recruitment of six participants, there was little indication as to the eventual size of the sample population. However, it was necessary for me to proffer an arbitrary number of 30 interviews in total in my proposed plan of work for the university’s ethics committee.

Identifying potential research participants

In my deliberations for identifying potential research participants, it was useful to take on board the advice given by Parahoo (1997 p.219):

“In practice, researchers must have good reasons for including and/or excluding units of population and must clearly define these criteria”

Consequently these were my considerations: 1) Cohorts of nursing students (adult, child, learning disability, and mental health branches) following a three year programme; 2) adult branch students are the largest group, thus increasing

recruitment opportunities. Furthermore, they are more likely to secure employment in the local NHS trust, which favours accessibility for Phase 2 of my investigation; 3) final year students as I would be able to follow them up again when they were newly qualified Registered Nurses within the timeframe allowed for my degree; 4) the smaller child and mental health branches would pose logistical difficulties in Phase 2 of the investigation as they are more likely to be employed further afield; 5) learning disability course is not offered at this university; 6) my experience lies in adult branch nursing.

All adult branch students at the university are located on either of two campuses to follow a mirrored pre-registration nursing programme (Appendix 11: Spirituality content). And they are subsequently allocated for clinical practice within those designated areas. So a calculation of my journey from home to both campuses for data collection showed that this was manageable.

Inclusion criteria

The inclusion criteria for potential participants were identified to be, a) adult branch student nurses; b) final year students; c) students that were likely to seek employment locally, d) different cohorts (to increase recruitment potential); e) located on either of the two campuses which catered for intakes of adult branch students.

Exclusion criteria

The exclusion criteria were: a) other branches of nursing; b) student nurses in years one and two; c) Participants who for Phase 2 were unlikely to seek employment in a local NHS trust; d) any student who for other reasons would not be able to complete Phase 2 interviews for example pregnancy, a planned employment break, or agency work.

Gaining access to potential research participants

Having identified the main features of my sample group, access to these potential participants in the Faculty of Health Studies was needed. Therefore, after liaising with a contact within the university, time was allocated for me (usually at the end of a teaching session) to talk about my investigation and recruit potential participants. The students were given a letter inviting them to consider taking part in the investigation, a participant information sheet, and a consent form. They were asked to take the information away with them and respond by signing the consent form within a week if they wished to participate. Some students signed on the presentation day, but others signed up later. Eventually I recruited thirteen adult branch nursing students from various cohorts who committed to participate in both phases of the investigation.

Overview of interview activity

The interviews for Phase 1 of my investigation were conducted at intervals from March 2012 through May 2014, and the duration of each interview was from 24 to 44 minutes (Table 5.2). The data analysis from the individual interviews were

digitally recorded, transcribed and then subjected to analysis. The interview transcriptions took more time than expected, between 7 and 10 hours, not just because of their length, but the necessity to replay some sections at times to understand what the participants were saying, especially when they spoke quickly or quietly.

Table 5.2 Phase 1 interviews

Participant	Campus	Cohort	Gender	Interviewed	Interview duration (minutes & seconds)
1	1	September 2009	Female	07/03/ 2012	35:51
2	1	September 2009	Female	23/03 2012	26:51
3	1	September 2009	Female	24/04 2012	34:38
4	2	September 2009	Female	26/05/ 2012	24:09
5	2	September 2009	Female	06/06/ 2012	30:56
6	2	September 2009	Female	19/06/2012	28:33
7	2	March 2010	Female	28/01/ 2013	40:19
8	1	March 2010	Female	18/02/ 2013	32:06
9	1	March 2010	Female	22/02/ 2013	25:58
10	2	March 2010	Female	28/02/ 2013	37:43
11	1	September 2010	Female	19/09/ 2013	37:58
12	1	September 2011	Female	25/03/ 3014	31:41
13	2	September 2011	Female	08/05/ 2014	44:08

Table 5.2 displays a list of the number of participants involved in this investigation, together with their campus location, cohort, gender, and the date and duration of each interview.

Interviewing

Interviewing which involves asking questions is the most common form of gathering data, and health professionals in their everyday work are familiar with interviewing people. However, a research interview can be described as a conversation with purpose to explore the views, experiences, beliefs and/or motivations of individuals on specific matters (Gill et al., 2008). And Parahoo (1997 p.281) endorses this statement by saying:

“Verbal communication is the most effective means available to humans with which to convey our feelings, experiences, views, and intentions”

Therefore, qualitative interviews are believed to provide a deeper understanding of social phenomena than would be possible from a quantitative method using for example, a questionnaire. The most common source of data collection in grounded theory is in-depth interviews (Polit et al., 2006), in order to -

“delve deep beneath the surface of superficial responses to obtain true meanings individuals assign to events and the complexities of their attitudes, behaviours and experiences” (Bowling, 2009 p.407).

Accordingly, this was the prime purpose for choosing face-to-face in-depth interviews for my investigation. However, the following is an overview of three types of interviews that were considered and compared for the particular characteristics they could bring to the investigation in hand.

Types of interviews and characteristics

Three main types of interviews are explained together with their related features: structured, semi-structured, and unstructured.

Structured – feature a list of predetermined questions prepared on an interview schedule to obtain the information needed (Bowling, 2009). The researcher asks all the participants the same questions in the same manner and order (Holloway and Wheeler, 2010). Structured interviews are more fitting for quantitative research purposes, as they are inflexible and do not allow for further exploration, which is needed in this instance.

Semi-structured – this type of interview is chosen when the researcher has a list of topics that must be covered in an interview (Polit et al., 2006). The researcher uses an interview guide to open up conversation about the topic and as a reminder to include all the question areas (this investigation, Appendix 12). Semi-structured interviews afford the flexibility to follow-up responses for further elaboration. Thus the interviewer encourages the participants to talk freely about the topics (Parahoo, 2006). Semi-structured interviews fitted my qualitative grounded theory investigation to elicit the understanding, and the impact of pre-registration spirituality education in nursing practice. But it was necessary to open up conversation by asking a few open-ended questions from my interview guide, then, as the interview progressed participants talked more freely and the interview was more unstructured.

Unstructured – these interviews are purposeful conversations with the participants, requiring advance thought and preparation by the researcher. Unstructured in-depth interviews are typically long and could last a number of hours (Polit et al., 2006), and may be difficult to manage. However, a researcher could introduce some structure by selecting a number of areas within a topic to

focus on (Parahoo, 1997). This pattern also fits well with grounded theory as theoretical sampling (discussed on p.140) also guides further areas for questioning. But, further details concerning Constructivist grounded theory will be presented next.

Constructivist grounded theory

Constructivist grounded theory method was chosen for this investigation, and the rationale together with other versions of grounded theory were previously discussed in chapter 3. Constructivist grounded theory developed by Charmaz (2006), promotes a flexible approach that veers away from a mechanical application, with the assumption that social reality is multiple, processual, and constructed, as explained below:

“the researcher’s position, privileges, perspective, and interactions are taken into account as an inherent part of the research reality” (Charmaz, 2014 p.13).

Therefore, a pragmatic approach is one where both the participant and the researcher contribute to the research reality, so that it is constructed as opposed to being discovered. Accordingly, the researcher’s values play a part in shaping the facts they identify. So Constructivist grounded theory is a contemporary revision of the basic principles of classical grounded theory (Morse et al., 2009). And Glaser and Strauss’s (1967) original ideas of an inductive, comparative, emergent, and open-ended approach are implemented (Charmaz, 2014). There is also an emphasis on action and meaning, which are essential features of pragmatism.

Literature review and theoretical sensitivity

An initial review of the literature before starting this investigation gave me some sensitivity about the topic of spirituality and spiritual care in nursing. However, when my investigation was underway there was a need to guard against an obscured view for developing categories due to possible 'contamination' from my prior knowledge (Schreiber and Stern, 2001), and professional background. In essence sensitivity assists the researcher to comprehend, "meaning and respond intellectually (and emotionally) to what is being said in the data" (Strauss and Corbin, 1990 p.41), so that the concepts realised are grounded in the data. In addition, Strauss and Crobin (1990) inform that theoretical sensitivity will assist the researcher to put forward the participants' views. Therefore, the relevant factors mentioned above, together with my personal qualities as a researcher, also my immersion in the data during collection and analysis, contributes to theoretical sensitivity (Strauss and Corbin, 1990).

Demographic information and theoretical sampling

The participants' gender, age, religious/non-religious beliefs, or clinical areas were not predetermined in this investigation. Therefore, during Phase 1 different cohorts were sampled especially in relation to spirituality education in their respective nursing programme located in centre 1 (C1) or centre 2 (C2).

Although the programme content is similar, there is the possibility for certain aspects to be delivered by different member/s of the teaching team for example, spirituality to do with death and dying. However, certain demographic information useful for theoretical sampling for example, age, religious/non-religious beliefs, became available after the 1st interviews, so were only useful in Part 2 of the

investigation for theoretical sampling. This information became worthwhile for pursuing how the core concerns may vary within the substantive field (Glaser and Strauss, 1967, Gibson and Hartman, 2014) of the newly qualified Registered Nurse participants. Glaser and Strauss (1967 p.48) emphasise that the basis of theoretical sampling is for “purpose and relevance”, not to verify facts but to generate theory (Glaser and Strauss, 1967). Therefore, theoretical sampling was ongoing, creating a systematic and relevant reason for the collection of more data, to develop the properties of categories for constructing theory. This process continued until theoretical saturation/sufficiency when no new properties emerged (Charmaz, 2014).

The use of memos

A full description of memos was given in chapter 3 (pp.139-140), so repetition will be avoided here. However, memos were on-going throughout this investigation. After considering some of the participants’ answers to recognizing patients’ spiritual need, I wrote memos of my early thoughts, and one example is given below in Table 5.3:

Table 5.3 Memo on recognising spiritual need

<p>April 2012</p> <p>Religion is easily and specifically identified within the perception of spirituality, although there is a degree of uncertainty as to identifying patients’ spiritual need. Communication skills both verbal and non-verbal, as well as developing a nurse-patient relationship, seem vital in recognizing spiritual needs.</p>
--

This example of a conceptual memo (Table 5.3) confirms that participants readily identify religion within spirituality. However, recognizing the spiritual needs of

patients perhaps may be more difficult if it is not of a religious nature. But participants were able to appreciate that effective communication skills and the nurse-patient relationship are essential factors in recognizing spiritual needs. And this indicates the awareness for developing competence in this area.

Being immersed in the data

A lot of time was spent immersing myself in the data by listening to the interview recordings, revisiting the transcripts, reworking aspects of my analysis, and writing down my thoughts and ideas in numerous memos to capture the bigger picture. For example, Table 5.4 captures some of my theoretical thoughts concerning facilitation of patients' spiritual needs following the fourth interview.

Table 5.4 Theoretical memo relating to facilitation of patients' spiritual needs

May 2012

There seems to be little awareness that they could be attending to spiritual needs anyway in other small, relevant and appropriate ways such as, holding a patient's hand, compassionate care, and treating the patient with dignity and respect. All these aspects are not restricted by professional boundary - such actions transcend professional boundaries.

Participants were attending to some spiritual needs in an integral way within their everyday nursing practice, but were unaware of this. But attending to these fundamental aspects of spiritual care is the responsibility of all who may be a part of the multidisciplinary healthcare team.

Challenge and chaos

As a novice researcher, the process of consecutive memo writing, and analysis was found to be a seemingly challenging and chaotic experience at times, due to the complex and cumulative thinking required (Corbin and Strauss, 2008).

However, as a result of my interaction with the data throughout this investigation, my memos about the categories and their properties were useful, and my ideas became more coherent. Accordingly, this procedure assisted me in making connections within and between categories and properties in the process of analysis (Charmaz, 2006, 2014). Nevertheless, the process throughout was not linear, and at times was rather difficult for me to tolerate, as there came a point where phase 2 data collection commenced as scheduled, and phase 1 was not yet finished. The inevitability of this overlap was a reality, in that I recruited participants from four different cohorts for phase 1 data collection. So some interviews for Part 1 were carried out at intervals in response to theoretical sampling during this overlap. The interviewing process in total for Part 1 and Part 2 occupied 36 months (March 2012 – March 2015), as interviews were conducted at the participants' convenience, and typically only one in a week. Furthermore, Part 2 interviews were scheduled to commence six to eight months post-qualification.

Coding process

Main rationale for coding

Coding begins the process of analytic interpretations to reveal the real life experience of participants, which is the prime purpose of my investigation. Thus,

the main rationales of coding were kept in mind: 1) to procure categories from the data, and 2) to incorporate these into a cohesive theory. Charmaz (2014 p.120) offers the following advice:

- Remain open
- Stay close to the data
- Keep your codes simple and precise
- Construct short codes
- Preserve actions
- Compare data with data
- Move quickly through the data

Charmaz (2014) states that: the first two points are about the researchers' attitude towards coding, while the others suggest how to do the coding. These points were useful while connecting and interacting with the data. But it was necessary to discipline myself to move on, by curbing my tendency to linger through the data.

Asking relevant questions for coding

The following four questions together with the preceding points were also useful during the coding process as a reminder to remain focused on the essence of the topic from the participants' perspective:

“to arrive at a set of well-developed categories closely related to the data and each other in a fully integrated theory” (Gibson and Hartman, 2014 p.82):

1. What is this data a study of?
2. What is actually happening in the data?
3. From whose point of view?
4. What category does this incident indicate?

(Adapted from Birks and Mills, 2011 p.96)

Therefore, coding is the central link between data collection and developing an emergent theory (Charmaz, 2006), which employs theoretical sampling and constant comparison in the process for this grounded theory investigation.

Grounded theory coding

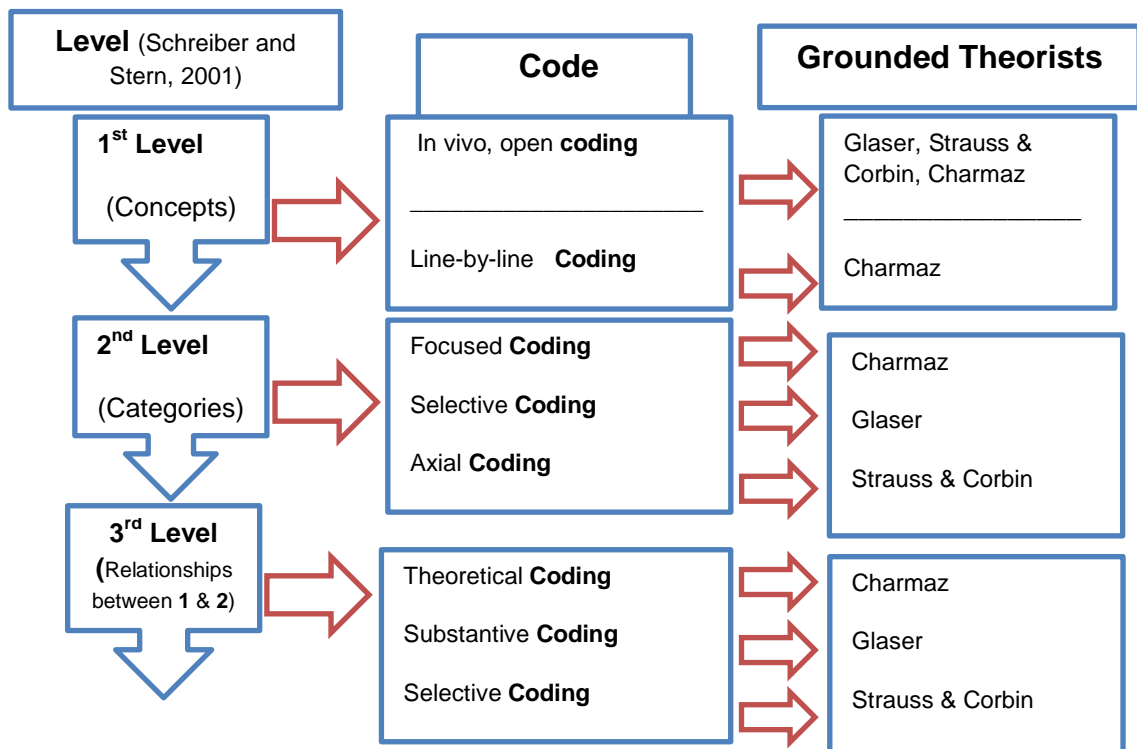
Grounded theory creates codes by defining what is seen in the data, unlike quantitative logic, which applies preconceived codes to data (Bowling, 2009).

Thus, the grounded theorist employs an on-going interactive technique used to develop categories that are closely related to the data and each other, leading to an interrelated theory (Gibson and Hartman, 2014).

Different coding names in grounded theory

Grounded theory may take different forms (Glaser and Strauss, 1967), and after reading numerous texts, my agreement rested with Schreiber and Stern ((2001), as the coding systems were found to be rather confusing at first, as different names are attached depending on the researcher's preference, as illustrated below in Figure 5.1.

Figure 5.1 Coding levels, types, and theorists



For example, the meaning is the same for initial coding whether the term line-by-line (Charmaz, 2006), or open coding (Glaser, 1992b) is used. But, Charmaz (2006) comments that the terms used is secondary to the initial overview of the units of data to conceptualise notions. Moreover, early on it was necessary to tolerate some ambiguity during the interactive process, while grappling to make analytic sense of my data, in order to interpret participants' tacit meanings (Charmaz, 2014). This was an essential activity throughout my data analysis, to identify and capture the participants' value in their experiences, meanings, feelings and assumptions.

Summary

In this chapter I have outlined the procedures for this investigation relating to ethical protocols, and the recruitment of a convenience/purposive sample of final year adult branch pre-registration student nurses from the University concerned. There followed explanation of the techniques and processes used during data collection and analysis, including an overview of the interview activity before elaboration of the constructivist grounded theory used in this investigation. Finally, the main rationale for coding and the different coding levels are explained.

The next chapter will elaborate the essential stages necessary for coding and analysis of the findings of Phase 1 of the investigation with examples from participants' interviews as relevant. This provides clarity and demonstrates openness to the overall processes.

CHAPTER SIX: PHASE 1 ANALYSIS AND FINDINGS

Phase 1 analysis and findings

Introduction

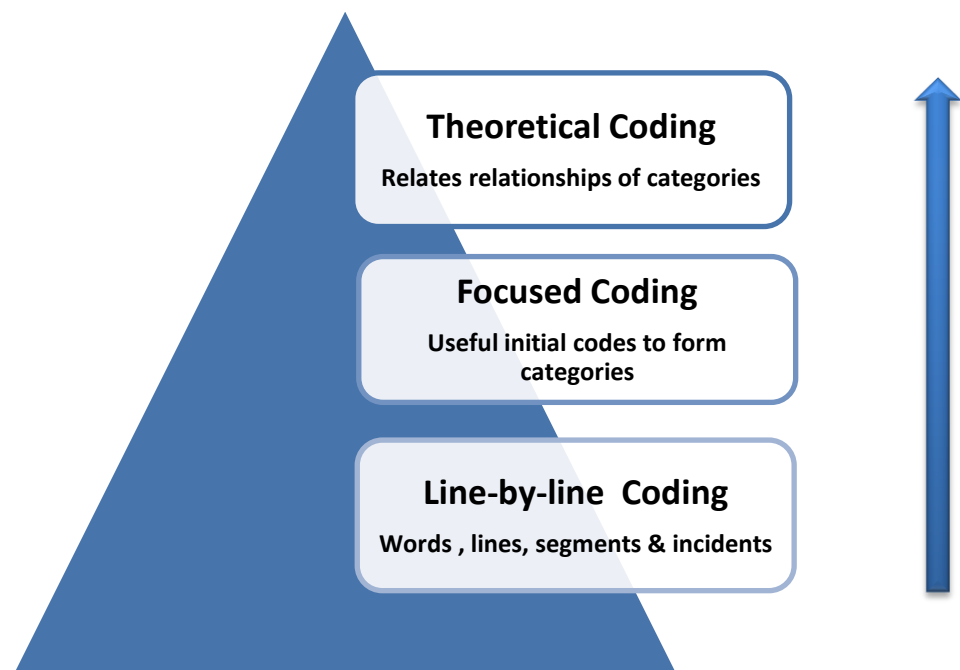
During Phase 1 of this investigation I had the opportunity to explore the impact of spirituality education first-hand from the perspective of final year pre-registration nursing students. This was achieved through in-depth interviews for this grounded theory investigation to gather and analyse rich data. Glaser (2002a) states that grounded theory findings should explain participant's experiences, not just describe them. Accordingly, important coding features for categories are highlighted, and supported by relevant excerpts from the participants' transcripts.

This chapter details the coding and analysis process as follows: Participants' transcripts were subjected firstly to Line-by- line coding, which generated a number of meaningful codes. Secondly, through Focused coding these initial codes were subsequently reduced to the main categories: perceptions of spirituality and spiritual care, accruing spirituality education, and opportunities to provide spiritual care; at the same time the participants main concerns (Glaser, 1992b) were noted. These concerns were: explaining spirituality, remembering spirituality education and the content, and uncertainties surrounding facilitation of spiritual needs. Thirdly, theoretical coding allowed for the construction of the core category (Enablement), which connects the main categories, and offers the participants' the potential capacity to resolve their main concerns.

Data analysis

The interviews and memos created a 'mountain' of data which at times became a concern for me as to how best to handle the same. So the levels of coding for constructivist grounded theory (Figure 6.1) provided a useful signpost for moving forward. Hence, the data analysis process in this investigation from line-by-line coding through to theoretical coding will be explained next. At various points excerpts of interview transcripts will be included to convey the participants' subjective meanings, as well as demonstrate the researcher's openness.

Figure 6.1 Three levels of coding for constructivist grounded theory



In Figure 6.1 the levels of coding that are applicable to constructivist grounded theory have been extracted from Figure 5.1(p170), and displayed on a pyramid in ascending sequence as indicated. This shows the progressive order followed from line-by-line coding, through focused coding, and then theoretical coding.

Construction of codes

Codes were actively constructed by naming data that are identified as being significant, so describing my understanding of the participants' view (Charmaz, 2014). It was also necessary to be reflexive (as explained in chapter 3) throughout by being aware of my opinions, values, beliefs and experience. This was necessary because as a health professional one should not create a bias in the results of the investigation, by as it were, contaminating the data collection and analysis process (Wilson, 2012). Nevertheless, there was also a consciousness that this was an interpretive study, and my interpretation of the participants' views therefore was necessary.

1st level coding: (line-by-line)

This process of line-by-line coding is intense in terms of remaining open to all possible theoretical understandings. This is achieved by developing tentative interpretations about the examined verbatim accounts of participants (Wilson, 2012). Corbin and Strauss (2008, p.160) affirms line-by-line coding as “fracturing the data”, to examine and capture the participants' words to describe their views, meanings, feelings and experiences.

The bigger picture

According to Green and Thorogood (2014), the opportunity to, ‘step back’ and open up to all potential avenues of enquiry, is necessary to gain as full a picture as possible of what is going on. Subsequently, following each transcription of

interview data, I proceeded with 1st level coding (line-by-line), comparing data with data, applying an open but critical view, as I highlighted words and excerpts of interest. I utilised the 'review comments' tool in Microsoft Word 2010, to carry out the initial 'line-by-line coding' (Charmaz, 2006, 2014, Urquhart, 2013), or as termed by some researchers 'open coding' (Glaser, 1992b, Strauss and Corbin, 1998, Artinian et al., 2009, De Chesney, 2015), to break down and examine the data to form concepts and properties (Corbin and Strauss, 2008, Gibson and Hartman, 2014). During subsequent interviews, questions were changed in order to follow-up on important leads in an incremental way towards theory development. Line-by-line coding is exemplified in Table 6.1 where possible codes of meaning are given to the data as participants express their understanding of spirituality.

Table 6.1 Examples of Phase 1 Line-by-line coding
(R = researcher; C = centre; P = participant)

Excerpts	Codes
<p>(R). Can you tell me what you understand by spirituality?</p> <p><i>C1 (P2) In my opinion it's people's beliefs, whether they are religious or not, whether it's after-life type of thing. I'm very vague on it - I haven't got a definite idea, but I would say it's generally about people's beliefs.</i></p> <p>R. OK you said <i>spirituality</i> was about peoples' general beliefs?</p> <p><i>C1(P2) Yaaaa, I don't I don't know, I mean - religion comes into it but then beliefs about after-life and stuff like that would come into it, so I suppose it covers quite a broad area. I can't say quite definitely what it is or how it's definitely defined.</i></p> <p><i>C1(P1) ... it doesn't necessarily have to be religion, it's what they base their umm values and beliefs and way of living on ...</i></p> <p><i>C2 (P4) I think it's hard to put your finger on anything really ... a lot of people believe it to be religion, but I think it's more about beliefs ... anything that you believe.</i></p> <p><i>C1(P9) I kind of believe that spirituality is – it's not a particular religion, it's not – I say it's more your own personal beliefs.</i></p>	<ul style="list-style-type: none"> - Broad idea of spirituality including the metaphysical - Not clear - something to do with an individuals' belief - Not sure, but religion is a part - The metaphysical is a part - A broad concept - Unable to define spirituality - A broad understanding of spirituality - Values and beliefs - Significant to the individual's way of life - Aware of others opinion - Spirituality is many things - A broad concept of spirituality - Individual beliefs

Spirituality In broad terms

In the examples above (Table 6.1) I have demonstrated my openness to possible codes within the data, which gives a useful overview from the participant's perspective. Here it is seen that the participants understand spirituality to be broad (Heriot, 1992, Golberg, 1998, RCN, 2011a), and some would refer to religion as well as the metaphysical (McSherry and Ross, 2010), but found it

difficult to actually define spirituality. This dilemma of defining spirituality is mentioned by researchers such as, Coyle (2002), and also Kevern (2013, p.9) who asserts:

“... despite difficulties of definition, the notion of ‘spirituality’ points (however vaguely) to something fundamental in human beings and therefore person-centred care ...”

This assertion adds support to the view that spirituality is significant to holistic nursing care (Dossey, 1989, RCN, 2011a). What became evident is that, without exception, all 13 participants found it difficult to define spirituality, which is in keeping with the findings of previous research, for example, Oldhall (1995), McSherry (1998), Narayanasamy and Owens , (2001), Tanyi (2002) Van Leeuwen and Cusveller (2004), Sartori (2010a), Burkhart and Schmidt (2012), and Reinert and Koenig (2013b), illustrating its nebulous nature. Furthermore, the majority of participants (12 out of 13) actually described spirituality as including religion, demonstrating an understanding of its ‘umbrella’ status. However, this does not eliminate the on-going effort by individuals to define spirituality as exemplified with gerunds in Figure 6.2 below.

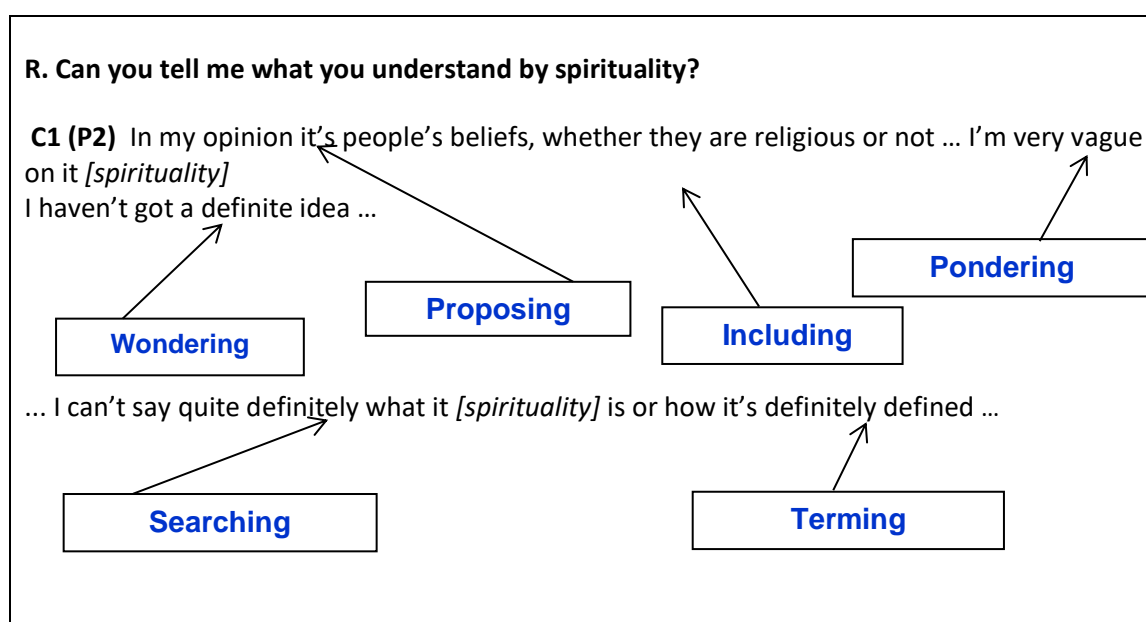
Gerunds

A gerund is a noun made from a verb by adding “ing” to create an impression of action in the coding (Charmaz, 2006), which Glaser (1978) suggests helps to detect processes. Therefore, according to Charmaz (2014, p.120):

“We gain a strong sense of action and sequence with gerunds”.

This coding for actions as advocated by Charmaz (2006) is preferable to coding for themes which remain at a descriptive level, instead of constituting a process. So the example in Figure 6.2 shows how I have subjected portions of significance from a participant's transcript (P2) to gerunds (indicated in blue) which demonstrate participants' active engagement with the concept.

Figure 6.2 Example of Gerunds



Struggling to understand spirituality

The data seems to come alive by emphasising implicit meanings and actions of the gerunds, wondering, proposing, including, pondering, searching, and terming, around what has been described by Clarke (2009) as, the 'chaos and ambiguity' of spirituality. These gerunds about the understanding of spirituality reveal the way participants' struggle to pin down a neat definition of the term, and Swinton (2006b) comments, that spirituality is difficult to define when removed from its religious roots. Furthermore, some researchers comment that

spirituality definitions seem to lack rigorous critique (Pesut, 2008a, Clarke, 2009). But a neat definition is not necessarily desired, as this may limit its breadth of understanding within further debates, according to Clarke (2013). And Pike (2011) favour varied conceptualisations to cater for personal spiritual definitions, cultures, and individual preferences, which makes subjective logic. Thus the individuality of spirituality is undisputed given its subjective understanding, and the sentiments of Slay (2007 p.26), echo that spirituality is an -

“expression of a person’s humanity, whatever it is that helps to shape that person” .

So as each person is a unique being, they are likely to have a different perspective of spirituality.

Sometimes participants will use special terms in their interview conversations (Charmaz, 2006, 2014, Schreiber and Stern, 2001), which should be considered for their significance. These are known as ‘In-vivo codes’ which I will now discuss.

In-vivo codes

In essence In-vivo codes should be helpful in preserving the meanings, views, and actions of participants, but they may, as in the case of this investigation, reflect the condensed meanings of a general term, as seen in Table 6.2. Overall such simple In-vivo codes may reflect the participants’ preference to use more straightforward and professional language related to conversations connected to nursing. In Table 6.2 the participants’ In-vivo codes of ‘it’s’ in the excerpts are

seen and represent the word ‘spirituality’. Therefore in this investigation, there were no In-vivo codes of useful significance for analysis and integration into the theory (Charmaz, 2014).

Table 6.2 Example of In-vivo codes

C2 (P5) I understand spirituality to be individual to a person, it's, its what makes a person them, it's unique to everybody...

C1 (P9) I say It's more your own personal beliefs ...

C2 (P6) It's individual, I think umm it's a range of all the experiences in your life ...

Needless to say, I had to remain focused on each stage of the analytical process in my investigation to put forward a cohesive picture of what is going on in the data. So impressions from the initial coding confirm that some of the difficulty for participants to grasp spirituality may indeed lie with its general characteristics, although there is also an individual and personal agenda, (Heriot, 1992, Golberg, 1998, Young and Koopsen, 2005). However, the next stage from line-by-line coding is focused coding, which will now be discussed.

2nd level coding: (Focused coding)

Focused coding pinpoints the most significant and/or frequently occurring initial codes (Engward, 2013) to synthesise, integrate, and organise large amounts of data (Glaser and Strauss, 1967, Charmaz, 2006). The process of selecting words and phrases that contain a single unit of meaning (Schreiber and Stern,

2001), contributes to generating categories, which have been described as being the same as concepts (Charmaz, 2006, 2014, Birks and Mills, 2011). These categories are distinct and are a part of how we construct phenomena, and how we classify them (Dey, 1999). So focused coding allowed me to reduce the original list of categories (Glaser and Strauss 1967), thus assisting my movement across the interviews to compare the experiences, views, actions and interpretations of the participants (Charmaz, 2006, 2014). The main categories were identified as, perceptions of spirituality, accruing spirituality education, and opportunities to provide spiritual care (Tables 6.3, 6.4, and 6.5), and these will be explained next.

Table 6.3 Phase 1: Focused coding (category 1)

Segments of transcripts	Interpretation	Category
<i>C1 (P1) [spirituality] The basis of a persons' belief, not always religion; Values, beliefs, way of living, also a source of help.</i>	Spirituality is defined to be more than religion, and inclusive of ones values, belief system and what constitutes a person's way of life.	Perceptions of spirituality and spiritual care
<i>C1 (P3) I think it's [spirituality] a bit of everything really ... a lot of the caring side of nursing.</i>	Spirituality is not separate from the nursing care given to patients.	
<i>C2 (P6) Spirituality takes into account people's religion or non-religion It's what makes a person individual.</i>	Spirituality here is understood and defined as contributing to a person's individuality.	
<i>C1 (P8) I don't particularly link it to religion, it's your own personal belief. It's a holistic approach looking at life</i>	Spirituality is a personal belief which may not be religious. It is also a holistic approach to life.	

These examples reveal that the participants' typical understandings of spirituality were associated with: a person's way of life - religious/non-religious (P1, P6, P8);

values and beliefs – whatever people hold dear, their individual opinions (P1, P6, P8); also the care given within nursing, and a holistic concept (P3, P8). All these features seem to concur with the suggestion that, spirituality is “notoriously difficult to define” (Slay, 2007 p.26). However, in spite of the difficulties in perception for defining spirituality, participants had recognition of its significance in the life and nursing care needs of individual patients. Accordingly the category of ‘perceptions of spirituality and spiritual care’ is demonstrated in the participants’ excerpts in Figure 6.3 above.

So continuing with focused coding Category 2: ‘Accruing spirituality education’ in Table 6.4, show examples of opinions the participants had towards spirituality education in their nursing programme and other sources, and its benefit to furthering their knowledge in this area.

Accruing spirituality education

I have used the word accruing in the context of spirituality education within nurse education programmes, to express the accumulation of various sources of information and skills in this learning area. The amalgamation of formal and informal education is necessary and adds value to innate qualities, life experiences and the gaining of relevant skills in practice.

Table 6.4 Phase 1: Focused coding (category 2)

Segments of transcripts	Interpretation	Category
<p><i>C1 (P1) Well the course taught to us ... in general ... about spirituality, religion, beliefs, values which all sort of interrelate ... they have talked to us about various points when a person might need particularly say, spiritual support ... they made us aware that it's part of holistic nursing care.</i></p> <p><i>C1 (P3) Well there wasn't much in my training spiritual wise, but I think everything to do with the course and all of the caring aspects that we've gained from the classroom have helped me in practice ... overall it's actually being in practice and working with patients you seem to pick up quite a lot ... a placement within a palliative care setting really I think opened your eyes and in loads of different ways in which you can provide spiritual care.</i></p> <p><i>C2 (P4) I don't think it really does, to be honest we don't do a huge amount on spirituality at university. We have the odd session here and there but I think it's quite hard when you do have the sessions to really clarify what spirituality is, I think it's kind of up you to make your mind up yourself what it is ... I don't think nurse education prepares you ... maybe the teaching sessions if anything have just made me more aware of spirituality, although I would do what I would do anyway ...</i></p> <p><i>C2 (P7) I don't think we do enough, I don't think there is enough in the syllabus ... perhaps it's an innate thing being able to respond to peoples' spiritual needs ... I really enjoyed the sessions I was really interested ... I thought that [spirituality] was really important ...</i></p>	<p>Spirituality education in the nursing programme was beneficial and was related to holistic care and the potential spiritual needs of patients.</p> <p>Although actual spirituality education content in the nursing programme was small, it was recognised that spirituality was an integral part of all nursing care. So the academic input was useful, but the clinical practice experience was vital, and in particular palliative care experience to increase knowledge and skills in this area.</p> <p>A small amount of spirituality education on the nursing programme was acknowledged, but did not result in a clear understanding. As a result, you are unprepared, although more awareness of spirituality was gained. Nonetheless, it's one's personal inclination that motivates spiritual care.</p> <p>Again spirituality education was perceived to be insufficient. However, it is suggested that the ability to respond to people's spiritual needs could be innate. Spirituality is important.</p>	<p>Accruing spirituality education</p>

As seen in Table 6.4, participants seemed to have mixed opinions regarding spirituality education in the classroom: Participant 1 gained a fairly comprehensive grasp of spirituality and spiritual care, but a significant comment

made (P3, P4) was that spirituality in the nursing programme was not always explicit, but inadvertently present. Thus, students are required to make the necessary discovery and connection within other caring topics for example, communication, ethics, giving personal care. However, if student nurses are given some guidance to recognise spirituality within other aspects of nursing care, this link would become standardised and contribute positively to understanding the concept. But spirituality is regarded as important by the participants, and there probably is an innate element to responding to spiritual needs (P7). However, experiential learning in palliative care was highlighted (p3).

It seems that spirituality and spiritual care for the most part may be hidden, although its existence cannot be denied within the concept of holistic care that nurses aspire to. And, there was evidence that some students detect the presence of spirituality in other aspects of care covered in the classroom (Wallace et al., 2008), and could then translate this knowledge into their practice. This reinforces the belief that spiritual care is a part of everyday nursing (Clarke, 2013), and is integral to holistic nursing care. The overall impression given by participants was that spiritual care is unscripted, and they were keen to engage in this caring activity as best they could. So being able to reflect on the overall content of spirituality education, should assist participants to a better understanding (Mooney and Timmins, 2007, Burkhart and Schmidt, 2012).

While participants acknowledged some spirituality education in their nurse training, in most instances they said that the input was insufficient, an issue reaffirmed by Callister et al (2004), McSherry and Jamieson (2011), Çetinkaya et

al. (2013), Abbasi et al. (2014). Accordingly, participants said they would like more theoretical input relating to spirituality in their pre-registration programme, which clearly reflects their feelings of insufficiency in this area.

No doubt, adequate spirituality education to provide more information and clarification would benefit nurses in this area of holistic care. In addition, collaboration between students, teachers and mentors in the clinical area has the potential to provide optimal learning outcomes (Giske and Cone, 2012).

Furthermore, as asserted by Benner and Sutphen (2007), it is in clinical practice where student nurses are able to grasp the nature of specific situations, and this also applies to spiritual care, as seen in the Baldacchino (2015) study. However, as demonstrated below in Table 6.5, participants were interested to take the opportunities available in their placement areas to facilitate spiritual care for patients to the best of their abilities.

Opportunities to provide spiritual care

The whole purpose of spirituality education in pre-registration nurse training is to equip students with the knowledge, understanding and skills they require, to facilitate the spiritual needs of patients (Seymour, 2006, Lewinson et al., 2015).

The clinical practice area is the place where spiritual care is realised with real patients, as the variety of relevant accrued knowledge and skills come together.

Table 6.5 Phase 1: Focused coding (category 3)

Segments of transcripts	Interpretation	Category
<p>C2 (P4) ... getting somebody in that is from their religion ... you can just sit and listen to them really, it's accepting ... you are there to support them ... to me, holding someone's hand as they die , to me is as spiritual as it can get really ... as they are passing over into the, into you know, their other life...</p>	<p>There is an awareness of the spiritual in presence and touch.</p>	<p>Opportunities to provide spiritual care</p>
<p>C2 (P5) ... they had everything they wanted with them in their time of death, and therefore I feel that that sort of acknowledged all spiritual needs were met.</p>	<p>Attending to the spiritual individual needs of the patient was fulfilled.</p>	
<p>C2 (P7) ... I think just touching her hands and holding her hand when I went and spoke to her helped her ... I felt that she gained a little bit of something from that ...</p>	<p>Touch is recognised as beneficial to the patient.</p>	
<p>C1 (P8) ... you have to go along with what they want ... maybe some of them follow some Christian beliefs but not all of them...</p>	<p>It is the patient's spiritual agenda that is uppermost.</p>	
<p>C2 (P10) ... Just bringing them reassurance ... just sitting there and listening ... it might mean a lot of things ... it's just that they know you are there</p>	<p>Reassurance, active listening and presence has potential benefits for patients.</p>	

Table 6.5 shows that participants were aware of a number of ways to facilitate the spiritual needs of patients, and they were willing to assist in whatever way they could. Some participants recognised presence and listening as important aspects of spiritual care (P4, P10), also the need to go along with the patient's wants and wishes (P5, P8), thus demonstrating individualised care. The value of touch is recognised (P7).

Hence, through focused coding I generated the main categories: 1) Perceptions of spirituality; 2) accruing spirituality education; and 3) opportunities to provide

spiritual care. These prominent categories fitted all 13 interviews in phase1. And theoretical coding at level 3 then completes the final coding (previously illustrated (Figure 6.1, p.174).

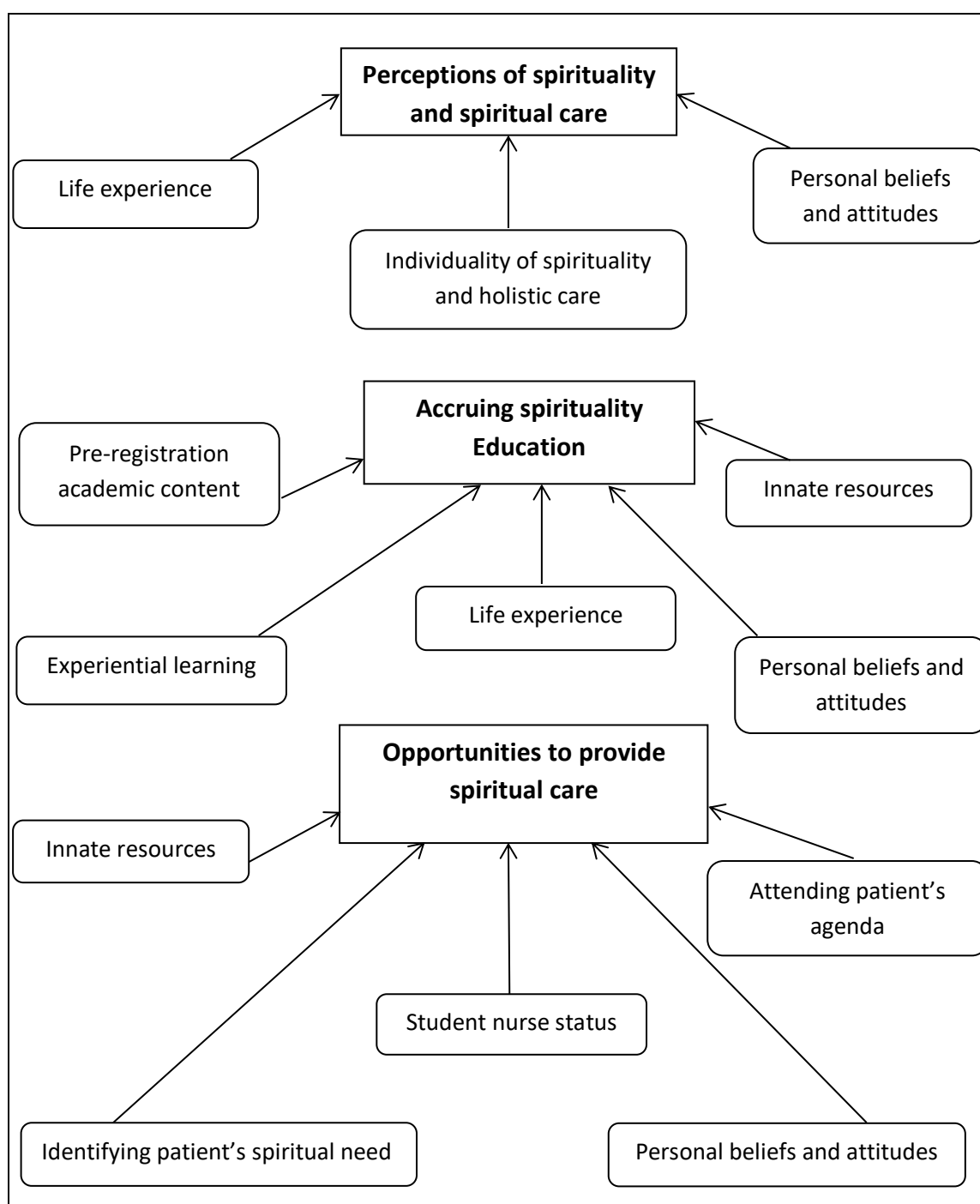
3rd level coding: (Theoretical coding)

The purpose of theoretical coding is, to indicate possible relationships between the categories that have developed during focused coding towards an integrated and explanatory substantive grounded theory (Hernandez, 2009). And Charmaz (2006 p.63), confirms this and states:

“theoretical coding is a sophisticated level of coding that follows the codes you have selected during focused coding”.

Consequently, the three main categories constructed from my focused coding: perceptions of spirituality, accruing spirituality education, and opportunities to provide spiritual care, are illustrated in Figure 6.3. The connections I have made between each of these three main categories and their properties, also how some properties also relate to other categories, come together to provide meaningful content.

Figure 6.3 Theoretical coding - main categories & related properties



The above categories and properties in Figure 6.3 will be explained and developed in the following section.

Perceptions of spirituality and spiritual care

The perceived content of this all-encompassing concept meant it could be described as being inclusive of factors such as, personal beliefs and attitudes, life experience, individuality of spirituality and holistic care. This is reflected in the excerpts of transcripts taken from participants' interviews and presented in Table 6.3, p.182 (my comments in blue). However, it is important to note that the property of individuality of spirituality and holistic care contains the participants' perception of patients having a spiritual need also recognising the same. Both these crucial aspects will now be elaborated as they have a direct bearing on facilitating spirituality in clinical practice which is necessary for patient wellbeing.

Perceptions of patients having a spiritual need

As all healthcare workers respond to a variety of health needs, it is useful to confirm that a need denotes something that is required or necessary, and implies the capacity of an individual to benefit from a particular intervention, such as spiritual care. Peoples' health needs are important and they influence the planning of care. Bradshaw (1972 pp.640-641) identified 4 types of needs: 1) normative need, 2) felt need, 3) expressed need, and 4) comparative need. In relation to this investigation, an awareness of all four types of need is relevant in assessing and planning spiritual care for patients. A brief definition and examples of the various needs and how they relate to spiritual needs is given in Table 6.6.

Table 6.6 Bradshaw's 4 types of social need related to spiritual need

Type of need	Definition	Examples of spiritual needs
Normative need	Need that is defined by professionals. These are not absolutes, and may vary according to the individual professional or their organization.	Compassion, dignity, and respect in all nursing care (DH, 2015c, RCN Scotland, 2016)
Felt need	Need perceived by an individual. Felt needs are revealed through communication.	The need for privacy to pray or meditate. - Some form of spiritual assessment is useful for discovering felt needs.
Expressed need (Demanded need)	Felt needs turned into action - Help seeking.	Requesting to go to the hospital chapel (if able), or a visit from the hospital chaplain/other.
Comparative need	Individuals with similar characteristics to those receiving help.	Care plans in hospice and palliative care settings; end of life care (Leadership Alliance for the Care of Dying People, 2014)

Spiritual need was one of the early issues to be coded in this investigation, and perceptions of spirituality, has influence on acknowledging that patients have spiritual needs. This recognition/awareness should potentially precede a response with spiritual care. Thus, I was prompted to explore this aspect concerning acknowledgement of spiritual need with participants as exemplified in Table 6.7.

Table 6.7 Example of acknowledging that patients have spiritual needs

Participants' excerpts	Explanation
<p><i>C1 (P2) I think everyone's got a spiritual need, umm whether they can communicate that spiritual need, whether they know what it is themselves, whether they've actually thought about it in depth – I don't know ...</i></p>	<p>It is assumed that individuals have spiritual needs, but they may not be fully aware of it or be able to articulate the same.</p>
<p><i>C2 (P10) I think everyone has a spiritual need – to what degree and level that could be, probably varies from that individual's perception of their spiritual need.</i></p>	<p>There are different levels of spiritual need according to the individual's perception.</p>
<p><i>C1 (P11) Well I think they probably do [have spiritual needs], but I'm not sure that every environment within the health service needs to be catering to that. So if you are in sort of short stay surgical ward I'm not sure that that's important in some ways. I think that in palliative care, oncology, and sort of terminal illness it's vital that that's a need that needs to be met ...</i></p>	<p>Patients have spiritual needs but meeting these needs may not be a priority in short-stay clinical areas. However, spiritual care is important for palliative and end of life patients.</p>

One participant (P11) although acknowledging that patients have spiritual needs, was doubtful whether such concerns needed to be addressed in some acute clinical areas. Accordingly, and in line with theoretical sampling, this particular comment was followed-up for comparison (Glaser and Strauss, 1967) later in phase 2 interviews, when the participants are newly qualified Registered Nurses and working in their preferred clinical areas. Although it was confirmed by participants that patients had spiritual needs, how they could actually identify these needs was important.

Identifying spiritual needs

In Table 6.8 participants reveal how they identified spiritual needs by offering a number of suggestions, including the thought that getting to know the patient would be helpful. Moreover, some participants did feel that conversations with patients as well as recognising non-verbal cues, is key to identifying spiritual needs. But as seen below (P5) also mentioned the advantages from assessing the patient holistically, thus considering all their care needs, and this would also inevitably give some indication of a patient's spiritual need.

Table 6.8 Example of identifying spiritual needs

Participants' excerpts	Explanation
<i>C1 (P2) I don't know – I always, I always take it back to religion and beliefs ... I don't know how you'd recognise it – I don't, you got to get to know, well I think you've got to get to know the patient or they have got to start the conversation ... I don't quite know how you'd recognise it.</i>	This participant is in a quandary about recognising spiritual needs apart from the religious aspects. However, she thinks that getting to know and talking with the patient may be helpful.
<i>C1 (P3) Umm (pause) I'm not sure really umm, whether sometimes maybe they might ask for input, but that's very rare.</i>	There is uncertainty about recognising spiritual needs, and patients' expressed spiritual needs are not a common occurrence.
<i>C2 (P5) ... talking to a patient and finding out ... body language conveys it, so just by generally assessing your patient in a more holistic manner and looking outside the box rather than just on the inside the box condition" ...</i>	Effective verbal and non-verbal communication, contribute to a holistic patient assessment to recognise spiritual needs.

According to Narayanasamy (2010, p.38) “provision of spiritual care in response to spiritual needs should be given as readily as any other aspect of healthcare...” this would realise nurses’ aspirations of holistic care.

So although students acknowledge that all patients have a spiritual need, they unearthed some difficulty identifying what those needs could be (P2, P3), but having an open mind is useful (P5). This is a dilemma, and one wonders how they will be able to adequately meet the spiritual needs of patients on an on-going basis, and this is a further aspect to follow up through theoretical sampling in Phase 2 of my investigation. But the participants’ personal attitudes, life experience, beliefs, as well as the individuality of spiritual needs was included in their perceptions of spirituality (Figure 6.3, p189). However, the significance of spirituality education in the pre-registration nursing programme may be a vital component in furthering attention to the spiritual dimension within holistic care.

Initial impressions

Impressions from the initial coding confirm that some of the difficulty for participants to grasp spirituality may lie with its broad concept. According to Pesut et al (2008), secularisation of spirituality is a reflection of a pluralistic, post-modern society, revealing a growth in this more open view of spirituality (Paley, 2008a), which should not be overlooked. Rather, it should be assimilated into our understanding and response to the way spirituality is currently seen. However, there was agreement by the participants that spirituality consists of religious and non-religious beliefs (Golberg, 1998, McSherry et al., 2008, Ross et al., 2014).

And Table 6.9 below presents a brief summary of my initial impressions from the findings of Phase 1:

Table 6.9 Brief summary of initial impressions of findings

Category	Initial impressions
1) Perceptions of spirituality and spiritual care	Although the participants found it difficult at first, they conceded that spirituality was more than religion, and that it was very individual. They were also aware of, and respected the value spirituality may hold for patients. Furthermore, perceptions of patients having spiritual needs and the identification of the same was also included in their overall perceptions of spirituality. Accordingly, they became aware on reflection that caring with compassion, dignity and respect are spiritual aspects. So the category of 'perceptions of spirituality and spiritual care' is clearly demonstrated in the participants' excerpts as seen in Table 6.3 (p203)
2) Accruing spirituality education	Participants realised that the small amount of spirituality education received in the nursing course, relevant life experience, innate resources and any experiential learning all contributed to their learning. But they recognised that knowledge and understanding of spirituality and spiritual care was on-going process. They also thought there should be more spirituality education throughout the nursing course to adequately prepare them for the spiritual dimension of their role. However, formal academic input from the nursing programme, as well as informal knowledge from various sources, contribute to accruing spirituality education.
3) Opportunities to provide spiritual care	The participants were motivated to incorporate spiritual care within their everyday holistic nursing care practice. They felt challenged in this area at times, but this did not dissuade them from endeavouring to facilitate the spiritual needs of patients. Thus, the properties of innate resources, personal attitude/beliefs, identifying patient's spiritual need, and attending patient's spiritual agenda, were all demonstrated in relation to opportunities to provide spiritual care.

Table 6.9 summarises my initial impressions as a result of line-by-line and the focused coding for Phase 1 of this investigation. But the challenge of addressing

spirituality in everyday nursing activities warrants further attention by identifying the participants' main concerns.

Therefore, having addressed the main categories and related properties, the analytical process now lead me to the identification of the participants' main concerns, and their means of resolution as a result of the core category (to be discussed later in this section).

Participants' main concerns

The general focus of grounded theory is to discover the main concerns of the participants about what is happening in the research situation (Glaser, 1978).

The whole process is data driven and provides explanations on the phenomenon being studied, to eventually find a theory that adequately demonstrates the resolution of the participants' main concerns. Therefore, from my analysis of the data in Phase 1 of this investigation I was able to identify the following three main concerns: 1) Explaining spirituality; 2) remembering spirituality education and the content; and 3) uncertainties surrounding facilitation of spiritual needs. These will all be discussed in turn with relevant support from samples of participants' transcripts.

Explaining spirituality

The participants seemed to struggle in their efforts to explain what spirituality is about, which is not unusual (Golberg, 1998, Thomas, 2015). Nevertheless, the

majority were able to put forward various aspects of the concept as seen in the following excerpts:

C2 (P7) I think it's something to do with the essence of somebody and what makes that person tick, whether it's religious or non-religious beliefs, it could be it's what makes that person the person that they are - if that makes any sense.

Here the participant reveals some uncertainties when trying to explain spirituality, for example in phrases such as “I think it's something to do with ...”, and “it could be ...”

C1 (P11) ... I don't know, but I think spirituality is something that everybody feels or has, it's linked with who you are, your soul and your belief systems ...

Again this participant echoes some uncertainties about spirituality, but she then goes on to affirm some metaphysical notions of spirituality that could apply to everybody.

C1 (P9) I kind of believe that spirituality is - it's not a particular religion, it's not - I say it's more your own personal beliefs, and it's something that - it's a very holistic approach looking at life and beyond life.

Spirituality is identified to be more than religion to include personal beliefs in this life and beyond. The holistic approach to nursing care is highlighted in supporting such beliefs. It is evident from the examples of participants' transcripts that explaining spirituality is a concern to the participants, thus a clearer understanding of spirituality and spiritual care would be beneficial. But another area of much concern is spirituality education and its content.

Remembering spirituality education and the content

Remembering spirituality education affords the participants a relevant knowledge

base from which to build further information in this area. The main difficulty concerns the presence and content of spirituality education particularly in the first and second years of the nursing programme, for example:

C2 (P6) anything I can remember was from the third year.

And –

C2 (P7) I think we had a couple of sessions, I don't know whether it was the first year – definitely the third, definitely the second. I think perhaps we touched a little bit in the first year, but I remember we definitely had dedicated sessions in the second and third year, but I can't remember back as the first – too long ago for me to remember.

So this inability of a number of participants to remember when spirituality took place in the earlier years of their nursing programme and the actual content of the same, concur with the findings of a study by Linda et al (2015), that not being able to remember what, when and how they [research sample] learned spiritual care “depicts a strong notion that spiritual care was not sufficiently catered for ...” (p.9). This scenario could have an effect on the nursing students’ competency at this stage to meet the spiritual needs of patients, because overall there was a lack in their preparation.

So recollections of participants as to the inclusion of spirituality education in the first two years on the nursing programme, was imprecise, and information overload given as a probable reason for this as exemplified in the following views:

C1 (P8) I don't know – it's a full-on course ... there are certain things that you need to be taught in the classroom ...

And –

C2 (P10) I can't remember if I did in the first year, we might have touched on it a bit, but I think when you are in the first year there's so much to take on board, it probably was there but not as much as in my third year ... I don't really recollect the first year to be honest.

Also -

C1 (P11) I think the syllabus in the three years is quite full already.

But remembering spirituality education could also be the result of two other things: firstly the infinitesimal content in the overall curriculum, and secondly its sometimes unobtrusive presence, compared to the more obvious representation of other subjects in the nursing programme. These are examples:

C2 (P5) ... I think too much is focused on the clinical, the condition rather than the other needs of the patient. They all go on about holistic care – but what does holistic care encompass really, whereas we focus a lot on interventions and how that directly affects the patient, rather than the other side[spiritual].

Also –

C1 (P8) I think it's mentioned a lot over the three years – but it's involved in ... cultural beliefs and stuff we have ... I wouldn't say we specifically have focus on spirituality.

But this common occurrence of participants' inability to remember accurately when they had spirituality input in their nursing programme, could also suggest the low priority given to this domain in nurse education, or the lack of importance participants' attached to the subject. Nevertheless, it is seen that even a limited amount of spirituality education has the potential to create an interest for further knowledge and understanding of the concept.

C1 (P2) we had a very good, very informative lecture ... I thought wow! this is something really important, something that we need to cover, something we need to understand because everyone is so very different - every patient is so very different and you need to cover everybody's needs ... I can't remember when the lecture was, but that's the only thing I remember that covered any sort of spirituality at all was that lecture in three years ... I don't think it was covered enough by any means.

And -

C2 (P6) I think anything I can remember was from the third year ...it was just one lecture, from a Professor trying to explain what spirituality was ... it was too short But then I actually wanted to know more, understand it better but you didn't have that opportunity...

However, being able to recognise aspects of spirituality in other topics is also a useful complement, which was recalled by some participants:

C1 (P3) I think everything to do with the course and all of the caring aspects that we've gained from ... the classroom have helped me in practice.

Again –

C1 (P8) I think it's [spirituality] mentioned a lot over the three years - but it's involved with the holistic side, and cultural beliefs and stuff we have - I wouldn't say we specifically have focus on spirituality ... it doesn't mean that we haven't any - not that I can recall.

Furthermore, participants were aware that spirituality and spiritual care is a part of holistic nursing:

C1 (P1) they made us aware that it's [spirituality] part of holistic nursing care ... we should be taking that into account ... may affect them [patients] physically and mentally as well if we don't fulfil that [spiritual] need.

Notwithstanding this lapse in memory about spirituality education in the earlier years of the nursing programme, all remembered some spirituality education in

their third year. I suppose this is logical, being the most recent coverage of the subject. But there is no denying the views of participants for wanting more spirituality education.

C1 (P2) I think there should be something [spirituality content] every year as we have in other areas in other subjects.

And -

C2 (P7) I don't think we do enough, I don't think there is enough on the syllabus. I think umm (pause) I suppose if it can be taught as well - perhaps it's an innate thing being able to respond to peoples' spiritual needs and listening and that kind of thing.

Thus a conclusion is drawn from the Phase 1 data that spirituality education does not occupy a consistent recognisable place in the nursing programme. And one participant (P7) questioned if spirituality can really be taught. But what also became apparent from the data were the possible uncertainties some participants had about facilitating spiritual needs.

Uncertainty surrounding facilitation of spiritual needs

On the whole participants struggled to describe how they had facilitated spiritual needs, and they were inclined to look for religious examples. This could be due to a tendency for reverting to a narrow concept of spirituality, but also the integral nature of spiritual care that is often contained in everyday nursing activities (Clarke, 2013), and therefore not readily recognised (Golberg, 1998). But spiritual care involvement can cause some concern for students, as explained in the next example:

C1 (P1) I know I am ... still learning about recognising needs, but also I think you're very aware of not just spirituality but other things in general. You're very aware of what you ... can and can't say because you know you've got limitations ... trying to meet and help their needs [spiritual] but not go over ... the boundaries of what we should be doing as a qualified nurse, or student nurse in this case.

The student nurse role is seen as limited in terms of not being able to adequately recognise patients' needs in general. Furthermore, participants expressed some caution in trying to meet spiritual needs appropriately within professional boundaries.

One participant could not affirm that she had met patients' spiritual needs, but from the remainder of the answer given, it seems obvious that she was referring to the religious aspect of spirituality. In addition, attending to the religious side of spirituality is seen as something for her to be very cautious about for fear of unfavourable accusations, if misunderstood by both patient and colleagues:

C1 (P2) I don't know that I have (pause). There was something in the media a while ago wasn't there about umm (pause) a nurse who prayed with a patient? and she got into terrible trouble for it? ... You need to keep your distance at the same time as keep caring for them an, an meeting their other needs (pause) - I'm not sure ... I think it's something you should be able to do - but I don't know where the boundaries are.

Consequently, there appears to be an element of cognitive dissonance between thoughts of spiritual care and certain corresponding actions of a religious nature. However, another participant recognised attending to spiritual needs in a more general way:

C1 (P12) I think it's [spiritual care] built into what you do anyway ...

Admittedly there may be uncertainty about meeting spiritual needs, but picking up on cues from the body language of patients or conversations with them, could be a useful indication of where to begin in offering spiritual support. And the following participant states what she would do in the situation below:

C1 (P2) ... if someone needs spiritual help in hospital, you call the chaplain...

Referring to a chaplain or other religious leader seems to be an obvious and straightforward option.

The data also revealed that the necessary aspects of compassion, respect and dignity in good nursing care were often forgotten and not recognised as being spiritual by many participants when reflecting on the facilitation of spiritual care (Byrne, 2002). In addition, the significance of, not just doing to, but being with them [patients] (RCN, 2011a) is not always appreciated as a part of spiritual care. However, an exception is made with the following participant:

C2 (P13) ... to me just being there ... we are meeting the spiritual need without realising that we are doing it.

However, being alert and sensitive to patients' spiritual need cues is a really important way of assessing in this dimension of care:

C1 (P3) I'm not sure really ... but I think it's noticing if a patient is down or, or not happy in a situation and working your way around that to try and improve that for that patient.

So spiritual assessment by observation is one way of finding out what kind of spiritual care is needed. In addition, engaging in conversations with patients could also contribute to an informal assessment:

C1 (P2) ... treading on egg shells in that area ... when you want to have a discussion like that [spiritual] ... you can't just brush the surface – you don't get the full story – you need to build a picture of the patient's feelings and beliefs in that [spiritual] area.

Although this participant is cautious, the nurse-patient relationship is seen as contributory to spiritual assessment, which in itself could be a form of spiritual care (Tiew and Drury, 2012).

Participant 4 did not really feel that she had met a patient's spiritual need, although mentioning sitting, talking and support:

C2 (P4) it's difficult to point out really - I don't, I don't, I couldn't maybe point out - err one scenario where I feel I have met a patient's spiritual needs, but you know, you sit and you talk to patients and you support ...

However, in palliative nursing there is no doubt that spiritual care is prominent:

C1 (P3) I spent a lot of time with palliative care - in the palliative care setting so umm, in that setting it [spirituality] was a very big part of the nursing care.

And –

C1(P12) It [spirituality] wasn't brought to my forefront until I went to a hospice palliative care setting, ... trying to meet the spiritual needs in that palliative care setting, it kind of introduced to you that there is more about people's wants and beliefs and things, and it is highlighted how important it is to address those needs ... from that I have been able to understand it in other areas of nursing.

Clearly these two participants are in agreement that the spirituality education they received as a result of palliative care experience was significant. There was a coming together of theory and practice which resulted in a rounded learning experience. They also appreciated the importance of the spiritual dimension for those patients and indeed others elsewhere.

Throughout phase 1 of my investigation no other care situation with a specific focus on spiritual care is mentioned, which reflects the higher priority given to spirituality in hospice and palliative care settings. This could suggest that spiritual care may be regarded as less important elsewhere, but a more plausible explanation is that it rises in priority for palliative and end of life patients (Puchalski et al., 2006, Healthcare Quality Improvement Partnership, 2016). Having identified and explained the participants' main concerns in Phase 1 of the investigation, my focus of attention is now directed towards the core category that was constructed, which has the capacity to resolve the main concerns.

Glaser (2002b) asserts that the core category will earn its significance and status by accounting for most of the variation in processing the participants' concern/issue that has emerged in the data, similar to what is demonstrated in this investigation. Gibson and Hartman (2014) provided a number of points (Table 6.10) that were duly considered, and found helpful during the selection of the core category for phase 1 of this investigation.

Table 6.10 Selecting the core category (from Gibson and Hartman 2014 p.94)

1. It must be central, and related to as many other categories as possible. It should be dominant and account for a large portion of variation in pattern and behaviour.
2. It must reoccur frequently. This leads to the perception that it is a stable pattern and can be related to the other variables.
3. It should be related easily with the other categories.
4. The core category should enable the development of the theory rather than make it difficult.
5. It should be highly variable and ought to have frequent relation to other categories.
6. The core category ought to be closely related to a dimension of the problem.

Table 6.10 lists a series of factors relevant to selecting the core category/categories. The dominance of the category/categories in close relation to a significant proportion of the data is emphasised. However, theoretical coding is not solely the core category but there is a conceptual relationship to other categories and their properties (Figure 6.3, p189). This relational model will integrate the substantive categories into a theory.

Core category in Phase 1

The core category constructed in Phase 1 of this investigation, has characteristics for the greatest explanatory relevance, as well as the ability to connect the main categories (Corbin and Strauss, 2008 , Gibson and Hartman, 2014). A core category is also said to have analytical power through its ability to elucidate theoretically the epitome of the research findings (Corbin and Strauss, 2008 p104). In Phase 1 of this investigation the core category of 'Enablement' (make possible) was constructed. Enablement is empowering, and in the context of this investigation, it is about the participants having the understanding, resource and opportunity, to engage appropriately in delivering spiritual care to patients. So the core category of 'Enablement' was associated with a number of other categories but in particular: a) Perceptions of spirituality and spiritual care; b) Accruing spirituality education; c) Opportunities to provide spiritual care (Figure 6.4). In the following section I will explain the connection of these particular categories with 'Enablement'.

Figure 6.4 Core category – ‘Enablement’

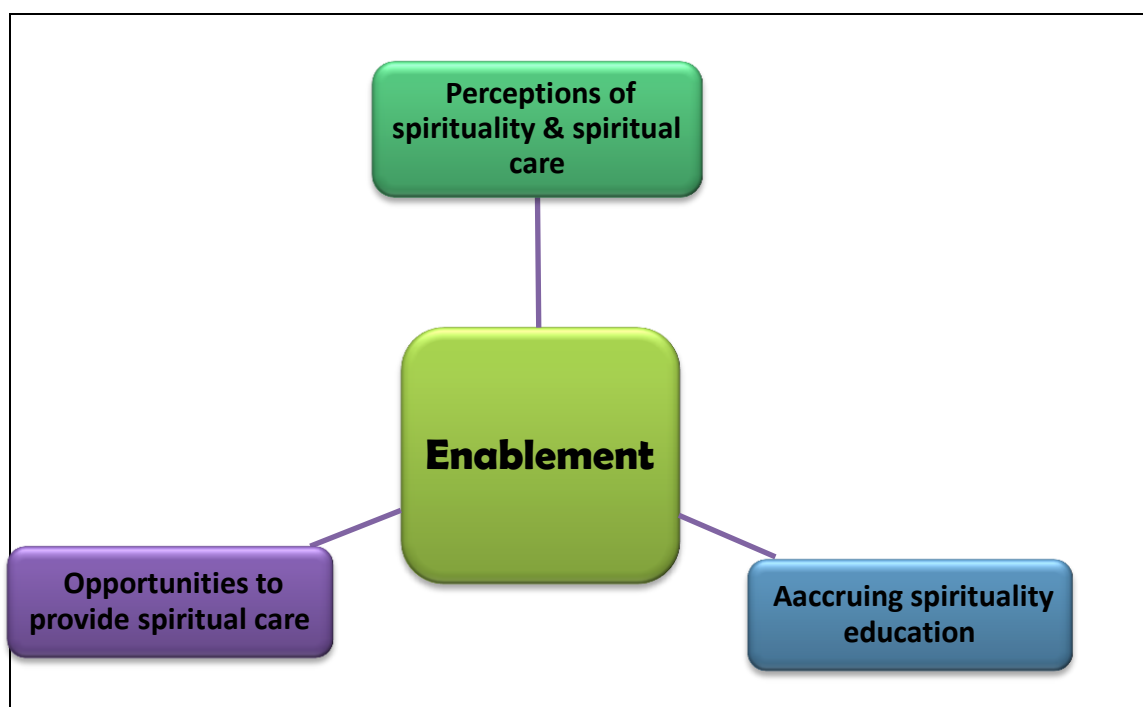


Figure 6.4 illustrates the relationship between ‘Enablement’ and three the main categories namely, ‘perceptions of spirituality and spiritual care’, ‘accruing spirituality education’, and ‘opportunities to provide spiritual care’. Enablement then becomes a connecting resource for resolving various uncertainties in order for the participants to become more confident and competent in relation to understanding spirituality and spiritual care and facilitating the same.

Perceptions of spirituality and spiritual care and ‘Enablement’

The participants’ conceptual understanding of spirituality and spiritual care was a resource for potential utilisation for subsequent interactions with patients.

Essentially, they saw spirituality as being important in the care of patients (Ross et al., 2014). As a result, perceptions of spirituality created an awareness that patients have spiritual needs, albeit on different levels, ranging from the most

fundamental for example, respect, dignity and compassion, to the more specific, for example, the need to pray, reading of sacred texts, being able to see and enjoy the natural environment. Therefore, perceptions of spirituality and spiritual care by participants contributed to 'Enablement' to resolve the first main concern of 'explaining spirituality'.

Accruing spirituality education and 'Enablement'

Spirituality education contributes to 'Enablement' both as a result of the pre-registration programme and from various other sources such as, life experience and experiential learning. This personal reservoir of knowledge and understanding is available for equipping participants with the necessary resources for response to the spiritual needs of patients. Knowledge and understanding also helps to furnish sensitivity and competence (Callister et al., 2004), leading to more confidence; which in this case is a self-assurance in one's ability to respond appropriately to the spiritual needs of patients in the clinical setting. So a lapse in memory in relation to formal spirituality education is compensated by accruing spirituality education from a number of sources. This factor offers a resolution for the second main concern of 'remembering spirituality education and the content'.

Opportunities to provide spiritual care and 'Enablement'

The clinical area provides the zone for hands-on nursing care, and this is where spiritual care ceases from being a mental and theoretical entity, to its desired practical application. Nurses are educated to fulfil their caring role in various

clinical settings, and this is endorsed by (Callister et al., 2004) who perceive nursing education and clinical practice as playing a meaningful part in the development of a sensitive ability for nurturing the human spirit. Opportunities in nursing practice, also increases competence and confidence for 'Enablement' in all clinical areas. Therefore, once again the inseparable and integrative nature of spirituality and spiritual care is highlighted. Thus, 'Enablement' has the potential to confirm facilitation of the spiritual dimension as participants reflect on their opportunities to provide spiritual care in everyday nursing situations, so resolving the third main concern of 'uncertainties surrounding facilitation of spiritual needs'.

Summary

The coding involved in the analysis of phase 1 of the investigation was elaborated to show the researchers' openness and transparency to represent the views of the participants. In addition, the various levels of coding were illustrated in relation to the constructivist grounded theory being used in contrast to other variants of grounded theory. As a result of the coding process being grounded in the data, the participants' main concerns were identified. Furthermore, this process eventually led me to construct the core category of 'Enablement', which is inextricably linked to the main categories, and these links provide an explanation of how the participants are able to resolve their main concerns. 'Enablement' encourages participants to become more open and receptive to the possibilities of learning to improve spiritual care for patients. This learning process cultivated a positive approach, which informed their aspirations and

willingness to facilitate spiritual care in clinical practice areas.⁴ Moreover, their learning experience in clinical practice gave them the opportunity to put into action whatever knowledge and skills they have acquired for delivering spiritual care. Accordingly, 'Enablement' opens the understanding to reveal the potential for responding to the spiritual needs of patients, and therefore provides a motivating cogency for participants to fulfil the spiritual dimension of their role within holistic nursing care.

Points to be explored in Phase 2

At the start of phase 1 interviews, participants were asked about their perception of spirituality and spiritual care. The majority understood spirituality to be a broad concept covering religious and non-religious beliefs. Participants then affirmed their ideas about all patients having a spiritual need, and that this should be ascertained and attended to. They readily identified religious needs, but were ambiguous at times concerning the non-religious. Furthermore, what I term as 'Fundamental Spiritual Care' (FSC), are represented in the nurse's attention to compassion, dignity, and respect (Lewinson, 2015). These aspects were often not mentioned in relation to spirituality until the participant's attention was drawn to them by the author. It will be interesting to find out if these aspects of spiritual care are more readily recognised and referred to post-qualification.

As regarding spirituality education, some very mixed responses were given from participants on both campuses, and within different cohorts as to the degree and

⁴ During Phase 1 of the investigation the author gave a number of conference presentations (appendices 13, 14, 15, 16 & 17).

practical benefits of such academic in-put. On the whole they felt that more space needed to be allocated to the subject in the programme. However, they did mention other contributory sources of knowledge and experience, for example, life experience, innate resources, experiential learning in palliative and hospice settings, which were all valued. Together, the various sources of knowledge and experience provided resource, and encouraged confidence to fulfil the spiritual dimension as best they could within holistic nursing care. But although participants recognised that spiritual care should be a part of the nurse's role, they were less certain of how to take this forward with their current levels of knowledge, understanding, skills, and experience. This is another issue explored in Phase 2.

CHAPTER SEVEN: PHASE 2 ANALYSIS AND FINDINGS

Phase 2 analysis and findings

Introduction

The purpose of Phase 2 of my investigation is to continue exploring through theoretical sampling, pertinent areas relating to spirituality and spiritual care as identified by the participants in Phase 1. This process will ascertain the transferability and sustainability of pre-registration nurses' spirituality education and its impact on clinical practice. So the post-qualification plan entailed interviewing the participants six to eight months after commencing their first nursing positions as newly qualified Registered Nurses within local NHS Trusts (except for one person who took employment in a private nursing home). I was pleased that 12 of the 13 participants interviewed for Phase 1 were able to return for the 2nd and final interview. However, a recent bereavement was the reason one participant was unable to participate further at this stage. The very fact that participants returned for the 2nd interview, demonstrated a strong level of commitment, motivation and interest in the spiritual domain of nursing, even so I was careful to maintain that all participants felt valued (Bowling, 2009), by showing a keen interest in everything they had to say, and thanking them for their participation.

At the commencement of Phase 2 more demographic information in the form of: age range, ethnicity, and religious/non- religious beliefs, as a result of conducting Phase 1 interviews (Table 7.1). Furthermore, I could now confirm their chosen clinical area of employment. All this additional demographic information was useful for further theoretical sampling in Phase 2 as necessary.

Table 7.1 Phase 2 participants' demographics

Participant	Gender	Age 20-30	Age 31- 40	Age 41-50	Age 51 +	Ethnic origin	Religious/non-religious	Clinical area
1	Female	X				White British	Catholic	Gynecology (Gyne)
2	Female			X		White British	Baptist	Elderly care (Elc) (care home)
3	Female	X				White British	Church of England	Medical (Med)
4	Female	X				White British	Non-religious	Critical care (Crc)
5	Female	X				White British	Agnostic	Haematology & Gastroenterology (H & G)
6	Female	X				White British	Atheist	Intensive therapy unit (ITU)
7	Female		X			White British	Church of England	Theatre (Thea)
8	Female		X			White British	Church of England	Intensive therapy unit (ITU)
9	Female		X			White British	Non-religious	Medical (Med)
10	Female			X		Black Caribbean	Christian	Surgical (Sur)
11	Female				X	White British	Non-religious	Orthopaedics (Ortho)
12	Female	X				White British	Christian	Unavailable for interview
13	Female	X				Black African	Christian	Medical (Med)

Table 7.1 - All participants were female, half (6) were age of 20-30, with one Black Caribbean, and one Black African; all others were White British (Office of National UK Government, 2011a). Participants of the Christian faith were (7), while others (5) identified themselves as non-religious, agnostic, or atheist. Clinical areas were varied, and given abbreviations, which will be used as in text.

Phase 2 procedure

As before, all interviews were digitally recorded, personally transcribed and analysed in a cyclical way. So Phase 2 analysis was carried out in the intended constructivist grounded theory manner previously employed for Phase 1. This involved: theoretical sensitivity, theoretical sampling, and constant comparison and analysis, to include line-by-line, focused, and theoretical coding. This process allowed the data collection and analysis to be narrowed down to identify main categories (Glaser and Strauss, 1967, Charmaz, 2014). This process also led to the main concerns being identified in Phase 2, namely: transient recognition of some aspects of spiritual care, dominance of physical care, the low priority of spiritual care in most clinical areas, and insufficient knowledge about spirituality and spiritual care. I then showed from the data how these main concerns were resolved, as a result of the development of the core category of 'Efficacy' for Phase 2.

Three areas explored in Phase 2

The following three areas to be explored were identified as important to the participants during Phase 1:

- 1) Perceptions of spirituality and spiritual care
- 2) Accruing spirituality education
- 3) Opportunities to provide spiritual care

Perceptions of spirituality and spiritual care was a main factor for responding to patients' spiritual needs while participants were students, and so it was pertinent to explore this further in the context of the participants' changed role as newly qualified Registered Nurses. Next, accruing spirituality education and its potential impact for current nursing practice is a major issue of debate. Therefore, having had some pre-registration spirituality education, it is necessary to ascertain the competence of nurses to facilitate spiritual care in a consistent way post-registration.

Finally, the opportunity to provide spiritual care while engaged in everyday nursing activities was an important feature for exploration, as the fundamental aspects of compassion, dignity, and respect were often unrecognised or overlooked as spiritual by the participants. However, these facets of care should be a constant in all patient encounters (NMC, 2015). Nevertheless, the NMC Code (NMC, 2015) does not overtly state that these fundamental aspects relate to the spiritual. Accordingly, this could explain some of the ambiguity experienced by participants. Accordingly, all the above areas will be investigated further for specificity within the context of the participants' qualified nursing role

Phase 2 analysis and findings

In this next section I discuss the analysis and findings, together with participants' transcript excerpts. I also compare as relevant pre/post qualification coding to identify where significant similarities and differences occur. These are discussed for their impact and implications. I will now proceed to address the aforementioned three areas post-qualification: 1) Perceptions of spirituality and

spiritual care, 2) Accruing spirituality education, and 3) Opportunities to provide spiritual care.

Perceptions of spirituality and spiritual care: post-qualification

Now that participants are newly qualified Registered Nurses, it is important to know their present views regarding perceptions of spirituality and spiritual care, as this could affect the way they care for patients, and Barnum (2011) puts it like this:

“Our sense of the spiritual tells us ... how we are in the world and what moves us to care about the universe and the people and the things in it ”
(Barnum, 2011 p.63).

Therefore, our spiritual perception influences our motivation to care for people and other things in our world. I will now continue by looking at perceptions of spirituality and spiritual care separately.

Line-by-line coding: Phase 2

Perceptions of spirituality

Line-by-line coding (Table 7.2) was undertaken in the same way as outlined in Phase 1, but comparisons were made with participants' earlier definitions to identify any change. This was done for all 12 participants, but only two examples are shown. Participant (P1) had unchanged perceptions of spirituality since qualification, which would suggest some stability in her previously held beliefs and understanding.

Table 7.2 Line-by-line Phase 2 coding for perceptions of spirituality

Pre-qualification views	Post-qualification views	Codes
(P1) ... the basis of someone's belief. It doesn't necessarily have to be religion ...	(P1) I don't think it's changed a great deal in terms of what I understand it to be.	Unchanged since qualification
(P2) ... people's beliefs, whether they are religious or not ... I'm very vague on it ... I can't say quite definitely what it is or how it's definitely defined ...	(P2) I cannot differentiate between religion and spirituality - I have a very big struggle doing that, I think probably because it has never really been explained to me, probably because I was brought up very religious	Tends to define spirituality more in religious terms

However, participant (P2) was still grappling to sort out other meanings contained in the term spirituality, apart from religion being the first thought. She attributes this dilemma to her religious upbringing (Baptist). Further theoretical sampling revealed that this view was not shared by other participants with a religious faith as shown in the following examples:

(P3) It's [spirituality] a bit of both – yea, it can be quite a lot of things really, whether it's religious or not, just making the patient feel like they are being cared for (Church of England)

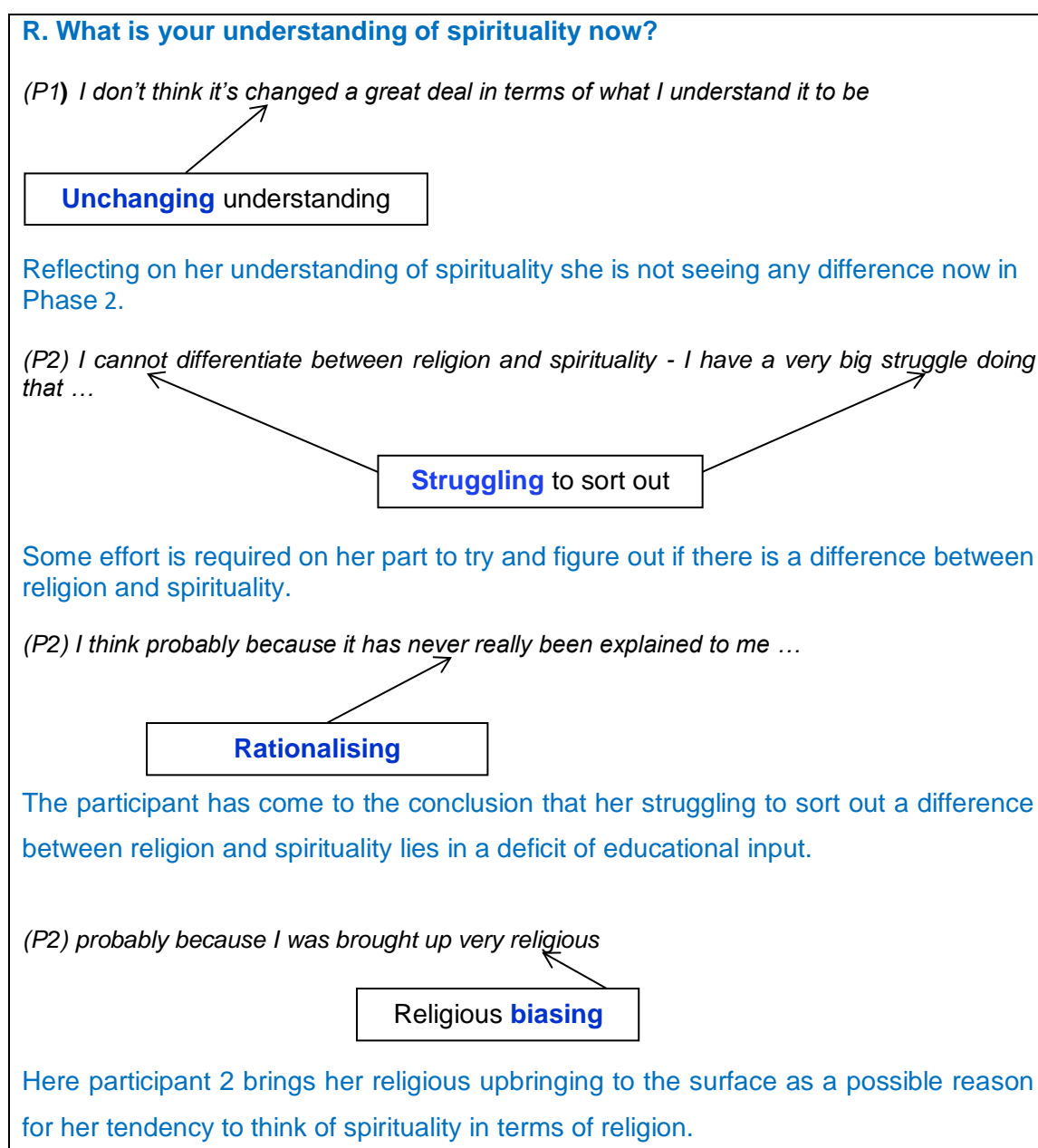
Here there is a clear understanding that spirituality concerns both religion and other non-religious aspects. Whatever the belief, it is necessary to convey care for the patient. Furthermore, in the next excerpt a person's being is emphasised:

(P8) For me, I feel spirituality is to do with you as a being, and it may not have any bearing on religious beliefs ... (Church of England)

The importance and worth of the individual's mortal existence is uppermost and may not have any connection to religion. Therefore, understandings of spirituality by participants 3 and 8 are not dominated by their personal religious following.

The gerunds in Figure 7.1 further illustrate that the participants are making active efforts to articulate their understanding of spirituality now. For participant 1 her understanding of spirituality is presently unchanged. However, participant 2 continues to struggle with clarifying spirituality, and engages in a rationalizing process by identifying a lack of relevant information about the concept, as well as biasing from her religious upbringing.

Figure 7.1 Gerunds from Phase 2 interviews



Perceptions of spiritual care

Spiritual care implies some action by the participants in response to identifying a patient's spiritual need. Therefore, the concept of spiritual care which is set in the reality of holistic nursing care is the everyday responsibility within the nurse's role. Phase 2 of this investigation sought to confirm the participants' perceptions of spiritual care now that they are Registered Nurses and in the following Table 7.3 are some examples:

Table 7.3 Line-by-line Phase 2 coding for perceptions of spiritual care

Pre-qualification views	Post-qualification views	Codes
<p><i>(P3) I'm not really sure cause umm, I've not come across any patients with strong beliefs of umm, religion or anything like that ... I've come across some patients with beliefs which I don't hold, but I didn't really touch on it with them ... they'd never talked about that subject, so I didn't either ... which I think I could improve on, but I'm not sure.</i></p> <p><i>(P11) ...I've dealt with quite a few end-of-life people as well, and I'm not aware that any of them were particularly religious. Some of them were Christians, but were quite happy just to have – like a priest who would come ... as long as you are appreciating that person and going with what they want, then holding hands is very important, and it is about being there isn't it, and feeling that you are there for them.</i></p>	<p><i>(P3)... if it's more of a religious need, then I find that that can be difficult for me personally to sort of sort out or help with ... I'd always contact a chaplain or somebody who the patient want to see because they can better give that spiritual care ... I can be caring and compassionate to patients ...</i></p> <p><i>(P11) ... if they feel they have a spirituality it's about giving their life meaning, and as a nurse it's about recognising that and trying to address that ... because they are individuals with a need... it's this holistic way of caring for people, you are not just dealing with the physical body, you are dealing with that person as an entity</i></p>	<p>May still have personal difficulty meeting religious spiritual needs.</p> <p>Efforts to facilitate religious spiritual needs. Holistic nursing care involves caring for all the patient's needs.</p>

The views participant 3 had concerning spiritual care were basically unchanged over the few months since becoming a Registered Nurse. She still felt some uncertainty about personally handling religious spiritual needs, but would always refer the matter on to those she felt could best deal with it. The participant shows an awareness of and sensitivity to the need for spiritual care, and is willing to facilitate the same. Participant 11 at first thought of spiritual care in religious terms then included holistic care, which encompasses the spiritual dimension.

These two examples are typical of the post-qualification views of the rest of the participants showing that they were motivated to support spiritual care in their everyday clinical practice. In addition, the source of such motivation is aptly expressed by the following:

(p1) It's generally having the knowledge and the inclination as well to actually want to look into and help the patient in terms of their spiritual need.

Thus motivation comes not only from the acquisition of spirituality knowledge, but also from an inner will to respond to patients' spiritual needs. And what was also apparent at this time was an increase in the participants' confidence and potential level of competence to facilitate spiritual care, as stated next:

(p3 ... my confidence is growing a lot in the profession, and I find it a lot easier to do these things [spiritual care] after a few months...

Also –

(p5) ... you are confident as a qualified nurse ...I think you have that confidence to step forward and do those things [spiritual care] for the patient that you might not have done as a student.

Confidence to facilitate spiritual needs increases with being a Registered Nurse. And another point that emerged concerned the type of work area. Participant 7

who worked in the operating theatres, felt that she might have had a different opinion of spiritual care if she was working in another area:

(P7) Probably because of where I am working ... (I'm working in theatre). If I was working in a different domain I think it might have changed – I don't know.

I was not clear about the answer she gave, so this led me to probe further by asking the question: I Why do you think it might have changed if you were in another area?

(P7) I don't think where I'm working the patient is still your focus ...your patient contact is less and you don't have as much interaction with your patient, because your patient is more or less under anaesthetic ...

Working in theatre where patient interaction is less could possibly change perceptions of spiritual care. Here opportunities for spiritual care seem to be connected to the conscious state of the patient, and not necessarily related to the fundamental hands-on care that should be given to each person with compassion, dignity, and respect. In line with theoretical sampling, another participant working in a critical area (ITU), where patients were more likely to be unconscious was interviewed on this matter and Table 7.4 below presents the views to spiritual care pre and post qualification.

Table 7.4 Spiritual care at critical illness times

Pre-qualification views	Post-qualification views
<i>(P8) Although it's important that in all care that you get it [spiritual care] right, umm we are all only human and to get it right every time is a big ask of anybody, and therefore, I think at the end of life it is vital to get it right ...</i>	<i>ITU (P8) I treat the patient with the utmost respect, talk to the patient, even though they are unconscious, make sure I am explaining everything that I'm doing, and just try to do it with a bit of dignity and respect.</i>

As seen in Table 7.4, the participant in Phase 1 thought that if it is humanly possible, it was important to get spiritual care right for all patients. We see that in Phase 2, as a Registered Nurse working in an area where a patient's condition is critical, her perception of spiritual care clearly was not dependent on the conscious state of the patient. In other words, her perceptions can be regarded as enhanced, and she demonstrated that spiritual care was an integral part of her everyday nursing care activities. Thus, the core of nursing practice, including spiritual aspects, should be person-centred care, which is tailored to be experienced as right by the person receiving it (Manley et al., 2011). Still another aim in Phase 2 was seeking to find out more about accruing spirituality education and its impact to equip participants to deliver spiritual care.

Accruing Spirituality education

It was clear from the participants that spirituality education was not solely dependent on classroom teaching, but more an accumulation of various learning opportunities. A most notable comment made was that Pre-registration spirituality education enabled participants to be more aware of the importance of spirituality in the lives of individuals:

(P1) The main thing that came out of it [spirituality] from my education was first of all, to be aware that people have spiritual needs ... I'm still aware that people have spiritual needs, and that that's important in patient care ... having the knowledge and the inclination to want to look into and help in terms of spiritual need.

The pre-registration spirituality education in the nurse training programme had a durable effect in terms of spiritual awareness. In addition, having a predisposition

for attending to spiritual needs was regarded as helpful. So having an inner inclination (Clarke, 2013), is expressed in the following:

(P10) I am more aware of it [spirituality] to incorporate it into the care I give, yes - in some respect I suppose I'm on the look-out for it ... you pick up the vibes ...

This awareness of spirituality prompts the participant to take action for including the spiritual in nursing care activities; also responding to spiritual need cues is given recognition. However, for some this education did not settle certain on-going conflicts to do with religion in the concept of spirituality, and this is reflected below:

(P2) I do feel more comfortable with it [spirituality and spiritual care] but I still need to pinpoint what exactly comes under that umbrella - I still seem to go straight down the religious route - and it's not that - it covers so much more. And I think this is something that I am going to try and push with the team ... it's something that I will be bringing in, looking at myself and spreading to the rest of the home team.

Feeling more comfortable with spirituality and spiritual care does not seem to erase some of the ambiguity of what is contained in the term 'spirituality'. There is still a tendency towards the religious aspect of spirituality for this participant, although she is aware that spirituality is a much broader concept. Despite some misgivings, the participant as a Registered Nurse says she intends to promote spirituality and spiritual care within the nursing team. This speaks volumes in terms of the importance that should be attributed to spirituality education in the nursing programme, to inform and motivate students so raising the awareness of spiritual care in clinical areas. This participant is empowered to be pro-active, so becoming a change agent for the spiritual dimension of nursing in her work area. And this pro-activeness is also demonstrated by another participant:

(P3) "... it's difficult to change the mind-set of a lot of people to ensure that spiritual care is given to everybody ... if we show others, then we can potentially pass that information on".

A relevant point is made here in that in the customary ways in which some nurses care for patients they may not give adequate attention to spiritual needs. But this participant envisages being a role model for spiritual care.

Hands-on learning

What also transpired was that, participants rated highly the hands-on learning of spirituality and spiritual care in some clinical placements, and this valuable part of their learning experience is endorsed by Barnum (2011) also Prentis et al., (2014) who state:

"... we cannot teach spirituality merely as content. That is simply not adequate." (Barnum, 2011 p.95); and "Spirituality involves more than subject knowledge ... experience in practice provides a variety of learning opportunities ..." (Prentis et al., 2014 pp.49 & 50).

Therefore, from the opinions of the participants and researchers, the significance of learning spiritual care other than in the classroom environment deserves more focus. Furthermore, in their study Gisk and Cone (2012 p.2012) emphasise integrating theory and practice by stating:

"... ongoing clinical experience equip students to understand and integrate theoretical learning into practice".

So according to Barnum (2011), Prentis et al., (2014), and Gisk and Cone (2012) they appreciate that the acquisition of spirituality knowledge goes beyond theory, with an acknowledgement of the importance of spirituality education in the

clinical setting; this point was reiterated by a number of students for example, participant 9:

(P9) ... it's the experience [spiritual care] you get while on the ward with different patients ... I'm not saying that the nurse education is not fantastic, because it is, and you need that side as well to back up and reinforce, but I wouldn't say that was a leading factor in my spiritual thoughts and opinions ...

Although spirituality education in the classroom is well regarded and valued by participant 9, the spiritual care experience in the practical setting of the ward is reflected on, and is highly rated because of the interactions with different patients. This was especially the case for those participants who had hospice or palliative care learning experience. So reflection on all learning experiences is a great asset for nurses to be able to adapt and transfer knowledge and skills for use in other clinical areas.

Reflective learning

Reflection involves thinking about something that has already been done to understand and make sense of it, and so make changes as necessary (Taylor, 2006). Accordingly, reflection is seen as a strong learning activity for grasping the meaning of spiritual care (Van Leeuwen et al., 2008, Prentis et al., 2014), although having the opportunity to put that theory into practice is vital. The following participant highlights the importance of reflection in the learning experience:

(P10) ... a few palliative patients that I've cared for ... meeting their need [spiritual] yea – how people were treated and actually just looking at family and relatives' facial expression as well, looking at how they are responding to the situation ... knowing that I have actually met that need – I've made a difference –

they actually perk-up when they see you and I think that makes me more comfortable to keep going – keep doing it [spiritual care], yea – it makes a difference.

This participant reflected on meeting the spiritual needs of palliative patients and their family members. She was satisfied with the care she had given and felt confident to replicate such spiritual care with other patients.

In addition, being involved in actual hands-on care brings a reality to the intricacies of responding sensitively within this dimension of holistic care; to which O'Brien (2008 p.131) contributes:

“all nurses have the responsibility to be aware of and sensitive to their patients’ spiritual needs as a dimension of holistic health care”.

Such sensitivity goes hand-in hand with all spirituality education whether in the classroom or the clinical setting. Thus, the impact of accruing spirituality education is variable, but wherever the knowledge, understanding and skills are gained, it is contributory, and is appreciated by the majority of participants as influential to their overall ability to respond with spiritual care.

Opportunity to provide spiritual care

It transpired that apart from participant 7, none of the other participants working in critical areas felt that the nature of their work might affect their perception of the opportunity to deliver spiritual care. Overall it could be said that there was some identifiable positive change for the participants in terms of growing confidence regarding the perception of spiritual care, and competence in their ability to facilitate the same in their different work areas. Some had a broader

concept than when they were students, which may be the result of being more aware of the spiritual dimension of nursing within holistic care. Yet some participants thought that having sufficient time was a significant factor in their ability to address patients' spiritual needs, as illustrated in the next section.

Time dependant spiritual care

In Phase 1 participant 11 thought that perhaps it was not necessary to consider the spiritual needs of patients at all times (Table 6.4, page 184). This came as a result of certain observations she had made, especially the fast 'through-put' of patients in short stay surgical units. Therefore, time was an issue. Through theoretical sampling of participants in a variety of clinical areas I discovered that, the issue of not having enough time was mentioned frequently as a possible hindrance to delivering spiritual care. The pressures of physical care and paperwork seemed to render attention to spiritual care more challenging. However, some participants realised that not all spiritual care was dependant on time, as it was integral to all aspects of nursing in the form of compassion, dignity, and respect:

Gyne (P1) ... there are certain obligations within your shift including paperwork, drugs, and physical care, and you know what you need to get done within your shift to make sure that you cover the things you are responsible and accountable for within that shift ... you haven't got as much time to spend ... as you did as a student ... it can be quite challenging at times to sort of bring it [spiritual care] into your care, and you do your best ...

This participant feels that the responsibility and accountability as a Registered Nurse to complete all required duties within a shift, makes facilitating spiritual care challenging. However, this is not the case for the next participant.

Elc (P2) ... you have more time with the residents in the sort of place that I work in, so yes it's [spirituality] discussed more - there is more time for it.

In contrast to the previous participant, time constraint is not an issue in the elderly care nursing home environment where Participant 2 works. But with the following participant time as well as staffing issues appeared challenging.

Med (P3) ... with time constraints and lack of staff that's [spiritual care] made impossible, and the only way you can give spiritual care is if you have finished all the physical jobs, or you are doing it during that time ... you can at the same time as doing something physical for a patient, speak to them and give them some spiritual care.

At first participant 3 relates that time constraints and lack of staff impinge on her ability to give spiritual care. However, she then reveals that spiritual care can coincide with physical care. But a busy ward with competing patient demands presented a dilemma for participant 10:

Sur (P10) ... not when we are very busy - it's very difficult to put that time in with an individual, cause there's occasions where I had patients with two different needs ... dressing needs changing, and another lady who was diagnosed and had not got long to live, and also it's meeting her spiritual needs – speaking to her, making sure that she is not forgotten ... everyone needs time and I felt my time was spent too much on one person when this person needed, and that's why I found it very challenging, I had to divide my time up to everyone...

Participant 10 found it difficult to apportion her time among the patients in her care, especially when she was very busy with varying patient priorities. There seems to be a hint of guilt for spending too much time with one patient, because she was aware of the need to adequately divide her time between everyone, which was challenging. However, the nurse-patient ratio and much paperwork were highlighted as seen below:

Ortho (P11) I think as a qualified nurse I have very, very little time with patients, and I think that's the greatest shame ... I have 14 patients, and so much paperwork to do ... it's more for me about time, I would like more time to spend with the patients trying to meet those [spiritual] needs so that they do feel they have had holistic care.

Shortage of time to meet spiritual needs was attributed to a combination of the responsibility for looking after 14 patients, plus much paperwork. Participant 11 would welcome more time for the spiritual within holistic nursing care. But participant 13 does not seem to have an issue with time.

Med (P13) ... for me, time has no barrier for providing spiritual care ... everything we do in nursing we are touching patients' spiritual life in one way or another ...

Here participant 13 discloses that time for her is not a hindrance to providing spiritual care. In fact, she goes on to qualify this by saying that everything you do for a patient involves the spiritual, a suggestion also made by Clarke (2013). The idea that everything the nurse does for the patient involves the spiritual is a reflection of FSC: compassion - being kind and courteous and seeing the person in the patient, dignity - promote patient's feeling of worth and value to themselves, and respect - demonstrate that you value the patient, (Lewinson, 2015), which may all be overlooked at times.

But the spiritual dimension in everyday nursing is fundamental (RCN, 2011b), nonetheless there may be some uncertainty in recognising these fundamental aspects as spiritual within the participant's care activities. Hence, this ambiguity surrounding fundamental spiritual needs post-qualification was theoretically sampled.

Ambiguity facilitating fundamental spiritual needs post-qualification

On the basis of information that emerged from Phase 1, FSC was not readily identified within holistic care by a number of participants, until prompted by the researcher. Therefore, it was important to find out what participants see as spiritual care now, because this is likely to influence the knowledgeable facilitation of the varying spiritual needs of patients. The opinions of the participants are represented in the following:

Med (P3) I think being compassionate to your patients is something that every nurse needs ... compassion, dignity, and respect ...

This participant identifies compassion, dignity and respect as being a consistent part of patient care, but there is no outright link to spirituality here. Perhaps there is an underlying assumption of spiritual care that does not need to be explicitly articulated at this level. However, this is not the case as seen with the next participant:

ITU (P6) ... you have to have compassion in this job anyway, and to meet the spiritual needs of somebody you have to be a caring compassionate person ... I do think you have to have the core nursing values and you have to encompass spirituality ...

Compassion is seen as a given core value for the job of nursing, and this is part of the spiritual care for patients. And again in the next excerpt compassion is highlighted:

Ortho (P11) It's this holistic way of caring for people ... you are dealing with that person as an entity ... and that includes dealing with people compassionately ... I think dignity is just a basic that everybody should be given... nursing definitely should be encompassing, in any meeting we have with people ...

The element of sensitivity is introduced by participant 8 in addition to addressing spiritual needs within holistic care, and this sensitivity is implied as innate and perhaps linked to one's personality:

ITU (P8) ... you need to address spirituality - respect, dignity, communication - but I think you are either sensitive to it or you are not. So I am the type of person that is quite sensitive to meeting people's holistic needs ...

Although spirituality is not mentioned outright in this excerpt by participant 8, it is contained in compassion, dignity, and respect. Furthermore, as expressed in the next excerpt, nursing care is recognised as a spiritual activity, which may be unobtrusive at times, and dignity, compassion and respect are clearly seen as a part of this:

Med (P13) We do touch their spiritual life ... nursing is already a spiritual job. Nursing patients you are already touching their spiritual life whether we realise it or not ... treating your patient with dignity, compassion and respect is also another way of showing spiritual care ...

So when looking at facilitation of spiritual needs, the three elements of compassion, dignity and respect are seen to be applicable to all patients. According to Clarke (2013 p.43), compassion is, "essential to spiritual relationships and so to spiritual care", and I am in agreement with this, suggesting that all three elements mentioned above are fundamental to spiritual care and should go hand-in-hand (Lewinson, 2015).

Focused coding: Phase 2

Focused coding in Phase 2 followed the same process as in Phase 1 (pp.181-188). It allowed me to generate three categories through identifying and condensing the most significant and frequently occurring initial codes, and these

were: 1) Essentials of spiritual care, 2) Education for spiritual care, and 3) Delivering spiritual care (Tables 7:5, 7.6, 7.7).

Essentials of spiritual care

The essentials of spiritual care could also be regarded as a part of the essentials of nursing care activities, in fact Clarke (2013 p.57) proposes that “nursing is a spiritual activity”. ‘Essentials’ as used here is seen as the main ingredients of something which determines its character. Moreover, it is intrinsic with the awareness that compassion, dignity, and respect are attributes of high-quality care (Prentis et al., 2014), and indeed constitute FSC which is essential in all nursing activities for optimum patient care and wellbeing.

‘Essentials’ of spiritual care is further illustrated by Baldacchino (2011a) who expresses spiritual care in terms of ‘being’ more than ‘doing’. Here ‘being’ is about the therapeutic use of self in care, which should be at the root of all religious and non-religious spiritual care, whereas ‘doing’ concerns nursing processes. Table 7.5 illustrates the content of this category with examples from transcripts that highlight certain aspects that the participants deem as essentials of spiritual care.

Table 7.5 Phase 2: Focused Coding (category 1)

Segments of transcripts	Interpretation	Category
<p>(P1) ... to be a good nurse you should always be delivering compassionate, kind care, and treating people with dignity and respect anyway.</p>	<p>Caring for patients with compassion, dignity, and respect was regarded as what should be expected of a good nurse.</p>	<p>Essentials of spiritual care</p>
<p>(P3) ... in a hospice, I saw a lot of spiritual care ... and it showed me a lot of compassion, dignity, and respect – everything that should be given ...</p>	<p>The demonstration of spiritual care in the hospice setting was seen to be comprehensive.</p>	
<p>(P4) ... Just sitting by the bedside holding their hand – not even speaking, just having somebody there ... I think it's just basically being there for a patient ... we respect them and stuff like that ...</p>	<p>Simply holding a patient's hand or just the presence of the nurse could meet someone's spiritual need.</p>	
<p>- (P5) I couldn't pinpoint anything ... your general day-to-day jobs that you do I suppose could be classed as helping them in that [spiritual] sort of way ... without specifically thinking 'that's a spiritual need' ... each person's spirituality could be very individual ... you do what you can as you're working...</p>	<p>Spiritual care comes with the general day-to-day job of the nurse in meeting patients' individual needs - it is not a separate activity.</p>	

In Table 7.5 participant 1 and 3 highlight compassion, dignity and respect as givens in spiritual care, whereas participant 4 draws attention to the significance of presence. However, participant 5 portrays the integral nature of spirituality that is attended to in everyday nursing activities.

Knowledge and skills for spiritual care

Knowledge and skills for spiritual care is the purpose of spirituality education in pre-registration nurse programmes. Therefore, this is a crucial area to explore as it has the potential to provide participants with some essential tools for delivering spiritual care. What is also important and unique to this investigation, is to ascertain the transference and impact that such learning has over time. There is also the realisation that all necessary knowledge for spiritual care does not come solely from a theoretical standpoint, but other sources such as life experience, and innate resources (an 'in-built propensity) for example, to care with compassion. Table 7.6 demonstrates participants' appreciation of theoretical and other sources of knowledge that together contribute to spirituality education:

Table 7.6 Phase 2: Focused Coding (category 2)

Segments of transcripts	Interpretation	Category
<p>(P1) ... you can sit in a class and have it[spirituality] in mind, and the knowledge - and yes this is what I am going to do, and yes, you do your best in practice to do that really, to the best of your ability.</p> <p>(P2) I suppose a lot of it comes naturally from the sort of person you are. What I've picked up throughout life, I don't do anything else; listening to people, learning from their life experiences ... the type of upbringing I've had - yea definitely - I put it down to my mother and the upbringing she has given, and made me into the sort of person I am.</p> <p>(P3) Definitely the placements because you are working in practice, you're working with patients, you are seeing what their needs are ...</p> <p>(P5) It's just something [spiritual care] I suppose when you are working, it just comes naturally really... you just get on with it and deal with it as it comes along ... I think you care for people how you are as a person ...</p> <p>(P11) In the classroom you haven't got interaction with patients ... you can learn the theory to something, but you need to put it into practice, and I think placements are very important because you are having one-to-one with patients</p>	<p>The spirituality education gained in the classroom is put into practice to the best of her ability.</p> <p>The participant's upbringing and life experience contributed to her knowledge and skills for spiritual care.</p> <p>Knowledge and skills for spiritual care is gained in a practical way in the clinical placements with real patients.</p> <p>Spiritual care is seen as a natural response that comes from the kind of person you are.</p> <p>It is important for the theory and practice of spiritual care to come together in the clinical placement with individual patients to accomplish the desired purpose</p>	<p>Knowledge and skills for spiritual care</p>

Table 7.6 indicates that participants at this time rate their life experiences and innate resources for spiritual care higher than any amount of academic learning. Furthermore, a combination of academic and practical learning is highlighted as essential by participants for a complete learning experience. Thus taken together, all these learning experiences complement each other.

Delivering spiritual care

The actual delivery of spiritual care is the optimum goal of spirituality education in nursing. Therefore, gaining an insight into nurse practice in this area is vital.

And Vlasblom et al (2011) found that the training of nurses in spiritual care has a positive effect on the health care experience of patients. So delivering spiritual care as found in the Phase 2 data will be shown (Table 7.7). Participants reveal increased their confidence in delivering spiritual care as Registered Nurses.

Table 7.7 Phase 2: Focused Coding (category 3)

Segments of transcripts	Interpretation	Category
<p>(P1) <i>I am someone that's got my own spiritual beliefs ... actually having experience of spirituality yourself and actually know what spirituality can mean to someone, even if their way of spirituality is different to yours. I don't think there's much difference between as I was about to qualify, and being a qualified nurse in terms of my confidence to do that [spiritual care].</i></p> <p>(P2) <i>... your confidence builds, you are in one place for a lot longer, so you learn how to do the job in much more detail than you ever did in placement. You have more time with the residents in the sort of place I work in - so yes, it's [spirituality] discussed more ...</i></p> <p>(P3) <i>I don't find it difficult to provide spiritual care in the way I think spiritual care is ... my confidence is growing a lot in the profession and I find it a lot easier to do these things ... confident in myself, and confident in my role.</i></p> <p>(P7) <i>I don't think I would have a problem at all - I think I am quite open to addressing that [spirituality] it's an essential part of what we should be doing.</i></p>	<p>The participant's confidence to deliver spiritual care comes from her personal spiritual beliefs and experience, which is unhindered by any difference in the patient's beliefs.</p> <p>As a registered nurse she become more confident as she continued to work in the same clinical area, and was more able to discuss spirituality.</p> <p>Increasing confidence as a registered nurse enhances the ability to provide spiritual care.</p> <p>This participant feels quite comfortable and confident in addressing spirituality in nursing care.</p>	<p>Delivering spiritual care</p>

In Table 7.7 the participants indicated a number of factors that play an important part in delivering spiritual care: own spiritual beliefs and realising the importance

of spirituality to some patients (P1), confidence to facilitate spiritual care (P2, P3), and considering spiritual care as an essential part of everyday nursing (P7).

Thus, through focused coding in Phase 2 I have elaborated on three categories: 1) essentials of spiritual care, which was integral to nursing care and involved the therapeutic use of self and the processes of nursing; 2) knowledge and skills for spiritual care, where participants recognised for example, that life experience also innate resources complement academic learning; and 3) delivering spiritual care, being the ultimate goal of spirituality education. So their confidence in this area increased as they fulfilled the spiritual dimension of their role. Theoretical coding is now necessary for identifying the core category for addressing the participants' main concerns.

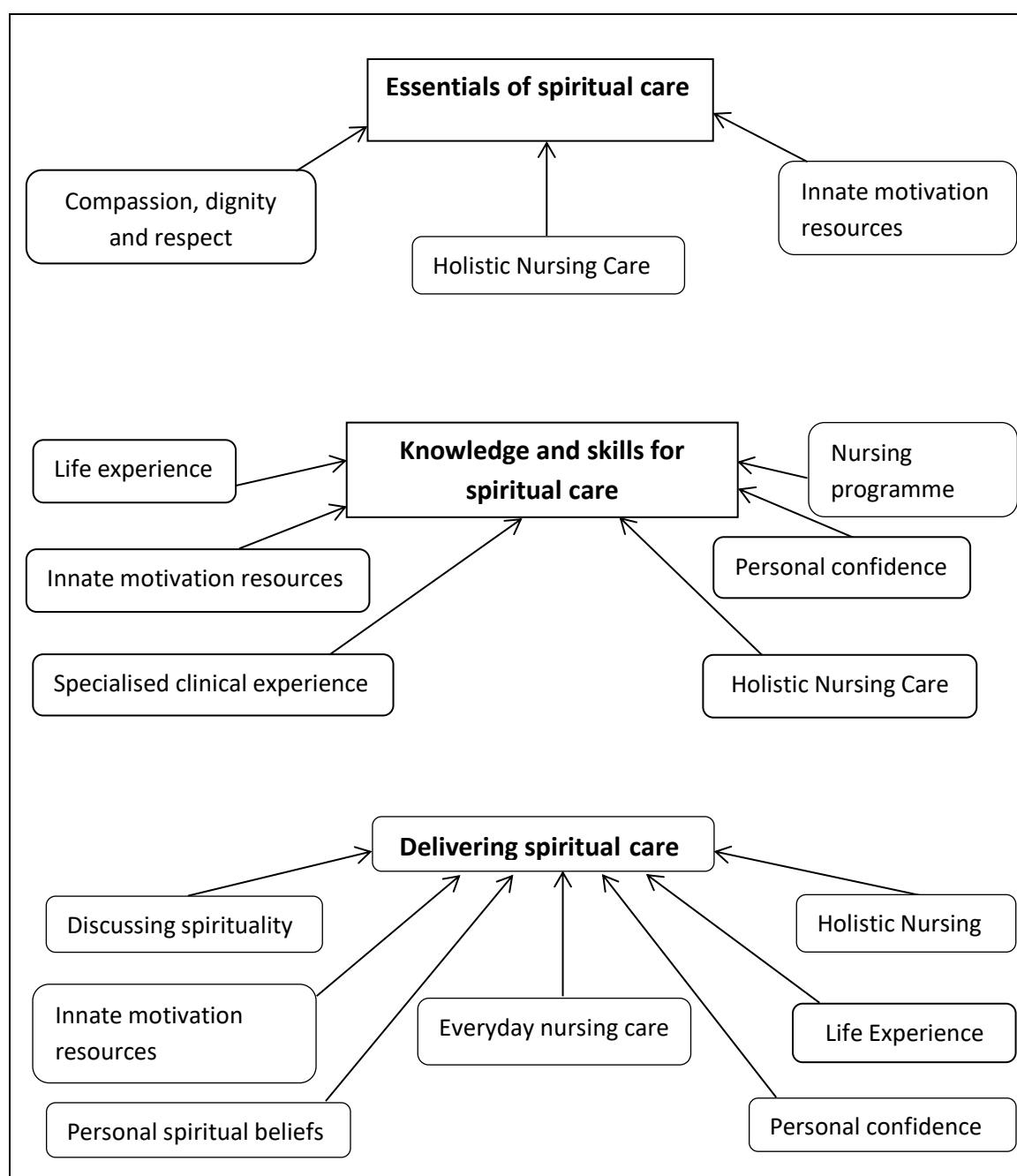
Theoretical coding: Phase 2

This section of the investigation covers the findings constructed from the Phase 2 data as a result of theoretical coding, detailing the main categories previously discussed, and the related properties. These properties will be discussed respectively, to reveal their significance to spirituality and spiritual care. There follows two further sections, one which identifies and details the participants' main concern, and the other discusses how these main concerns are resolved. Throughout and as before, relevant excerpts of transcripts that are grounded in the theory will be given to support various points.

In Figure 7.2 below, the three main categories as previously discussed (pp.233 - 238) are displayed: essentials of spiritual care, knowledge and skills for spiritual

care, and delivering spiritual care, together with their related properties. These properties which are supported by participants' transcripts were constructed over the three coding phases of my analysis, to provide meaning, content and substance for the respective category. Therefore, each property in relation to the various categories will be explained to demonstrate their relativeness.

Figure 7.2 Theoretical coding - main and related properties



Essentials of spiritual care and properties

The category 'Essentials of spiritual care' also concerns the essential aspects of nursing care which may be routine for example, preserving a patient's dignity, but constitute essential features of spiritual care, which were frequently not associated at first by participants. However, the participants have that inner sense that these essential features of nursing care are a given. These essential aspects of nursing and their relating properties will now be discussed:

Compassion, dignity, and respect

Spirituality is a phenomenon grounded in philosophy, and is perceived differently by individuals (Cooper et al., 2013), which also confirms the belief that spiritual care is a complex interpersonal relationship between nurse and patient (Burkhart et al., 2011). And these fundamental aspects of spiritual care (compassion, dignity and respect) as mentioned before in the findings of this investigation are contained in the multi-faceted activity of everyday nursing (Clarke, 2013). And as mentioned before, are not optional, but applicable at all times to all patients.⁵ Furthermore, Biro (2012 p.1009) expounds that "Spiritual care is integral to good nursing", and this indivisible characteristic is endorsed by Pesut (2008b p.167) who argues that, "Spiritual care is problematic in that it is difficult to identify". I am in partial agreement with this in relation to FSC, but there are other religious/non-religious aspects of spiritual care such as, praying, a visit from a chaplain/other spiritual leader, listening to preferred music, sitting in the garden, that are

⁵ The author highlighted patients' fundamental spiritual need for compassion, dignity and respect in an article written for the Nursing Standard in 2015 (Appendix 18a & 18b)

identifiable. However, as is the nature of spirituality, the profound benefits to the individual are significant but not tangible. Consequently, spiritual care can be regarded as a crucial feature of care giving (Ramezani et al., 2014), as it aims to improve people's morale and nourish their spirit (Callister et al., 2004).

Furthermore, FSC could be viewed as the catalytic essence of all spiritual care, because it promotes the action of something else without diminishing itself. As a result, in relation to spiritual care, it is unavoidably the duty of every nurse towards their patients. The following excerpts promote this belief:

(P1) To be a good nurse you should always be delivering compassionate kind care, and treating people with dignity and respect anyway ... if you really believe that it's [spirituality] important and that it's part of your patient care and that it can help them, then you're going to then think about it [spirituality] and incorporate it into your care - maybe more.

Attending to the three fundamental aspects of spiritual care constitutes the attributes of a good nurse. There is also the need for the nurse to appreciate the importance and benefits of spirituality within all aspects of patient care. However, the following participant emphasises compassion:

(P6) ... you have to have compassion in this job anyway ... you have to be a caring compassionate person in order to go the extra mile. So yea, I do think you have to encompass spirituality.

There is no question about the need for the nurse to be compassionate, and it is seen as a sustaining quality to overcome the challenges of caring. But in the next excerpt the emphasis is on dignity and respect:

(P9) ... it's all about dignity and respect ... that upholds spirituality.

Dignity and respect are perceived as supporting pillars in the spiritual dimension in nursing care.

Also -

(P11) I think dignity is just a basic that everybody should be given - nursing care has also to be about the softer virtues, and how we give care and compassion and meeting people's spiritual needs ...

Dignity, compassion and meeting people's spiritual needs are highlighted as 'softer' virtues of nursing care. The softer virtues is recognition of the spiritual dimension of caregiving within a biopsychosocial model of care, acknowledging the 'art' in the art and science of nursing (O'Brien, 2008, Helming et al., 2014). According to Peplau (1987 p.10), "The art of nursing is highly personal, always imprecise, and non-scientific." Moreover, these virtues as mentioned are seen by participants as appropriate for all patients:

(p13) ... treating your patient with dignity, compassion and respect, it is also another way of showing spiritual care ...

This participant reveals that dignity, compassion and respect are among the different ways of delivering spiritual care.

Innate motivation resources

Participants described how their innate resources for example, (P1) "*inclination*"; (P2) "*a lot of it comes naturally*"; (P13) "*the type of person that I am*", were helpful in motivating them to deliver spiritual care. Such resources seem to be inbuilt or cultivated in the formative years of life. The participants regard these resources as valued attributes that are permanent, being unaffected by circumstances and situations within and outside of the healthcare setting. These innate resources provide a natural outworking for spiritual care, to the extent that they may sometimes be taken for granted:

(P1) ... having the knowledge and the inclination to want to look into and help in terms of spiritual.

And –

(p2) I suppose a lot of it [spiritual care] comes naturally from the sort of person you are ... comes from within, the type of person I am.

Also –

(P13) ... the type or person that I am, the type of nurse that I am, I am very caring to my patients ... I haven't changed but I'm still getting better

There seems to be a level of spiritual care that could engender a natural response, and this is described as automatic by the next participant:

(P5) ... as a nurse it would be automatically inbuilt into you to deal with those [spiritual] responses as best as you can, even if you don't realise that it's a spiritual need, you would still automatically take care of it.

It would appear that nurses are seen to possess inbuilt qualities for responding to spiritual needs within holistic care.

Holistic care

The physical, psychological, social, and spiritual form the prime components of holistic care (Dossey et al., 2005), which participants were clear about.

Therefore, a logical assumption is that if the spiritual in holistic care is ignored, then holistic nursing care will not be achieved. There was recognition of the importance of spirituality as concerning treating people as human beings, and not defining them by their illness or condition:

(P1) I do believe spirituality is definitely an important part of total holistic integrated patient care alongside all the other responsibilities of physical care and paperwork.

Although the reality of other responsibilities of physical patient care and paperwork are mentioned, the importance of the spiritual dimension within holistic integrated care is highlighted, and Figure 7.3 is an example of many things that could be included in integrated care:

Figure 7.3 view of integrated care (Kings Fund 2016)



Figure 7.3 shows a conglomeration of ideas about integrated care, which illustrates the complexity of the term, and one also notes the inclusion of the word holistic. So integrated care could be said to be most effective when it takes into account the holistic needs of patients, which goes further than a, "co-ordination of care for individual service users and carers" (Ham and Curry, 2011 p.1). And this integrated holistic concept in patient care is captured by the next participant:

(P3) It's [holistic care] a bit of everything really, psychological, physical, spiritual care - all of those, all being of the same importance for good care to be delivered.

For this participant good nursing care is equated to the inclusion of psychological, physical and spiritual care, but she omits to mention social. The following participant describes how spirituality is essential to holistic care:

(P6) I think if you are gonna umm deliver a holistic - holistic care, then I think that spirituality needs to be encompassed within that, else we are not meeting every need of the patient ...

There is a clear recognition that without spirituality, holistic care is not possible, and therefore all the needs of the patient are not being met.

And -

(P7) It [spirituality] should be part of the care that we provide for every patient, the holistic kind of model of care ... is what we are supposed to be doing ... looking after our patients in every aspect ... it's the well-being of the patient - the whole patient ...

The response here views spiritual care as an integral part of holistic care, and that this is what nurses should be doing anyway for the wellbeing of the patient. Therefore, spiritual care should not be marginalised.

Also -

P8) For me holistic nursing is ensuring that the spiritual needs are met just as importantly as the physical needs ... treating people as a human being.

There is a sense that meeting the spiritual needs of patients may sometimes be the priority within holistic care and not always the physical. But in order to have the competence for holistic nursing, it is necessary to acquire knowledge and skills for spiritual care.

Knowledge and skills for spiritual care and properties

In Phase 2 of this investigation, the overall message from participants is that spirituality education in the nursing programme is recognised and appreciated, but insufficient for their needs. In addition, a follow-through of the theoretical content of the concept in the clinical areas with patients would enhance knowledge and understanding, leading potentially to better patient care.

However, it does appear that supporting patients in a spiritual way is not totally dependent on gaining more knowledge and understanding in a traditional sense, but possibly the kind of person you are as expressed earlier; those innate attributes perhaps that leads one into the nursing profession in the first place, for example the following participant describes:

(P3) Well I can tell you the qualities I think nurses should have - which is sort of caring, being able to actively listen, and being gentle with patients ...I think being compassionate to your patient is something that every nurse needs.

Illustrated in this excerpt are some aspects which are desirable for attention to the spiritual needs of patients. Although nurses come into the profession with these qualities, this is not a static status, and these qualities can be honed over time. However, such values may lapse at times in the nursing environment, and it is up to each individual nurse to confront the issues in a constructive manner. So apart from innate motivation resources, and holistic nursing care, which have already been covered, I will now discuss the other properties related to the category of 'knowledge and skills for spiritual care'.

Nursing programme

In this second part of my investigation, participants again reflect on the value and significance of the spirituality education in their training. They then rationalise its contribution to their overall knowledge and understanding of the subject, within their current professional practice. On the whole most participants regret not having enough input during the pre-registration programme, and some attribute their continued uncertainties and confusion about spirituality and spiritual care to this shortfall. However, they are prepared to utilise whatever knowledge gained from the programme in their practice:

(P1) I believe it [spirituality] should start within your nurse training - you actually value the importance of that, because then whether you really are spiritual or not, if you actually value the importance of it, then I believe you probably will try to at least attend to a patient's spiritual need, even if you are not particularly spiritual yourself.

It is not clear if the participant means that spirituality education should begin at the start of nurse training. Nevertheless, the point being made is that the importance of it would be valued, and endeavours to deliver spiritual care would be made regardless of the nurse's personal beliefs. However, although spiritual care is appreciated as important, the next participant is emphatic that the subject should be included throughout the nursing programme:

Elc (P2) We touched on it very briefly, we didn't go into any detail ... we need to spend a lot more time on that area within our training. I think spiritual care is extremely important, and that's why I think it should be covered in much more depth throughout our training ... I think for me I need it underlined, and bullet pointed, and highlighted, and laid out simply; It never was, which is why now I struggle with the whole idea at the moment. It has hampered the understanding, if I had had it plainly explained, the word 'spirituality' used more often, if we had

looked at things in a little more detail under that heading, yes, I would have got a much better understanding and got a head start of it.

The main point from the above is the need for more formal spirituality education in nurse training, and the participant attributes her present lack of understanding in this area to this situation. Additionally, the actual word 'spirituality' should be explained and articulated more as indicated in the following:

(P3) There were a couple of sessions where we went quite deep into spiritual care, actually asking ourselves what it [spirituality] is, what we can do about it [spirituality]. I think most lessons need to be based around compassion and spiritual care to begin with, to actually ingrain that into you so that you know exactly what you're meant to be doing...

Interestingly, the above participant remembers some content of spirituality sessions, but suggests that other lessons should have a compassion and spiritual care base. This could potentially make a strong impression that influences practice in general. Moreover, the next participant admits to benefitting from class discussions:

(P7) At university as part of my training we had a few sessions on spirituality, and that helped me to understand a little bit better ... discussing what is spiritual care - bringing it to the forefront of people's mind ... I think it does make you think about the essence of a whole person.

Some content within the formal pre-registration spirituality education is acknowledged as helpful in terms of further understanding, also an increased awareness of the whole person. Nevertheless, the following opinion suggests that many subjects in nursing need more than academic content:

(P9) I would definitely say that I have learnt more [about spirituality] being on the wards, but a lot of nursing you can't teach ... it's about being able to do the job that matters and not necessarily what grade you get during an assignment to

*show what your understanding of a patient and being able to meet their needs ...
you still learn more out in practice.*

While this participant does not discount the benefits of spirituality education in the classroom, she emphasises the learning experience gained in the ward situation. Furthermore, for this participant it's about the practical application of knowledge that matters more than academic grades. Additionally, the impact of learning experience for some participants in specialised clinical areas had a significant and positive effect.

Specialised clinical experience

The value of specialised clinical experience in hospice and palliative care is highlighted by some participants as significant in terms of the impact and contribution to their knowledge and understanding of spirituality and spiritual care.⁶ Participants commented that in hospice and palliative care areas spiritual care is a priority for the patients, and they learnt a lot, reflecting positively on the time they spent in those kinds of areas. They would emphasise that spirituality and spiritual care was talked about openly and actioned extremely well in those settings. Participants also commented that they had more time to devote to patient care which was also more favourable in general for spiritual care:

(P3) I think the main thing was, I had as a student quite a long placement in a hospice, and I saw a lot of spiritual care there and it certainly made me a lot more aware of it [spirituality] and given me ideas of how I can do things with patients, and showed me a lot of compassion, dignity, and respect – everything that should be given ... certainly that was good for me ...

⁶ The significance of learning opportunities in hospice and palliative care in relation to spirituality education was highlighted in a conference presentation by the author (Appendix 19).

Spiritual care in the hospice was conspicuous, and provided some conducive, learning opportunities for future practice in other clinical areas. It is also noticed that compassion, dignity and respect are acknowledged as key aspects of spiritual care. And the following participant added:

(P6) I did a twelve week placement in a hospice where they very much do deliver holistic care ... I've learnt more than I did here [the university classroom] because you are actually in the setting that you are supposed to be in and they teach you how to deliver it [spiritual care] and how to have conversations, and you do have the time in that kind of situation to sit and hold somebody's hand.

For this participant the extended placement in a hospice confirmed holistic care of patients. Spiritual care was a priority and the participant was taught how to have conversations with those patients, and there was time to sit with them. What was also referred to by a number of participants was the value that life experience contributed to their understanding of spirituality and spiritual care.

Life experience

Participants recount their life experience as being a significant factor in contributing to their attitude and personal resources for spirituality and spiritual care. In particular, family up-bringing and role models by parents and grandparents reflecting compassion, respect, and dignity were considered as valuable experiences. Consequently, these experiences are now ingrained in them, and contribute to their professional practice in a strong way. This is reflected as follows:

(P3) ... it's how I've been brought up, and I've always been brought up to treat someone how you would want to be treated yourself, and that's something that's been ingrained into me. It's not a thing that I would ever not do because it's just

the norm for me ... everything that I've picked up from parents and grandparents ... they have the same dignity and compassion ...

This participant's upbringing is described as having a significant and lasting effect with regards to the spiritual qualities of dignity and compassion.

Accordingly, she explains that expressing these qualities is normal for her. The influence of past experiences was also important for the following participant:

(P9) ... life experience before I was doing my training - that has brought me to be the person I am today. I'm not saying that the nurse education is not fantastic, because it is, and you need that side as well ... but I wouldn't say that was a leading factor in my spiritual thoughts and opinions.

Life experience features prominently in this participant's understanding of spirituality and spiritual care, and is rated above academic input in this area. But it is acknowledged that the spiritual dimension is also developmental:

(P10) I think I am more mature in the reality of it (spirituality and spiritual care) - mature about it, yea, more understanding.

A certain amount of maturation has come about over time that has helped in the understanding of spirituality and spiritual care. Furthermore, for another participant's previous employment, and being an older person were considered advantageous.

(P11) ... for me coming into nursing, I have just carried on with the way I was before, and I think in that work [not disclosed for confidentiality purposes] I became more compassionate ... as an older person, it's a continuation for me ... the whole of life is a learning experience.

What has been gained through life and the experience in a particular type of work have widened her understanding, and contributed to her developing more compassion to treat people holistically. However, confidence is an important

factor to possess as this boosts one's morale to take appropriate action for spiritual care.

Personal confidence

This is about self-assurance to believe in one's own ability to achieve something. In general and relating to spirituality and spiritual care, confidence is having a state of mind that decides the best and most effective course of action. And Clarke (2013), comments that because of poor spirituality education, nurses often say they lack the confidence for giving spiritual care. However, the participants in this investigation did allude to this previous comment to an extent, but felt that increased self-confidence comes with being a qualified nurse, also the fact that they have the continuity of remaining in one working environment. They also observed that patients regard qualified nurses differently to students, and tend to listen more attentively in conversations:

(P5) I think it does make a difference, you are confident as a qualified nurse ... as a staff nurse [Registered Nurse] you have that more confidence, you know that when you're talking to them [patients] they listen to every word you say ... I think you have that confidence to step forward and do those things [spiritual care] for the patient that you might not have done as a student.

This participant asserts that being a Registered Nurse brings increased confidence and empowerment to deliver spiritual care, which was not always the case as student nurse.

Also -

(P7) I don't think I would have a problem at all - I think I am quite open to addressing that [spirituality] it's an essential part of what we should be doing.

This participant is confident about meeting spiritual needs and sees this as an integral part of nursing care. So there is an assumption that confidence is a desirable attribute in delivering spiritual care to patients.

Delivering spiritual care and properties

The whole purpose of spirituality and spiritual care in relation to nursing practice is to adequately meet the spiritual needs of patients. In other words delivering spiritual care is the 'business end' of this dimension in nursing, and goes beyond theory and rhetoric. I will now elaborate on a number of additional properties (discussing spirituality, and personal spiritual beliefs) that feed into the concept of 'Delivering spiritual care'.

Discussing spirituality

As a result of the information gathered from participants, it appears that apart from the clinical areas of hospice, and palliative care, spirituality may only be discussed with patients on the odd occasion for example, when filling out admission paperwork. There is a feeling that if a spiritual matter is important to the patient, it should be raised in open conversation with other members of staff. Participants are in agreement that conversations of a spiritual nature should be normal within healthcare practice, and the following would indicate this:

(P2) ... we didn't touch on it [spirituality] at all apart from filling in paperwork and asking, "what religion are you?" - that was it. I'm working with older people mainly at the end of their lives ... so yes I cover it more now than I did in the majority of my placements throughout my training.

What is being articulated by this participant is that spirituality in some clinical areas may be seen as having more priority than in others for example, when caring for older people. There was awareness of a need for more openness and willingness to engage in spiritual conversations for example:

(P3) Yes definitely if it [spirituality] was something important, then it should be part of the handover, and I find that if I am giving handover and I know certain patients need spiritual care then I always hand that over. I think it should be talked about more - it should be talked about on the ward ...

This participant affirms that spiritual matters relevant to patient care should be discussed with the nursing team. And she was also careful to include spiritual matters in the handover as appropriate. This need for openness towards spirituality is also echoed in the following:

(P6) ... we need to be able to embrace it [spirituality] more ... I think more people should be open to discussing about it.

For this participant she felt that spirituality should be a normal part of relevant discussions about patient care in clinical areas. And the following participant describes how the clinical setting may determine the extent to which spirituality is discussed:

(P8) I think that's very important - I think it [spirituality] should be - but that's one of the reasons why I really wanted to work in ITU because I think it is discussed a lot more than in a general setting ...

So it is possible that matters of spirituality are important and are discussed more in critical care settings than in the general wards. But everyday nursing care is the domain of all nurses, and is just as important.

Everyday nursing care

Participants realise and describe certain types of spiritual care that can be given to each patient within their everyday nursing care, which Clarke (2013) says is distinctive and unique giving value to the ordinary daily tasks of care. The integral nature of spirituality within everyday nursing care happens almost automatically without the participant realising that they have met some spiritual need. However, other spiritual care of a religious or non-religious nature are not mentioned at this time. This serves to confirm that there are various levels of spiritual caregiving. Participants offer their opinion as follows:

(P1) I think it [spiritual care] is included within your patient care, and obviously physical patient care.

The integral nature of spiritual care is demonstrated in this participant's understanding of everyday patient care. And participants do identify aspects of everyday nursing that may be spiritual in nature:

(P3) There is a certain amount of spiritual care that you can give in your day-to-day nursing ... It's a bit of everything really ... it can be just talking to the patient as you are doing a bed bath.

Here again spiritual care is not singled out as something extra to do for the patient, but is very much part and parcel of general patient care. Yet spiritual care is individual for all patients, and this is brought out as the next participant says:

(P5) ... each person's spirituality could be very individual - you do what you can as you're working, anything they want you to do - anything that you can help them with just automatically. If they had a spiritual need, whether they realised that it was a spiritual need or not, you would do what you could to help.

Although spiritual care may be seen as integral and automatic to everyday nursing practice, the individuality of the patient is also recognised, valued, and respected. Additionally, a participant describes that such care appears seamless while attending to other needs, as with participant 9:

(P9) ... you don't actually stop and think that I am doing this because of their spiritual need. I don't think you can meet other nursing needs without spirituality - it's in everything else that you do, and therefore you can't respect someone's dignity if you are not meeting their spiritual need, you can't ... a good nurse will work holistically and encompass that within the needs of the patient.

This participant expresses quite clearly that in the course of everyday nursing care, attention to spiritual needs are inevitable. Hence, spiritual care is not seen as a separate care giving activity, but an embedded part of holistic nursing.

Personal spiritual beliefs

Personal spiritual beliefs were often seen in terms of religious beliefs by the participants. Some mentioned how their own personal spiritual beliefs influenced their nursing practice and attention to spiritual care. Others would say that their spiritual beliefs acted as a motivating factor in the care they gave to patients. Conversely, others detached their personal beliefs from their ability to understand and respond to the patient's spiritual need:

(P1) And because I am someone that's got my own spiritual beliefs, means that even if mine aren't the same as someone else, it made me realise the importance of it to people that have got one, whatever it means to them ... I know how spirituality helps me ... (Catholic).

Religious beliefs are not mentioned here, but from the demographic information this participant is of the Catholic faith. However, she is able to appreciate the

significant place spiritual beliefs may hold for others of differing traditions. A similar sentiment is shared by participant 2:

(P2) ... I was brought up very religious ... a lot of it [spiritual care] comes naturally from the sort of person you are. Trying to understand their point of view - I don't mind what beliefs people have, that's completely up to them, I wouldn't judge anybody for it – I haven't got a problem talking about that [spirituality] at all (Baptist).

Religious upbringing in this instance has engendered tolerance and respect for other people with different beliefs. There is no hesitation to having conversations about spirituality. However, religious upbringing or belief was not a prerequisite to providing spiritual care as outlined in the following:

(P5) ...I am not a religious person myself ... as a nurse you can try and help as much as you can, but you shouldn't have to agree ... you could refer it [religious matters] to someone else ... you could ask the patient if there is any relative that could help ... you wouldn't brush it off ... you are there for the patient ... (Agnostic).

An important point made is that it is not necessary to be religious to facilitate spiritual needs of a religious nature. What is also emphasised is that patients' religious spiritual needs should be taken seriously and not ignored. In fact it could be considered as negligence not to support patients' spiritual beliefs:

(P7) ... we all have our own spiritual beliefs, so not addressing it [spirituality] is a bit of negligence on our part really as a nurse, because it's part of the care we should be giving (Church of England).

The above participant suggests that nurses should be addressing the spiritual dimension within health care otherwise this could be regarded as a form of neglect. However, the next participant states that treating everyone as an individual comes naturally as a result of her Christian faith.

(P10) my beliefs ... as a nurse we are trained to say that we treat everyone as individuals, and I think for me as a born again Christian, it's a natural thing to do ... (Christian).

This participant's Christian faith is meaningful in her life and helps her in giving individualised patient care instinctively. But other contributory factors such as active listening and being open are positive features:

(P11) I think if you are open and listening to people, then that's spiritual care. Even though I am not religious, I do believe those things (Non-religious).

Spiritual care for patients and its significance is not really dependent on the nurse's personal spiritual beliefs. So what are the participants' main concerns in Phase 2 of this investigation?

Main concerns

The main concerns of the participants identified during Phase 2 were in relation to their concept of spirituality and spiritual care and their nursing practice as newly qualified Registered Nurses. The process of analysis involved remaining open to what is actually happening in the data, so discovering the main concerns of the participants, and how they resolve the same (Glaser and Holton, 2004).

Thus, the following held strong for the participants in this phase:

- 1) Transient recognition of some aspects of spiritual care
- 2) Dominance of physical care
- 3) The low priority of spiritual care in most clinical areas
- 4) Insufficient knowledge about spirituality and spiritual care

Transient recognition of some aspects of spiritual care

This main concern recurred with all participants as newly qualified Registered Nurses, and this could be due to the fact that spiritual care in their everyday nursing practice is inseparable from other care activities. Therefore, it was often not mentioned as a distinctive feature, in other words it was transient or fleeting in their recollection. For example, this is what some participants reported:

(P2) when I start thinking about it [spiritual care] , it comes naturally, it's what I do all the time - but I don't think of it as spirituality ... even though like I say I'm covering it every day in my work, but just not realising it.

This participant realised that when she stopped to think about the care she was giving, it became apparent that spiritual care was being given all the time while she addressed other patient needs. This discovery is further confirmed by the next example:

(P6) It's possible that I'm doing it [spiritual care] already and not really realised that I'm doing it - because you get so wrapped up in the moment ...

Again there is a level of spiritual care that is integral within other nursing activities, and therefore often not distinguished as something different.

Consequently it is carried out unawares as illustrated in the following:

(P9) You do it without thinking about it... meeting a spiritual need or desire - it's just fundamental things that you think are supposed to be met ...

Here we see that spiritual care is contained within fundamental patient care activities. And this opinion is further endorsed below:

(P13) you are delivering spiritual care ... we don't realise that we are providing our patients with spiritual care ...

As newly qualified Registered Nurses, spiritual care at a fundamental level as

previously discussed (page 210) was mainly an unconscious activity, performed as a natural part of everyday nursing. So although it is recognised as taking place, there is often no real need for specific validation. But there was a prevailing dominance of physical care.

Dominance of physical care

The priority normally given to physical care in nursing practice often dominates, and as a result spiritual care may not be appreciated as a significant component. Furthermore, while physical care has to be documented by nurses, this is often not the case for spiritual care at present. Hence, a comment by participant 1 elucidates this point:

(P1) the environment and the kind of patient you've got really can have an influence in terms of if [spiritual care] you've got people who need a lot of physical care - that has to take priority ... it can make it quite challenging at times to sort of bring it [the spiritual] into your care, and you do your best and you want to bring spirituality into that.

In this excerpt the participant states the pressures that arise at times in the care environment may understandably dictate priority for physical care. However, she is also aware of a necessity for spiritual care, which presents a challenge in terms of competing duties. This awareness of the need for spiritual care is also highlighted by the next example:

P4) I think nurses are aware and we should be looking at it [the spiritual] but it comes at the bottom of the list - you must get all your duties done, you must get all your tasks done, get all your observations done, and then if you have time, it comes last. And if it doesn't get done it doesn't get done. There is no backlash ... it's just forgot about.

This nurse is aware that she should take into consideration the spiritual needs of patients, but on a list of priorities this aspect comes behind other pressing duties that need to be recorded. The feeling is that there are no immediate professional consequences for not attending to spiritual care. This factor may contribute to a low priority being given to spiritual care in most clinical areas.

The low priority of spiritual care in most clinical areas

Spiritual care as seen above in the last excerpt may be relegated to the bottom of a list of duty priorities. The spiritual aspect within holistic care is not less than the physical, psychological and social components, but there are times in nursing when priorities must shift in the duty of care. But in general a low priority is constantly given to spiritual care. However, there are exceptions to this as in the case of palliative and end-of-life care:

(P9) Palliative care ... when patients are getting towards difficult times, they start to think about their spiritual wishes, needs and desires, when they have been given bad news maybe - they start to think about what it is they want ... end of life care definitely ... I do like my palliative work and that's why I keep going back to it all the time - so just in that setting it's very important to make sure that people's spiritual needs are met and that their wishes and desires are fulfilled ...

Participant 9 explains the reasons for spiritual care priorities at particular times in a patient's illness trajectory. She emphasises that it is important in palliative and end-of-life situations to prioritise spiritual care, and fulfil the patient's wishes and desires.

And -

(P3) Certainly in palliative care and after death as well, spiritual care always seem to take a big part of it because it's all respect and everything for the patient ... because it does seem to take a big priority in palliative and bereavement care and last offices.

As seen in this transcript, the participant realises that spiritual care is not only important when the patient is alive, but also in death, and qualifies this by the mention of being respectful to the patient.

The participants appreciated that spiritual care in palliative and end of life care is of significant priority, and they attribute value to such past learning experience. However, insufficient knowledge about spirituality and spiritual care still persists.

Insufficient knowledge about spirituality and spiritual care

The problem of insufficient knowledge about spirituality and spiritual care continues, and all participants in this investigation agree on this point. What is quite clear is that they appreciate the small amount of spirituality education provided in the pre-registration nursing programme, but recognise that this was inadequate for a comprehensive appreciation of the concept.

(P2) I think we touched on it very briefly, we didn't go into any detail, and it really does need to be looked at, we need to spend a lot more time on that area within our training ... I think spiritual care is extremely important, and that's why I think it should be covered in much more depth throughout our training.

There is no doubt that participant 2 believes that the formal spirituality education received in the nurse programme as a student was lacking. She also believes that because spiritual care is so important it should be addressed in detail in all three years of the pre-registration nursing programme. The following participant shares a similar view:

(P3) I think we would all benefit from a further expansion on it [spirituality and spiritual care] to ensure that everybody in practice is actually aware of it, and can do it. I think it should be throughout, definitely a strong emphasis in the first year and the last year - definitely throughout would be a lot better.

The benefits to be gained from more spirituality education would enable better awareness in clinical areas and enhance nursing practice. This view is taken further in the excerpt below to include the UK's nursing professional body the NMC, to do something about the inclusion of spirituality training in nursing programmes.

(P5) If they (the NMC) are putting in that it [spiritual care] should be part of the role, then there should be more within the training on it really. If they want you to be more aware of these spiritual needs then they need to provide more training to allow you to provide that role, otherwise if you don't have the understanding of it you are going to find it very difficult to provide that.

This participant makes it quite clear that the NMC has a responsibility to issue directive in relation to spirituality education, seeing that they state that this is a part of the nurse's role. This move would provide more exposure to the spiritual dimension for all nurses:

(P7) I think there needs to be more exposure to it, perhaps through education, because I know we only touched on it partly through our training ... guidelines for people to understand it a little bit better, perhaps coming from relevant bodies.

This participant sees education in spiritual care as a way forward for better understanding, and that guidelines from professional nursing bodies would be helpful.

Overview of main concerns

All the main concerns in phase 2 of this investigation: transient recognition of some aspects of spiritual care, dominance of physical care, the low priority of spiritual care in most clinical areas, and insufficient knowledge about spirituality and spiritual care, were discussed with supporting examples from participants' transcripts. It was seen how these main concerns could negatively affect their nursing practice as newly qualified Registered Nurses. As a result there is a need for these concerns to be resolved in order to enhance the participants' nursing practice as professionals. The following section will deal with the resolution of each of these concerns in turn.

Resolving main concerns

Unresolved concerns are likely to create discomfort and stress for nurses as they face the daily challenges of providing quality care (Ulrich et al., 2010).

Therefore, having identified the participants' main concerns, I will now look at their strategies to resolve them in order to support the spiritual dimension within holistic patient care.

Resolving transient recognition of some aspects of spiritual care

Participants did not consistently recognise the spiritual in the usual care they were giving. Nevertheless, on reflection this transient recognition was resolved because they were able to satisfactorily confirm to themselves that they had

engaged in spiritual care by treating their patients with compassion, dignity and respect. Therefore, According to Carson and Koenig (2008 p.126):

“Unlike physical needs, which can be observed and quantified, spiritual needs must be inferred from patient behaviour ... spiritual ministry requires nurses ... to use only the tool of themselves – their compassion, their listening skills, their kindness, and all the things that make them unique and giving”.

Participants began to realise that spiritual care at a simple fundamental level was not detached from the usual care they gave to patients, so specific recognition in this respect was resolved. Furthermore, Miller (2008 p.173) confirms this by saying:

“In reality, nurses have numerous opportunities to provide spiritual care to patients, because spiritual needs are not separate from other needs”.

Therefore, addressing spiritual needs can be a simple matter of truly caring for patients. Participants now appreciated and were comfortable with the level of spiritual care that did not need to be singled out, and was given on an on-going basis within everyday nursing. However, in order to further support patients in a spiritual way, the participants would informally assess their patients by observation, verbal or tacit means. As a result of this informal assessment they would respond as best they could to facilitate the spiritual needs of the patients in order to enhance their wellbeing.

Resolving issues related to dominance of physical care

Although participants told of the time constraints and shortage of staff leading to pressure of responsibilities to attend to the physical needs of patients, and complete all necessary paperwork within their shift of duty, they were aware of

the importance of spiritual care, and made efforts to incorporate this in their everyday nursing practice. Ulrich et al., (2010 p.2) also identified that:

“Today's healthcare environment is demanding for nurses at a time when there is a critical shortage of staff to meet the multifaceted needs of patients”.

In addition, we are reminded that:

“nursing care is shaped by the social structures of the institutions of care ... higher nursing workloads ... (Llewellyn and Hayes, 2008 p.136),

This inevitably contributes to a time-constrained environment. However, participants were not prepared to be totally overwhelmed by these pressures in their endeavours to address the spiritual needs of their patients. They were convinced of the importance and value of spirituality and spiritual care, so demonstrated a determination to allow this dimension of care to feature in their nursing practice.

Resolving issues of the low priority for spiritual care in most clinical areas

The participants found the low priority for spiritual care was disheartening at times, but this created a resolve to be pro-active in their contribution to begin to initiate change within the clinical areas they were now working in. They talked of being a role model, raising the profile of spiritual care within the nursing team by discussing, documenting, and reporting relevant spiritual matters. In other words, participants were willing to step up to their leadership role as Registered Nurses, to inspire student nurses and colleagues to be more aware of and respond to spiritual needs, to the end that, spiritual care is viewed as a nursing responsibility that is integral to promoting the wellbeing of the patient (Lemmer, 2002).

Resolving the issue of insufficient knowledge about spirituality and spiritual care

Time and again participants would express their desire for more spirituality education to be better equipped to respond to the spiritual needs of patients within holistic nursing care. They utilised relevant life experience, experiential learning in hospice/palliative care (if they had this opportunity), and the small theoretical input from their nurse education programme. Although, overall they did not feel fully prepared, they looked ahead to other opportunities in the future to increase their knowledge and understanding in this area. This expectation and interest in furthering their knowledge and understanding of spirituality and spiritual care in the future in some way served to resolve this concern of insufficient knowledge about spirituality and spiritual care. Therefore, participants were optimistic and motivated to be pro-active where possible to increase their knowledge and understanding in this area to support the spiritual in patient care.

Supporting the spiritual in patient care

Figure 7.4 illustrates the anticipated outcomes of the participants in resolving their main concerns. As discussed earlier, FSC is known to take place in all patient care encounters, so remains a constant requirement for the patient and does not necessarily need specific formal assessment. Nevertheless, all spiritual care should be reflected on and evaluated formally or informally for its effectiveness, to guide required future nursing input. The nurse being sensitive to meeting the patient's spiritual need is central to all spiritual care (O'Brien, 2008),

and makes sensitivity a precursor to appropriate action in this domain. Patient's spiritual needs may be expressed for example:

(P4) I think basically I would try and sit and have a private conversation, just me and them. Try and ask them how they are feeling, what's worrying them, do they want to talk to somebody else - somebody from the religious side, or just somebody - even friends we could contact...

It is not a common occurrence for patients to specifically express their spiritual needs (as stated by participant 3, p.193) but more often it's the nurse's sensitivity in picking up cues from the patient in this respect for example:

(p10) Umm, out of conversations sometimes ... if it's about they are feeling a bit low, if it's in their face that they are looking drawn ... they are that worried, that concerned that you feel prompted to go in and sort of investigate what's happening ... that relationship to find out what's underneath, what's causing them to feel that way.

Engaging with patients in this way as Clarke (2013) discusses, has the potential to make an essential contribution to their spiritual wellbeing. Therefore, the participants in this investigation would respond to the patient's spiritual agenda; meaning, they would acknowledge, respect and facilitate those needs which are important to the patient. Accordingly, Figure 7.4 shows that meeting the patient's spiritual need agenda is the central motivating factor for spiritual care activity and not merely the nurse's efforts for beneficence.

Figure 7.4 Supporting the spiritual in patient care

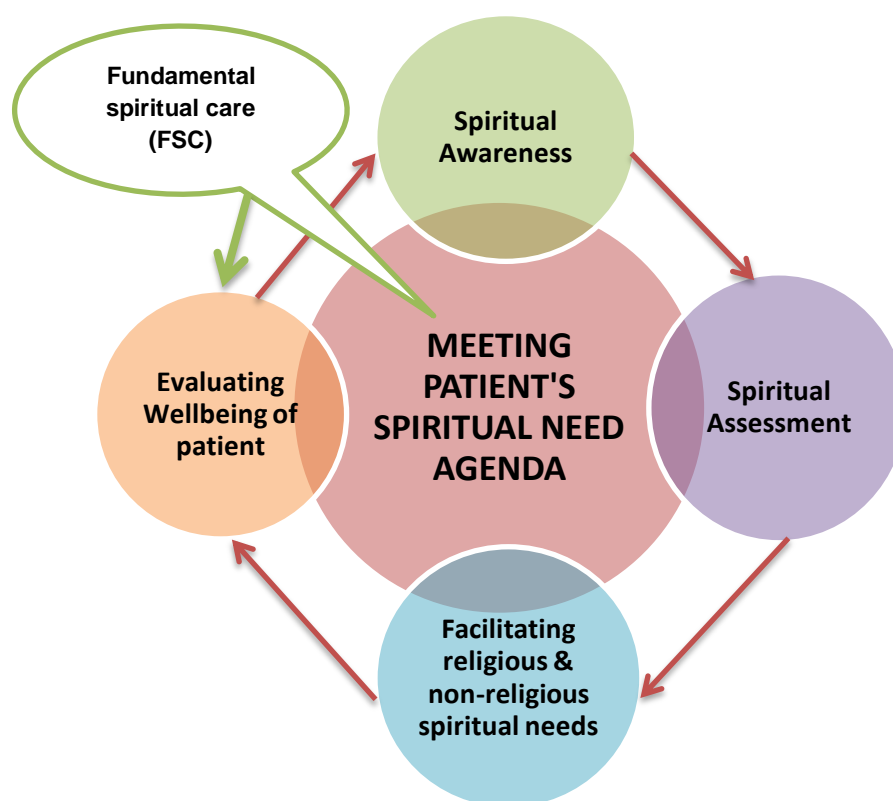


Figure 7.4 diagram starts with spiritual awareness, moving through spiritual assessment, facilitating religious and non-religious needs, and finally evaluating the wellbeing of the patient. FSC is the basis for all other spiritual care, and all aspects as mentioned contribute in responding to the patient's personal spiritual agenda. All the above stages of supporting the spiritual in patient care will now be discussed separately.

Spiritual awareness

Spiritual awareness in the context of this investigation concerns the participants' ability to be conscious of the spiritual needs of patients. This is a necessary requirement to be able to then facilitate those spiritual needs (Ross, 1997). Therefore, spiritual awareness is a state of knowing that spiritual needs exist presently within a patient care situation, and spiritual care provision in response

should be forthcoming while attending to other aspects of healthcare (Narayanasamy, 2010, Meyer, 2003). It is suggested by Harrison (1993 p.214) that:

“if spiritual needs are to be met then nurses must not only have some awareness of the importance of patients’ spiritual needs but also include some sort of spiritual assessment ...”.

Spiritual awareness if left isolated becomes impotent, because it then remains only a cognitive acquisition. Therefore, the usefulness of spiritual awareness can be seen in its logical progression to spiritual assessment.

Spiritual assessment

Spiritual assessment seeks to enquire about the patient’s spiritual functioning whether this is religious and/or non-religious. This assessment could be formal and in some cases may be a part of the admission process, or informally through verbal and/or non-verbal communication with the patient or significant others.

According to McSherry (2010 p.61) spiritual assessment relates to:

“the interaction of one human being with another within a caring relationship and therapeutic environment”.

Thus spiritual assessment includes attention to the following factors: conceptual (people’s definition, perceptions and understanding of spirituality); organisational (the relevance of people, places and processes); practical (implications); and ethical (issues and potential dilemmas) (Ross and McSherry, 2010).

Furthermore, this assessment should be patient focused and individualised, and responsive to on-going changes in the patient’s illness trajectory. The

participants in this study were all aware of informal ways of assessing the spiritual needs of patients in order to then facilitate the same.

Facilitating religious and non-religious spiritual needs

Facilitating religious and non-religious spiritual needs may be challenging not only because the concept is broad, but also the reality of responding to spiritual care in a way that reflects the UK's multi-cultural population. However, a search for meaning in life and events such as ill health are central to spirituality within the nursing context (Greenstreet, 1999). And there is convincing evidence to suggest that spirituality in nursing programmes contribute to student's ability to provide spiritual care (Meyer, 2003). However, this acquired ability needs to be sustained for adequate on-going attention to patients' spirituality within healthcare practice. Religious needs could be prayer, religious texts, a visit from a hospital chaplain or other religious person; non-religious needs could be music, art, poetry, nature, family members. Spiritual religious and non-religious needs are subjective, and the nurse is in the position of facilitator. What is always necessary when any form of care is given is to evaluate what has been provided for patient satisfaction and make future adjustments or improvements as necessary.

Evaluating patient wellbeing

The end result of facilitating spiritual needs is the achievement of patient wellbeing. In order to do this it is necessary to reflect on the process undertaken in facilitating those needs, while remaining open to revision as necessary. But evaluating is also about celebrating a positive process outcome, also giving

credit to others (Helming et al., 2014). Thus, evaluation is an on-going process of identifying if goals have been achieved (Llewellyn and Hayes, 2008). Such an evaluation process would offer constant opportunity to the participants for further improvements in spiritual care, which include those aspects that are at a fundamental level.

Fundamental spiritual care

This concept has already been discussed in Chapter 6 therefore to avoid repetition I will not major on this matter here. But this dynamic process as seen in the five components portrayed in Figure 7.4 (supporting the spiritual in patient care) is necessary to achieving the goal of addressing the patient's spiritual need agenda. It is said that spiritual care involves two critical elements: an intrinsic, as well as an extrinsic dimension (Puchalski et al., 2006). The intrinsic element would be the participant bringing something of themselves to the patient encounter, for example compassion, intuitive listening; whereas extrinsic spiritual care is about communicating with the patient about their spiritual issues, and recognising their needs in this area.

Consequently, the efforts of the participants in this pursuit of supporting the spiritual in patient care, leads to them aiming for 'Efficacy' as illustrated in Figure 7.5. 'Efficacy' is a core category and is thus revealed to be a leading and desired component by participants for delivering spiritual care; this will now be explored in some detail to anchor the participants' ambitions for effective responses to the spiritual dimension of nursing.

Efficacy

In 1977 the psychologist Bandura developed the social learning theory (Bandura, 1977) of which self-efficacy is a major concept. He observed that students' perceptions of self-efficacy influenced their decisions, choices, and persistence to engage in specific activities (Bandura, 1997). Self-efficacy and efficacy are sometimes used interchangeably at times (Pajares, 1997) and I have chosen to use efficacy in relation to this investigation. So efficacy is a strong personal belief by an individual that they are capable of performing certain activities in a specific domain, namely the spiritual dimension in this case. And according to Pajares (1997), the use individuals make of their knowledge and skills may have something to do with their self-perceptions of capability. The participants acquired knowledge, understanding and skills for competence, and efficacy to facilitate optimum spiritual care for patients. Moreover, Pajares (1997) states that when individuals possess a strong sense of personal competence in a domain, they will approach any difficult tasks therein as challenges to be mastered. Therefore, any challenges encountered facilitating spiritual needs are likely to be overcome by these competent newly qualified Registered Nurses. Figure 7.5 illustrates how efficacy supports the elements included in facilitating spiritual care needs of patients.

Figure 7.5 'Efficacy' in supporting the spiritual in patient care



Figure 7.5 depicts 'Efficacy' as the hub that supports the outlying structures that are involved in the spiritual care of patients. 'Efficacy' aims for optimum accomplishment in spiritual awareness, spiritual assessment, FSC, religious spiritual care, non-religious spiritual care, and evaluating patient well-being.

Thus, the resolution of the participants' main concerns leads them to pursue the core category of 'Efficacy' in delivering spiritual care to their patients as illustrated in Figure 7.5. This is important because their good intentions for the spiritual care of their patients will become reality in its practical application as expounded by Bandura (1997 p.61):

"People make judgements of their efficacy because these judgements serve functional purposes".

So in this case it is the participants' belief of achieving the anticipated practical goals of addressing the spiritual needs of patients. Thus, a high sense of personal efficacy is important to self-directedness (Bandura, 1997). Furthermore, research also shows that efficacy in spiritual care accomplishes the nurse's aspiration to deliver good patient-centred holistic care (Frouzandeh et al., 2015). And an indication of this is shown in the following excerpts:

(P1) ... you have got to adapt to each person as to how you bring it [spirituality] in ... you do your best in practice to do that really to the best of your ability. ... it can be quite challenging at times to sort of bring it into your care, and you do your best, and you want to bring spirituality into that.

This participant demonstrates efficacy to deliver good holistic care by making an effort to adjust to each person's spiritual perspective, and then to do her best to meet those needs, which can be challenging. And a similar example is given by the next participant:

(P2) ... the [patients] wishes are discussed with themselves or with the family - you learn how to do the job in much more detail... if they needed something [spiritual] in particular and I wasn't familiar with it, I would be quite happy to source it somehow - take advice from other areas - not a problem... how we can give them and their family the best possible care. And I think spirituality will be discussed a lot more in the future.

The participant emphasises learning attention to detail in her job, and in particular attending to the spirituality wishes of the patient/family. She would also make every effort to facilitate these wishes and provide the best possible care. And sometimes identifying spiritual needs may not be obviously apparent:

(P7) Perhaps recognising that there is something not quite right with them and you sit down and ask if there is anything you can do for them.

The participant is sensitive to cues from the patient and seeks to find out more and do something about it. Overall, what has been portrayed by the participants' excerpts is a strong sense of efficacy to deliver spiritual care to their patients.

Summary

This chapter presented the coding, analysis, and findings from data gathered in Phase 2 of my investigation. The three main categories of: essence of spiritual care, knowledge and skills for spiritual care, and delivering spiritual care were then constructed, together with their related properties, which contributed to the holistic concept of the spiritual dimension in nursing care. These main categories were applicable to everyday nursing care. The main concerns of: transient recognition of some aspects of spiritual care, dominance of physical care, low priority of spiritual care in most clinical areas, and insufficient knowledge about spirituality and spiritual care were identified. And the participants subsequently progressed towards resolving their main concerns in the following ways: 1) realising that spiritual care was a part of everyday nursing activities; 2) demonstrating the incorporation of spiritual care amidst the dominance of physical care priorities; 3) being pro-active in promoting spiritual care in the work environment; 4) an optimistic view of furthering their knowledge and understanding of spirituality and spiritual care. These endeavours contributed to supporting the spiritual in patient care, and the core category constructed was 'Efficacy' which was depicted as the hub in figure 7.5., and also contributed to the substantive theory in Phase 2. Now it is necessary to compare the findings of Phase 1 and 2.

CHAPTER EIGHT: COMPARISON OF PHASE 1 AND PHASE 2 FINDINGS

Comparison of Phase 1 and Phase 2 Findings

Introduction

The findings from this grounded theory investigation have been explained and discussed separately in chapters 6 and 7. It is now necessary to compare both Phase 1 and Phase 2 findings to see if there are any similarities, contrasts and new features. Accordingly, the exploration within this chapter involves comparing the concepts of: perceptions of spirituality, spirituality education, and delivering spiritual care. Both core concepts constructed from Phase 1 and Phase 2 are then combined to form the substantive theory, 'Continuing with Enablement for Efficacy', which proffers a theory for implementation of spiritual care by nurses. The operation of this theory is then fully explained.

Perceptions of spirituality

Phase 1: The participants' perceptions of spirituality in phase 1 were defined in religious and non-religious terms, but some initially tended to veer towards the narrower religious view (Ross et al., 2016). This came about mainly because of their personal religious upbringing. However, they were very much aware of this and would openly admit to spirituality being much more than religion for individuals. Examples put forward in response were, 'essence in life' (P5), 'one's core'(P7), representing an energising force for thought and action (Taylor, 2002); some talked about a belief in God and their personal religious beliefs; others brought in an awareness of the natural environment – trees, gardens; home environment - people, pets, artefacts. From the findings, key elements of perceptions of spirituality seem to be situated in: God, self, the environment and

others, which in their own way offer a sense of meaning and purpose, hope, and relatedness/connectedness, and these will now be briefly discussed to offer clarification.

Meaning and purpose - According to Burkhardt and Nagai-Jacobson (2002), finding meaning and purpose are essential elements of spirituality, that has relationships with God, self, the environment and others. This and the other key elements to follow are useful for nurses to understand as part of addressing questions about spiritual care (RCN, 2011a).

Hope - This is a spiritual need that is common to everyone (Owen, 1989), and can be described as being optimistic about a positive outcome that is related to an event or circumstance in one's life. It encourages a sense of energy exchange between individuals and their environment, and does not accept limitations (Carson and Koenig, 2004). Therefore, hope offers inner strength in the face of challenging health and other issues.

Relatedness/connectedness – This implies a relationship between two or more elements (Golberg, 1998), not necessarily of an inanimate nature, but could apply to a relationship for example, to a parent-child, or connection with a pet dog or cat. Furthermore, Burkhardt (1989) refers to harmony with self and others, and a feeling of relatedness to God. Therefore, as Young and Koopsen (2005) write, spirituality involves relationships with someone or something

beyond the self, and is linked to every aspect of life and provides purpose, meaning, strength and guidance. Young and Koopsen (2005 p.7) also suggest:

“Spirituality can be considered a basic human quality ... spirituality has many intangible aspects and is an intensely personal issue. It means different things to different people, and these differences are often difficult to describe”.

Therefore, it was the case that all participants conceded to the idea that spirituality was broad including both religious and non-religious beliefs. The fact that this concept is unique to each individual should be sufficient as an explanation, so precluding a pedantic stance about its understanding and definitions.

Inevitably, there was no tidy definition of spirituality, which was difficult for some participants to cope with initially, and resulted in a degree of confusion and anxiety to classify this concept in one place. And Clarke (2013 p.15) advises that:

“Tight definition can fix in place a single idea of a concept which then sets a particular course in discussions so shutting down further debate. Having a concise definition of a concept like spirituality has a deceptive assurance as it seems to increase understanding, but this may be an illusion”.

Invariably as definitions of spirituality are tailored to each individual it should be accepted that it will remain unclear in general terms. However, after the first interview, and when followed up six to eight months post qualification, it was discovered that participants' broad perceptions of spirituality was established. In addition, the participants' perception of all patients having a spiritual need was confirmed in Phase 1 and there was no further need to pursue this matter in Phase 2.

Phase 2: As mentioned above, perceptions of spirituality were largely unchanged over the preceding six/eight months since qualification. However, there was a suggestion that a participant's religious belief could make some difference to perceptions of spirituality, but through theoretical sampling, this was not found to be the case. Also there was another suggestion that the type of clinical area for example, theatre may make a difference to perceptions of the relevance of spirituality for those patients. Again theoretical sampling was carried out, and the suggestion was found not to be supported. Therefore, spirituality is wide enough to be applicable in various ways, inclusive of all patients in their care, and may relate to the following as seen in Figure 8.1. A person's values and beliefs may manifest in relational and behavioural ways, connecting with love, hope, peacefulness, forgiveness, and comfort (Miner-Williams, 2006). There is also the aspect of a transcendent search for meaning, purpose, and happiness.

Figure 8.1 Perceptions of spirituality - Adapted from Miner-Williams (2006)

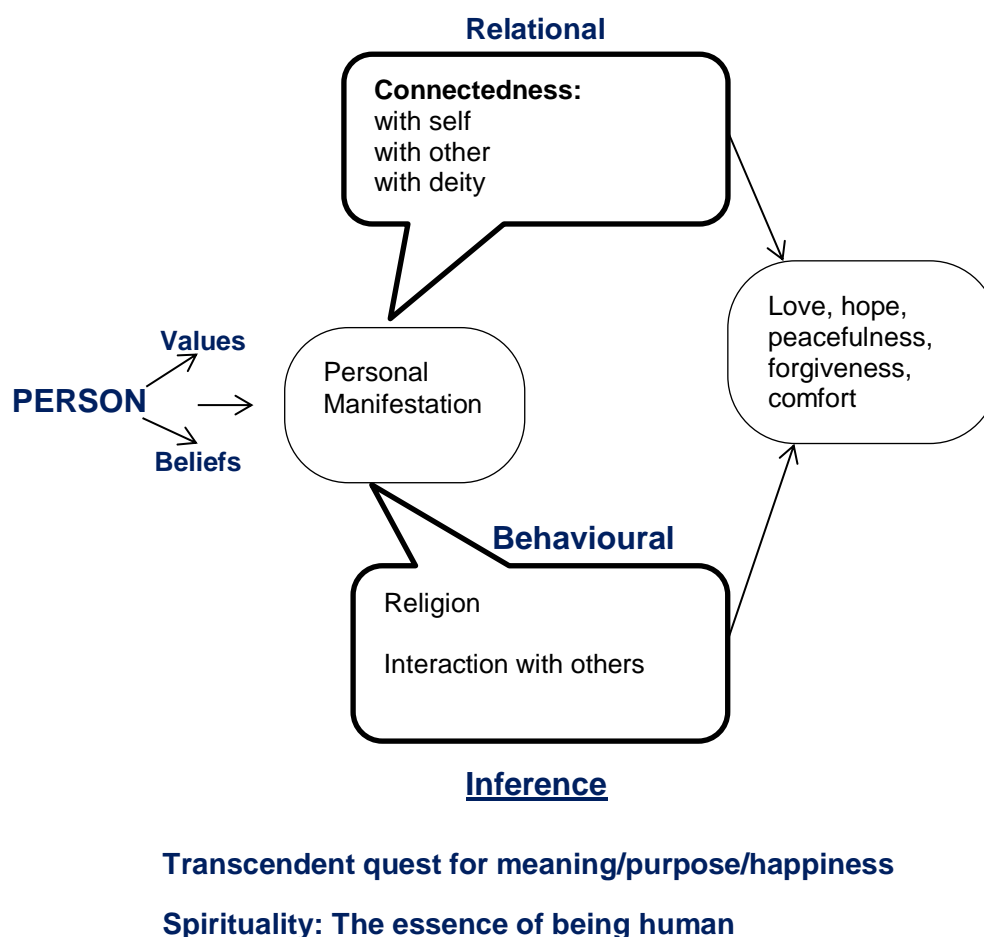


Figure 8.1 displays the relational and behavioural aspects of spirituality linked to common aspirations as stated above. The implication surrounds a person's search for their essence as a human being.

Recognising spiritual needs followed on from perceptions of spirituality, and what emerged from the data was that some participants found themselves in a quandary. But in Phase 1 they would talk about effective communication and holistic patient assessment as contributing to them identifying a patients' spiritual need. In Phase 2 it was more about the essence of spiritual care as in caring for patients with compassion, dignity and respect within everyday nursing activities.

Spirituality education

Phase 1: Participants acknowledged a modest amount of spirituality education in their nursing programme but were divided as to its real impact within a number of clinical practice areas. Information obtained from the college of nursing where all participants were enrolled, established that in the first year they were given a three hour lecture dedicated to exploring spirituality. After this point during the following two years spirituality was integrated in other sessions for example, cultural issues in professional care, palliative care, and care planning. Overall spirituality in-put in the nurse programme over the three years amounted to six hours in total. The small amount of time given specifically to spirituality education in this nursing programme is very evident in the context of the 2,300 hours of theory (including independent study), and 2,300 hours of clinical practice, as required by the NMC for all approved education institutions (NMC, 2010a p.9). However, it is not possible to identify other unobtrusive connections that could be linked to spirituality and spiritual care within the pre-registration programme. Nonetheless, this situation is not uncommon (Linda et al., 2015). The fact that most participants were unable to agree on the spirituality input in the nurse education programme apart from within the third year, would suggest that there was perhaps little or no linkage with other topics, and the same could be said for the follow-through in clinical practice. This issue will be discussed further in the next chapter. Another important point is the confirmation that the amount of spirituality education is insufficient in the overall nursing programme for participants to gain a firm grasp of the subject. At present spirituality seems to be 'swamped' by all the other subjects in the curriculum.

Nevertheless, what transpired was that the small amount of formal spirituality education these participants received did cultivate a greater spiritual awareness, so bringing this dimension of health more to the fore. It was also found that informal spirituality education such as life experience, made a positive and valued contribution to their knowledge and understanding in this area. What was however significant, was the benefit gained from putting theory into practice, also the enhanced knowledge and skills gained from any palliative or hospice placement. Nevertheless, on reflection all participants expressed that they would welcome more formal spirituality education throughout the three years of training.

Phase 2: The data revealed that the enhanced spiritual awareness the participants experienced as a result of their spirituality education was transferred and sustained in their new Registered Nurse status. And in particular response to the part played by spirituality education in the training programme, this is what some participants had to say:

(P1) It has equipped me for being a qualified nurse because you have had the discussions and the insight into the importance it can have for patients with spiritual needs. The main thing that came out of my education was first of all to be aware that people have spiritual needs ... I am still aware that people have spiritual needs ...

This participant is quite sure about the contribution spirituality education in the nursing programme has made. It has equipped her with necessary insight for her current practice six/eight months post-qualification.

(P10) I'm more aware of it [spirituality] to incorporate it into the care I give ...

The spirituality education gained as a result of the nursing programme served to raise her awareness of this dimension within her current nursing practice.

In fact the importance of spirituality and spiritual care was more of a priority now in terms of their responsibilities as registered nurses, and their confidence to promote this dimension within the care team. But they still lamented the inadequate theoretical preparation for the spiritual dimension of their nursing role as indicated by the following:

(P3) ... [Spirituality] wasn't integrated that well within my training. I think we probably had just enough on it, but I think we should all benefit from a further expansion on it to ensure that everybody in practice is actually aware of it and can do it.

This participant felt that spirituality was not integrated in the nurse education programme, but in spite of this she thought that the content was just adequate. However, she could see the practical benefits of more input for nurses in practice, which according to the next participant should contribute to better patient care:

(P7) ... I do think that it [spirituality] is still perhaps needed more in education, more exposure to it, I think that might be key to trying to get better patient care

A connection is made here between more spirituality education and better patient care.

On the whole, the participants were determined to use the knowledge, understanding and skills they had accrued (formally and informally) to facilitate the spiritual dimension within holistic nursing care. This emphasised the

suggestion that the impact of spirituality education in the pre-registration nursing programme is of significance, and can be transferred and sustained.

It is evident from this investigation that the provision of even a small amount of formal recognisable spirituality education (6 hours) within a three year nursing programme brought positive sustained outcomes to bolster nurses in the spiritual dimension of their role. However, these positive outcomes could potentially be multiplied if the content of formal spirituality education in nursing programmes were coordinated, increased, integrated and followed through in practice, as emphasised by Callister et al (2004 p.16):

“It is critical that spirituality be addressed in nursing education and practice”.

This culminating synthesis is a necessary way forward for the spiritual dimension in nursing (Baldacchino, 2015), and the designers of nurse programmes should consider this important factor.

Delivering spiritual care

Phase 1: Delivering spiritual care could range from the nurse's presence with a patient to arranging for someone from the patient's religious/faith community to visit. Spiritual assessment was mainly based on, informal conversations with the patient, observation of non-verbal cues, or at the patient's personal request, which participants admitted was very rare. The wide spectrum of possibilities for meeting the spiritual needs of individual patients created uncertainty at times for participants. There was also some hesitancy because of their student status, as well as a lack of clarity in dealing with some religious aspects of spiritual care for

example prayer, for fear of getting into trouble, as in the case of Caroline Petrie (Alderson, 2009).

However, there was the realisation that the nurse could facilitate spiritual care on a number of levels FSC, religious spiritual care, and general spiritual care (art, music, the environment). Participants readily accepted that they did not have to be religious to appreciate and facilitate the spiritual needs of patients. Spiritual care was seen as an integral part of everyday nursing and contributed to the fulfilment of holistic nursing. There was one query about the importance of spiritual care in acute clinical areas where the throughput was fast such as in day surgery. However, with theoretical sampling, various levels of spiritual care was realised, including FSC which applies to all patients all of the time whatever clinical area they are in. Nevertheless, participants would say that they would try their best to deliver spiritual care in the way they understood. Accordingly, FSC is contained within aspects of nursing care, which address the fundamental needs of humans, for example as listed by the Welsh Assembly Government (2003 p.6):

- Communication and information
- Respecting people
- Ensuring safety
- Promoting independence
- Relationships
- Rest and sleep
- Ensuring comfort, alleviating pain

- Personal hygiene, appearance and foot care
- Eating and drinking
- Oral health and hygiene
- Toilet needs
- Preventing pressure sores

The above aspects of fundamental care apply to all patients receiving nursing attention, and they also form the basis for a number of the nursing models for example, the activities of daily living (Roper et al., 2000); a model of self-care (Orem, 2001). The features of FSC as confirmed by the participants in this study are integral to the above activities of daily living or the model of self-care for example:

(P13) ... we are meeting the spiritual need without realising that we are doing it.

FSC is seen to blend into other aspects of care, in contrast to a visit from the hospital chaplain or a person from the patients' faith community.

Phase 2: Six to eight months post-registration, participants were just as motivated to deliver spiritual care to the patients they were responsible for, demonstrating sustained spiritual awareness. They were also keen to promote awareness for spiritual care among their colleagues by speaking about and documenting the spiritual needs of patients as relevant. Participants admitted to being more confident as registered nurses, and could now initiate certain religious or other spiritual care requests as appropriate so 'Continuing with Enablement for Efficacy' (to be explained shortly). However, the responsibilities and pressures of time in the work area to complete all the tasks they were

responsible for such as, physical care and paperwork were an ongoing concern. Nevertheless, they were mindful of ways to incorporate spiritual care even with the busyness of their workload, for example:

(P4) It's a matter of when you are with your patient, giving medications, doing a dressing – it's just talking to them rather than doing something in silence. Obviously I know sometimes you have to concentrate but it's just when you are doing a dressing, talk to them, chat to them and they chat to you, you try to reassure them ... when you are doing your writing do it with them, talk to them about it - it's just basically involving them, ...

For this participant even within a packed duty of care schedule, she thought of ways to incorporate spiritual care.

The next section will be an elaboration of the combined core categories to form the overall substantive theory as referred to earlier, to explicate the workings of the component parts, in order to demonstrate how the participants will potentially realise optimum spiritual care for patients.

Overall substantive theory

The purpose of this section is to bring together the emergent core categories from Phase 1 (Enablement) and Phase 2 (Efficacy) in this investigation to form the overall substantive theory labelled: 'Continuing with Enablement for Efficacy'. This theory explains the on-going ambition of the participants to support patients' spirituality and spiritual care within the scope of their competence in professional nursing practice.

Theory: ‘Continuing with Enablement for Efficacy’

Throughout this investigation while being mindful of theoretical sensitivity, I have engaged in the cyclical process of grounded theory through, data collection and analysis, theoretical sampling, and constant comparison to identify the participants’ main concerns. The overall substantive theory developed from both phases of this study resulted in the final construction of, ‘Continuing with Enablement for Efficacy’, so clearly arriving at a theory suited to its intended use (Glaser and Strauss, 1967). This theory of ‘Continuing with Enablement for Efficacy’ fulfils the criteria of ‘fit’ as it relates to the data in this investigation, and ‘work’ because it is relevant in explaining the actions of the participants (Glaser and Strauss, 1967), in their efforts to achieve the best possible spiritual care outcomes for their patients. Furthermore, this theory is meaningful and uncomplicated, making it understandable to both those in the nursing profession and the public. Accordingly, I will now discuss all the components contained in Figure 8.2 Model as they relate to ‘Continuing with Enablement for Efficacy’.

Overview of model for ‘Continuing with Enablement for Efficacy’

Enablement occupies a significant position which partners with Efficacy for providing optimum spiritual care, as seen in the model depicted in Figure 8.2. Enablement is of prime significance because it comes about as a result of various forms of spirituality education, both formal and informal, that the participants have acquired in order to be reasonably equipped to address the spiritual needs of patients. Efficacy then introduces a confidence to sustain the

motivation for meaningful engagement in the facilitation for spiritual care. The model encompasses a number of features: spiritual assessment and awareness, everyday nursing care; non- religious spiritual care; religious spiritual care; all these will now be discussed.

Figure 8.2 Model of 'Continuing with Enablement for Efficacy'

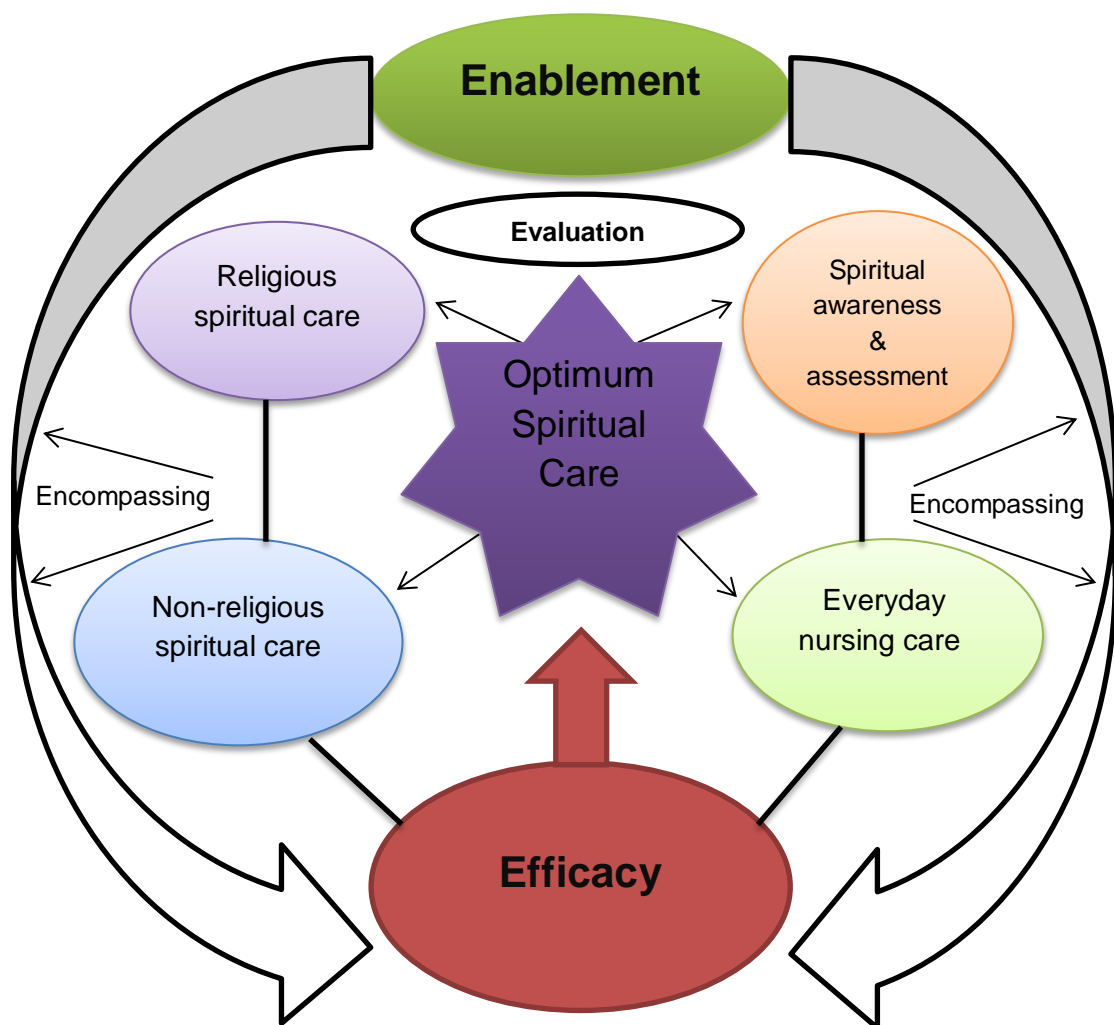


Figure 8.2 The model begins from the top with 'Enablement' (make possible) and this empowers participants for the process of facilitating patients' spiritual needs. As seen, the two concave arrows from 'Enablement' encompass various components concerned with spiritual care: spiritual awareness and assessment,

everyday nursing care, non-religious spiritual care, and religious spiritual care. Below and between the two converging arrows is 'Efficacy' (strong belief in personal capabilities to achieve a desired outcome) which engages as relevant, with various encompassing components. From here there is a moving forward to achieve the central aim of optimum spiritual care for patients. The small arrows radiating from optimum spiritual care indicates the link to the various components related to delivering spiritual care.

Spiritual awareness and assessment component

Spirituality is universal in the sense that every human being experiences it in some way. However, it encompasses many factors and permeates life extensively, so that each experience is individual (Miner-Williams, 2006), and therefore spiritual assessment is also individual and person-centred (Haugland and Giske, 2016).

As previously explained, one needs to be spiritually aware to then go on to spiritually assess patients. This is a logical progression that cannot be circumvented (Graham, 2008, Frouzandeh et al., 2015). Spiritual awareness portrays sensitivity to the importance of spirituality and the spiritual needs of patients. And it was the case that spiritual assessment was carried out most often in an informal way, as the participants generally had no tool within the care plans for this purpose in the various settings they were working in. However, those who previously had the opportunity of hospice or palliative care experience saw how the spiritual was a priority feature (Caldeira et al., 2016), in planning care for these patients. Such experience had a strong impact on the participants in terms of how a variety of spiritual needs could be met, and these skills were

transferable to other clinical settings. Participants were more sensitive to various cues in verbal and non-verbal communication (Miner-Williams, 2006, Haugland and Giske, 2016), that could indicate some form of spiritual need to be facilitated. What was heartening was that they were continuing to use these resources available to them for the purpose of spiritual assessment, and spiritual care.

Everyday nursing care component

This aspect was dealt with previously on page 256, so what needs to be said here is that, participants continue to be aware that spiritual care is an established part of the everyday nursing care, in other words it is integral to all the care they give to patients. Furthermore, there is room to improve, and in the words of (P13) in relation to the type of care she gave to patients:

(P13) ... I haven't changed, but I'm still getting better.

Therefore, there is a 'Continuing with Enablement for Efficacy'. As previously explained, Enablement brings an optimistic enlightenment to visible and not so visible spiritual care in nursing practice, and cultivates open and receptive learning in order to bring improvements to the patient's wellbeing. Whereas Efficacy is a strong personal belief in one's capabilities to achieve what one desires, and in this case it is good spiritual care for patients.

Non-religious spiritual care component

Non-religious spiritual care features are numerous to say the least, and would be virtually impossible to catalogue, as many facets reflect the ways that suit differing individuals (White, 2006, NHS Scotland, 2007). This could only be

describe here as a universe of possible experiences that any human may appreciate as being personally significant (RCN, 2011b). Hence the main duty of the nurse is to recognise and appreciate this diversity among patients as a result of their culture, upbringing, life experience, personal interests and preferences. An acknowledgement of an individual's non-religious spiritual needs in the health care environment is relevant and applicable, showing respect for that patient's point of view which provides them with potential avenues through which they may express or explore their spirituality. However, these non-religious spiritual features may apply to other patients who also have religious care need. But the religious spiritual care may take priority over the non-religious ones in times of illness (DH, 2009b). But as the participants 'Continue with Enablement for Efficacy' they are not restricted in their view of the wide range of non-religious possibilities patients may maintain as their spiritual need (Ross et al., 2016). Fulfilling some of these needs may be challenging, but efforts would be made to facilitate where possible and appropriate.

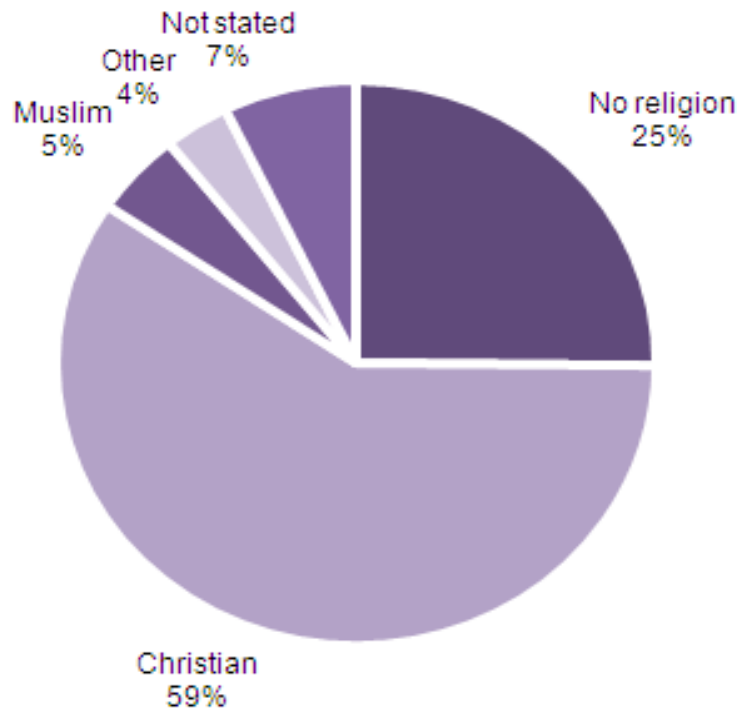
Religious spiritual care component

Religious spiritual care is easier to grasp (Sartori, 2010a), in comparison to non-religious care, as it is more specific for classification, although there are many forms of religion worldwide. Examples of the more well-known world religions in the UK are Christianity, Judaism, Islam, Hinduism, Sikhism, and Buddhism. The United Kingdom in this 21st Century is multicultural, meaning it is made up of several cultures or ethnic groups, and along with this comes a number of different religions that people may follow (DH, 2009b).

Religious affiliation in England, Wales and Scotland

In Figure 8.3 the Venn diagram shows the statistics of the religious groups for England and Wales from the 2011 UK census, followed by the information for Scotland.

Figure 8.3 Religious affiliation in England & Wales



Source: Census 2011- Office of National Statistics (Religious census)

Figure 8.3 displays information from the latest UK census (2011). It shows that Christianity is the largest religious group (59%) followed by those who are of no religion (25%). Muslims (5%) made up the largest of the minority religions. All other religions accounted for a further 4% in the population, and a further 7% did not state a religion (UK Government, 2013). Similarly, the census figures for Scotland were previously shown (p.40). Thus, taking into consideration these census information, it would be unreasonable to expect nurses to have a firm understanding of the many religions represented in the UK. Nevertheless, as

they encounter various religious differences in their everyday care they can respect such variety, find out more, and accommodate them in terms for example, dietary requirements, privacy for prayer or meditation, visits by specific religious leaders, and O'Brien (2008 p.139) is in agreement with this view and proffers:

“The nurse must attempt to respect and understand a patient's religious beliefs and practices, even if very different from his or her own ... The nurse must be spiritually supportive, assisting the patient whenever it is within the realm of his or her understanding and expertise, and recognise the need to seek outside spiritual or ministerial counselling ...”

So the nurse may or may not hold to a religion, but by 'Continuing with Enablement for Efficacy', participants would still endeavour to facilitate the patient's spiritual agenda within holistic care. Thus 'Continuing with Enablement for Efficacy' does offer a plausible way forward to support and promote the spiritual needs of all patients.

Operation of the model 'Continuing with Enablement for Efficacy'

The different components seen in the encompassing model 'Continuing with Enablement for Efficacy' (Figure 8.2), are connected and make a combined contribution to the participants' achievement of optimum spiritual care for their patients. Although spiritual care at a fundamental level often takes place within the everyday nursing care of the participants, there is still a need for spiritual assessment (often informal) within the overall on-going assessments made for each patient. This activity acknowledges the holistic and integral nature of

spiritual care in nursing practice. The assessment may probably identify specific religious and non-religious needs that the patient would like addressed, and the participants would endeavour to facilitate these particular requirements. The main driver for this facilitation towards optimum spiritual care of patients is, their 'Continuing with Enablement for Efficacy'. Essentially, the underpinning value of spirituality education in the pre-registration nursing programme, apart from instilling formal knowledge, also brought to the surface innate spiritual resources, and formed links with life experiences in this area. Therefore, spirituality education puts spiritual care in perspective within holistic nursing and brought some clarity to areas of uncertainty. Thus 'Continuing with Enablement for Efficacy' explains how the participants' resolve their main concerns by providing an impetus for them to move forward in attending to the spiritual needs of patients.

Summary

Having identified the main concerns in this investigation relating to perceptions of spirituality, spirituality education, and delivering spiritual care, the core concept of 'Enablement' was constructed from the findings of Phase 1 (chapter 6), and 'Efficacy' from Phase 2 (chapter 7). These were then combined to form the overall substantive theory: 'Continuing with Enablement for Efficacy' and was presented (model in Figure 8.2), together with explanatory details. An overview was then given of this theory, highlighting and reinforcing the possibility of the model's applicability for participants' to attain optimum spiritual care for patients as newly qualified Registered Nurses. What is uniquely demonstrated here is the participants' ability to carry forward and use the knowledge, understanding and

skills acquired during their pre-registration training to their qualified nurse status, which is a powerful example of what can be achieved in relation to even a small amount of formal spirituality education.

CHAPTER NINE: DISCUSSION

Discussion

Introduction

The previous chapters have traversed the journey in this longitudinal grounded theory investigation, concerned with, the 'Impact of nurses' spirituality education on clinical practice'. During this discussion I will cover seven aspects that arose from the findings as being important to the participants' knowledge and understanding of spirituality and spiritual care in this investigation: 1) Perceptions of spirituality in nursing - forms a context for the subject matter; 2) Perceptions of spiritual need in nursing – understanding that patients have spiritual needs; 3) Spirituality education and its purpose – appreciating the value of spirituality education; 4) Formal spirituality education – focus on pre-registration spirituality education and its benefits; 5) Spirituality education and the theory-practice link – complementing and consolidating academic learning in the clinical areas; 6) Informal spirituality education – the value of spirituality education from other sources; 7) Spirituality education and spiritual awareness and assessment – being aware of patients' spiritual needs and preparing to facilitate the same. Finally, the main purpose of this investigation will be discussed, which ultimately is to support spiritual care in nursing practice.

Perceptions of spirituality in nursing

Perceptions of spirituality underpinned this investigation as it was important for the participants to acknowledge their personal understanding of the subject matter (Cusveller, 1998, Tiew and Creedy, 2012, Ross et al., 2014) .This

understanding is useful in order to appreciate and relate to the patients' spirituality and spiritual need. And Carroll (2001 p.94) suggested that:

“Just as spirituality infiltrates all aspects of a person's Being, spiritual care infiltrates all aspects of nursing care”.

So the understanding is that spirituality is an inevitable part of individuals (Wright, 1998, Willard, 1998, Wright and Neuberger, 2012, Koenig, 2013), and spiritual care is embedded in nursing care (Sawatzky and Pesut, 2005, Clarke, 2013, Linda et al., 2015). Moreover, Van Leeuwen and Cusveller (1998) refer to a dual understanding within healthcare as, everyday religious expressions of spirituality (worshipping or reading of scriptures), and spirituality of illness or crisis (a response to disease, giving birth or imminent dying). Therefore, it could be conjectured that spirituality can operate at different levels (Sartori, 2010b). And in the context of this investigation the participants were aware of the former, but encountered the latter, albeit within a wider frame to include non-religious aspects, which Swinton (2007 p.9) refers to as:

“migration of spirituality from the religious to the secular ... opening up traditional understandings of spirituality to include dimensions which are epistemologically variegated and which no longer locate themselves within formal religious practices, traditions or systems. Spirituality is viewed as a general human need that can be met without any reference to the transcendent and with no necessity for involvement in formal religious structures”.

This view of spirituality as a general need within healthcare accommodates everyone, and Clarke (2013) adds that, spirituality in health care must be acceptable to people with a wide variety of beliefs and attitudes. The participants in this investigation acknowledged these views and endeavoured to accommodate the same in their nursing care practices. However, it is possible

that the participants' involvement in this investigation served to further broaden their understanding of spirituality and spiritual care, contributing to their perceptions of good effective care in this dimension.

Research has found that nurses' spiritual perspectives can provide a foundation to develop and support spirituality education in the nursing programme (Cavendish et al., 2004, Baldacchino, 2015), and the participants in my investigation used a number of descriptors for their perceptions of the complex concept of spirituality, which often resembled commonalities seen in the literature (Swinton and Pattison, 2010). Examples of these are: belief in and relationship with God (Stoll, 1989); a higher power or God (Tanyi, 2002); inner peace and inner strength (Narayanasamy, 1999b, Lundman et al., 2011); transcendence (O'Brien, 2008, Swatzky and Pesut, 2005, Clarke, 2013); the core of a person (Cunningham and Egan, 1996, Rogers and Wattis, 2015). Their perceptions of spirituality are set to inform their understanding of spiritual need, which is a necessary prerequisite for supporting spirituality in patient care.

Perceptions of spiritual need in nursing

Needs denote something that is necessary, and in relation to spiritual need it is a requirement of the self (Young and Koopsen, 2005). Indeed, the participants' perception was that all patients had spiritual needs, and apart from compassion, dignity and respect, it was up to the nurse to establish these if the patient or significant other did not directly express it. So apart from directly asking the patient, picking up on spiritual cues for example, body language, and religious artefacts, participants would talk of innate resource as being significant, a point

highlighted by Clark (2013), which contributes to their awareness and response to spiritual needs. Such instinctive opinions and responses to spirituality as a result of innateness, sit within the art component of nursing (Baldacchino, 2009). And (Peplau, 1987) adds that the art of nursing has the ability to inform and nourish nursing science and vice versa. Furthermore, Peplau (1987) says that useful nursing services are achieved when both the art and the science of nursing are retained, so at best, what is emphasised here is that professional nursing care should embrace both artistic and scientific dimensions (Tayray, 2009). Consequently, the nursing profession can lay claim to both artistic and scientific foundations which are based on research, theory, and concepts that centre on the art of caring. Bearing these foundations in mind, it is inevitable that the diverse set of practices and functions that make up nursing require specialised knowledge and skills, which include those for the area of spirituality (Tayray, 2009). Spirituality therefore occupies an established place within the art of nursing, and all the care needs of patients.

The participants perceived spiritual care needs to be about, caring and nurturing, religious and other beliefs. Therefore, perceptions of spiritual need, is also an indication of spiritual awareness. It has been said however, that considering a person as 'needy' is not favourable to a positive nurse-patient relationship because people are more than their needs (Clarke, 2013). However, this opinion of 'needy' could be overlooked when viewed with a wider lens, and in the light of research findings such as those of Narayanasamy and Owens (2001)(Haugland and Giske, 2016), in that a caring relationship when meeting the needs of patients can be transcending, fulfilling and spiritually rewarding for patients.

However, although the participants did begin to see spiritual needs within everyday nursing activities, this was not on a consistent basis in their student nurse experience, similarly identified by Sartori (2010a). Therefore, it would be useful for pre-registration spirituality education to give more guidance to students in relation to patients' spiritual needs as established within everyday nursing activities (Linda et al., 2015).

Spirituality education and its purpose

Pre-registration spirituality education and its impact in clinical practice was the prime focus of inquiry for this grounded theory investigation. The position is that nurses are expected to attend to all care needs of patients, which includes spirituality within the context of holistic care (NMC, 2010a, Cooper et al., 2013, Prentis et al., 2014, Ross et al., 2016). Furthermore, spiritual care as a nursing responsibility is integral to providing holistic care and is exemplified within Watson's theory of human caring (Watson, 1988). She believes that holistic health care is central to the practice of caring in nursing which should facilitate patients to achieve harmony between the body, mind and soul. Therefore, as spiritual care is a requirement for nurses (Van Leeuwen and Cusveller, 2004, Wright and Neuberger, 2012, Caldeira et al., 2016), then it follows that they need to be adequately prepared for this role which can be learned (Piles, 1990, Taylor et al., 2008, McCabe et al., 2013), and so justifies adequate spirituality education in the pre-registration nurse programme.

Nonetheless, spirituality education within the pre-registration programme although present to a small extent (Ross, 2006, Linda et al., 2015), is

sometimes contained within other topics (Grosvenor, 2000), which student nurses may not readily identify (Linda et al., 2015). This could present difficulties for students who may miss its inclusion if not prompted to recognise its presence. Consequently there is likely to be a 'disconnect' in the understanding of spirituality as a concept within all aspects of healthcare.

Formal spirituality education

In this investigation as mentioned earlier, students in the first year on the pre-registration nursing programme receive a distinct three hour session on spirituality and spiritual care. However, what emerged from this data was that in their final year a number of participants could not remember that they had this input, let alone the content of the session, a comment made by Ross (2006), also Linda et al (2015). The explanation given by some participants was that a lot of time had elapsed since having that initial spirituality input. However, although spirituality was integrated in other sessions over the following two years, most participants were only certain of its input in their third year. It would seem that spirituality although integrated in the nurse programme, was not clearly identified and joined-up throughout the three years. Therefore, students were unable to make the spirituality links with other subjects. This situation bares similarities to the findings in a study by Callister et al (2004) where only 15% of the participants reported significant learning about spiritual care during their nursing education. This response adds strength to the conclusions drawn from a study by Cone and Giske (2013 p.1958) that:

“It is important for spiritual care education to be explicit and continuous throughout nursing programmes to prepare students to recognise and act on spiritual cues”.

Moreover, following her research Seymour was convinced of the value of highlighting spirituality in curricular, to assist students to explore and learn about spirituality, spiritual needs, and spiritual care in the classroom (Seymour, 2009).

Despite the present shortcoming of pre-registration spirituality education in nurse programmes, there is agreement that spirituality should be addressed in nurse education and practice (Simsen, 1988, Ross, 1996, Maddox, 2001, Callister et al., 2004, McSherry et al., 2008, Attard et al., 2014, Frouzandeh et al., 2015, Caldeira et al., 2016). Furthermore, Stern and James (2006 p.898) stated that:

“a consequence of the requirement to deliver spiritual care ... is an apparent need for spirituality to be placed in policy context and to be properly defined”.

This action would at least legitimise the consistent inclusion of spirituality in nurse curricula, but may not necessarily have any influence on the nature of its content within individual programmes. And it is recognised that facilitation of effective teaching and learning of spirituality is challenging (McSherry, 2006a, Bennett and Thompson, 2015), but perhaps efforts to narrow the theory and practice gap would assist learning in this area. And the findings in this investigation revealed that mainly in hospice and palliative care areas was the theory and practice link for spirituality exemplified, and the participants’ understanding and skills for spiritual care were markedly increased, and valued. This is a complement to a statement by Ellershaw and Ward (2003) that the holistic care practiced in hospice, supports and directs philosophy and practice, and is widely regarded as a model of excellence. However, in the larger scale of

clinical experience such learning opportunities are few, so only a small number of nursing students would be offered this learning opportunity. Therefore, efforts should be made to replicate such examples of excellence as mentioned above in other areas.

Spirituality education and the theory-practice link

The consideration for the theory-practice link as highlighted earlier by Callister et al (2004), is a point not often addressed in relation to spirituality and spiritual care, although in the UK 50% of nurse education and training occurs in the practice areas (NMC, 2010a). This would suggest that spirituality is being inadequately addressed in nurse education not only in the classroom but also in clinical practice. Moreover, Cone and Giske (2013) view the support of students in clinical studies (placement areas) as fundamental for learning spiritual care; to which Lovanio and Wallace (2007), Van Leeuwen et al (2009a), Bennett and Thompson (2015) add credence in the sense that, clinical learning areas are significant as they afford students the opportunity to implement spiritual care. Yet from this investigation, it seems clear that justice is not being done to spirituality and spiritual care from an educational perspective within the clinical areas, and it follows that attention to this deficit would contribute significantly to the attainment of competence in this domain for nurses.

On the other hand, Kenny and Ashley (2005) reported that a significant number (45%) of children's nursing students stated that a lack of spirituality education in their nursing programme and clinical setting motivated them to increase their knowledge in this area independently, which bear similarities to some of the

findings in this present investigation. Participants talked of furthering their knowledge of spirituality in patient care as post-graduates. Independent study is admirable, and it could be one way of increasing formal spirituality education, by providing guided study in nurse programmes to standardise some of the main aspects of spirituality and spiritual care. And this is one idea for being more innovative in ways to delivering spirituality education.

What also transpired from this investigation was that participants were eager to embrace holistic care, but recognised the inclusion of the spiritual dimension was more difficult to grasp, which is somewhat akin with one idea that spirituality could be regarded as a 'slippery concept' (Swinton, 2001). And Greenstreet (1999 p.653) adds that:

"The concept of spirituality is so broad that without a familiar framework through which to view this nebulous aspect of care, many nurses would be unable to grasp its significance and complexity. The nursing process provides such a framework".

Although nurses are familiar with these frameworks, on the whole they do not adequately cater for spiritual care. However, Bennet and Thompson (2015 p.26) believe that:

"As part of a successful pedagogy, a course of action and theory-based approach must be translated into preparing student nurses to incorporate spiritual care into their emerging practices".

Such advances in teaching spirituality to nurses would be beneficial in narrowing the theory-practice gap in relation to this concept. Furthermore, spirituality education with planned theoretical and clinical components, have had a positive impact for nursing students, in providing a rounded learning experience,

(Baldacchino, 2008b, Vlasblom et al., 2011, Frouzandeh et al., 2015). Such examples provide useful ideas for nurse educators to consider and maybe adapt in their various programmes. However, spirituality education apart from formal programmes is also of importance.

Informal spirituality education

Learning is multi-dimensional in terms of how, when, and where it takes place, including formal courses as well as extending into all areas of life (Howatson-Jones, 2013). Furthermore, Alheit and Dausien (2007) believe that learning should take place 'lifewide' and cover what is experienced in the classroom and many other areas of life for example, cultural aspects, and learning within the family (Field, 2000), where background and tradition play a part. Participants not only engaged in the formal learning of spirituality in the classroom, but also drew on their life experiences to add to their knowledge and skills in this area, an opinion supported by Sartori (2010b). This investigation revealed that spirituality education acquired informally formed a significant contribution to that gained formally in the classroom. Participants used their relevant past experience to complement a fuller knowledge and understanding of the concept, as espoused by Sartori (2010b). Such beliefs are also shared by Seymour (2009) who suggests that other sources of knowledge and truth such as, personal beliefs, values and experiences are important. Accordingly, reflection which examines what has been learned is needed for all these different strands to come together, so that meaningful connections can be made (Howatson-Jones, 2013). Thus the participants, as a result of the interviews in this investigation showed

engagement with reflection, which according to Nardi and Rooda (2011) is a most prominent strategy, and demonstrates spiritual awareness.

Spirituality education and spiritual awareness, and spiritual assessment

One of the benefits of spirituality education in the pre-registration programme was that participants reported an increase in their spiritual self-awareness and awareness for patients' spiritual care, as seen in other studies, for example (Pesut, 2002, Baldacchino, 2008a). Participants were aware of their own faith/belief position within the context of spirituality and did not see these personal views as negatively affecting their ability to facilitate patients' spiritual needs, which agrees with other research (Chan, 2010, Nardi and Rooda, 2011, Ross et al., 2016). They were sensitive for the most part to the spiritual needs of patients, but sometimes on reflection, they realised that they had provided spiritual care unawares, similar to the findings of Van Leeuwen et al (2009a). But a further advantage of spiritual awareness is that it affords preparation for spiritual assessment, and spiritual care (Tiew and Drury, 2012). Furthermore, in order to assist learning, spiritual assessments and interventions could be made more obvious in clinical practice (Bennett and Thompson, 2015).

The participants were familiar with formal assessment procedures, but in relation to spirituality it may only amount to asking about a patient's faith tradition for example, whether Church of England, Roman Catholic, Protestant. Although these questions may be asked routinely on admission to in-patient care, they are insufficient for assessing more individual and complex spiritual concerns (Carson and Koenig, 2004). Moreover, Ruder (2013 p.363) states that:

“Nurse educators need to develop nursing curricula that address strategies for increasing students’ awareness of spiritual care”

This would indeed be an enhancement for students to grasp this concept.

However, in the reality of this investigation, the participants’ spiritual assessment of their patients was for the most part informal, being sensitive to body language and verbal cues. But Bennett and Thompson (2015) recommends formal preparation through education to recognise and act on spiritual cues.

Goal: Supporting spiritual care in nursing practice

This longitudinal investigation showed that the participants were aware that they may not possess a full knowledge of spirituality and spiritual care at present, but they were still keen to engage in the spiritual care of their patients. At times they were unsure of the scope this entailed, which is in agreement with the conclusions of Sartori (2010b). They sometimes overlooked what Clarke (2013) describes as, spiritual care in the natural part of everyday practice. Additionally Byrne (2002 p.73) elaborates in this way:

“it could be said that nurses are involved with spiritual care without necessarily being conscious of having the language to articulate the nature of the experience”.

Furthermore, Clarke (2013 p.4) says of nurses:

“...in the ordinary tasks they perform all day long, like helping a patient to wash ... spirituality changes from being something strange, ambiguous and esoteric to something that is alive and sparkling with possibilities”.

This attentiveness towards spirituality in everyday nursing, when identified by the participants, was evidenced in this investigation.

The impact of a conglomeration of pre-registration spirituality education was useful to inform and deliver spiritual care in the clinical setting, and from the findings in Phase 2 this appeared to be sustained. In fact as newly qualified Registered Nurses, participants were more motivated to make sure that the spiritual dimension was well represented within the holistic care they gave to their patients.

Delivering spiritual care is individual to every patient and there are no set procedures for this activity. Furthermore, Sartori (2010a p.17) posits:

“it is clear that spiritual and religious beliefs are individual and vary greatly between people”.

However, the participants were now aware of and more open to non-religious aspects of spiritual care, for example patients’ appreciation of art, music, the natural world, connection with significant others. On the other hand, when it came to religious aspects of spiritual care, apart from the patient’s request, arranging for the chaplain or other spiritual leader, the participants were more cautious, in case they overstepped professional boundaries. So as a result of reflecting on incidents within the NHS, for example the Christian nurse Caroline Petrie (Alderson, 2009), who offered to pray for a patient, and as a result management temporarily suspended her from work. Furthermore, nurses were confused and disgruntled when the management at a Hospital in West Yorkshire at the requests from Muslim patients and families, told nurses to move Muslim patients’ beds five times a day so that they face Mecca when praying (Cleland, 2007). Notably both incidents made national headlines in the UK, and are examples that highlight the tensions that could arise as a result of facilitating

some religious spiritual aspects in the NHS. Such incidents tend to be remembered for a long time, but should prevent other nurses or managers from dealing with religious spiritual matters in a similar way.

Nevertheless, in this investigation the participants endeavoured to respond to the patient's spiritual agenda as assessed within the holistic care for that individual. Furthermore, the need for spiritual care was viewed as relevant for all patients in all clinical areas, whatever the illness condition. And there was an awareness that spiritual care could operate at different levels for example, FSC, religious spiritual care, and non-religious spiritual care. So in fact different levels of spiritual care can be catered for juxtapose to other health needs priorities. However, one level of spiritual care that goes without question at all times is that of attention to FSC, which could be regarded as the foundation for all other spiritual care, and relate to personhood, that individual identity of every human being. Therefore, FSC is not optional, it is the remit of every nurse, and is integral to all aspects of nursing care. McSherry (2006b p.915) supports this opinion and states that:

“spiritual care permeates and integrates all aspects of care provision, just as spirituality integrates and unifies all dimensions of the individual”

Eventually what transpired from the participants in Phase 2 of this investigation is that they felt able to persist with their endeavours to deliver spiritual care, within the concept of holistic nursing, to the best of their competency. The impact of spirituality education acquired both formally (although regarded as insufficient) and informally (from a variety of sources) continued to motivate the participants to identify and address spiritual needs on an on-going basis as newly qualified

Registered Nurses. Thus the unique substantive theory of 'Continuing with Enablement for Efficacy' that was constructed in this investigation is grounded in the data. Moreover, it serves to explain the resolution of the participants' main concerns, so offering fulfilment for the spiritual dimension of their role.

Summary

The discussions in this chapter covered pertinent features from both Phase 1 and Phase 2 of this investigation: Perceptions of spirituality, spirituality education, and delivering spiritual care. During Phase 1 the participants were enabled to facilitate the spiritual needs of patients, even though in some clinical areas spiritual care frequently was in competition with physical care. Participants found that the pressure to prioritize the demands for physical care is a real challenge, even in times other than an emergency or high dependency/critical care. Furthermore, the participants are required to carefully and regularly document these activities, as well as report on them to other staff in the nursing team. But this is not the case for spiritual care in most clinical areas, with the notable exception of palliative and hospice facilities (Puchalski et al., 2006). However, the core categories of 'Enablement' from Phase 1, and 'Efficacy' from Phase 2, were brought together for the construction of the final and unique substantive theory, 'Continuing with Enablement for Efficacy', which ultimately offered strong explanation for all the categories constructed within the data. More importantly this theory explained how the participants resolved their main concerns, and represented their spiritual care ambitions in nursing practice. Furthermore, this longitudinal constructivist grounded theory investigation, by yielding this unique theory of 'Continuing with Enablement for Efficacy', clearly

demonstrates the transferable knowledge and skills, and sustained post-qualification motivation of the participants towards spirituality, and facilitating the spiritual needs of patients in their nursing practice.

CHAPTER TEN: IMPLICATIONS, RECOMMENDATIONS, LIMITATIONS AND CONCLUSION

Implications, Recommendations, Limitations and Conclusion

Introduction

This longitudinal qualitative grounded theory investigation delivers the first-hand experiences of participants' concerning their spirituality education and practice. I have faithfully presented the educational and research processes which have led to the findings of this investigation, interspersed with supporting evidence from participants' excerpts, and professional literature. The rigor adopted in this investigation addressed issues of trustworthiness and credibility, leading to the discovery of a substantive theory (Glaser and Strauss, 1967); 'Continuing with Enablement for Efficacy'. Accordingly, this chapter revisits the aim, objectives, and findings, before considering the implications, recommendations, limitations, and areas for further research.

Addressing the aim and objectives

Aim - Explore the impact of pre-registration nurses' spirituality education, and its transferability, and sustainability in the clinical setting.

So in order to do this the objectives were: 1) gather subjective information from final year pre-registration nurses/and when newly qualified about their perceptions, knowledge and understanding of spirituality and spiritual care, and 2) gain insight concerning participants' personal application of spirituality and spiritual care in clinical areas.

As a foundation for this investigation, relevant historical, international, national and professional literature concerning spirituality in healthcare, were sourced, analysed and discussed. Furthermore, a systematic literature review of pre-registration spirituality education with a focus on the adult branch of nursing was undertaken, to ascertain what had been researched and discovered in this area to date. As a result I identified a gap in the literature showing that, spirituality and spiritual care knowledge, understanding and skills gained in pre-registration nurse programmes had not yet been followed-through over time for transferability and sustainability in clinical practice. This information confirmed the need for my investigation, and I proceeded to strategise through the methodology and methods, the appropriate qualitative method necessary for gathering the data.

Grounded theory, the constructivist version (which values the interactions of the researcher) was chosen to obtain thick subjective data from the participants into their perceptions, knowledge, understanding and experiences of spirituality and spiritual care. I discovered that the participants were open to a wide understanding of spirituality and spiritual care that included religious and non-religious aspects. Furthermore, they reflected on, and shared their thoughts and feelings of how and when the spiritual dimension of patient care was taken into account in their clinical practice areas. So the first objective of this investigation was fulfilled by gathering and analysing this information.

Having accrued spirituality and spiritual care knowledge and understanding from their pre-registration nurse programme, as well as life experience, experiential learning and innate resources, the participants would facilitate the spiritual needs

of patients. However, at first they were not always aware that spiritual care at a fundamental level in the form of, compassion, dignity and respect, was taking place as they engaged in everyday nursing activities. This realisation helped them to better understand the integral nature of spiritual care, and that it is not an isolated feature of nursing. As a result of the data analysis for Phase 1, perceptions of spirituality and spiritual care, accruing spirituality education, and opportunities to provide spiritual care, I constructed the core category of 'Enablement' (make possible).

The crucial question in Phase 2 was whether the participants in their newly qualified Registered Nurse status, continued to use the knowledge, understanding, and skills as mentioned in Phase 1 in their nursing care. And what transpired in Phase 2 was that the participants were motivated to continue facilitating the spiritual needs of their patients in the various clinical settings in which they were employed. Again through data analysis the core category of 'Efficacy' was constructed for Phase 2. The on-going efforts of the participants to contribute to the wellbeing of their patients by facilitating spiritual care, gave rise to the substantive theory of 'Continuing with Enablement for Efficacy'. This subsequent information gave insight concerning participants' personal application of spirituality and spiritual care in their practice. Thus the second objective for this investigation was accomplished together with the substantive theory.

The findings of this investigation demonstrated participants' broad understanding of spirituality and spiritual care, also their value of academic and other sources of spirituality knowledge. Accordingly, they confidently and competently progressed in their understanding and 'actioning' of spiritual care in everyday nursing activities for patient wellbeing. But now the implications and recommendations of my investigation will be considered.

Implications

From the evidence grounded in the participants' data, it is clear that:

- 1) Spirituality and spiritual care is perceived as an important part of everyday nursing practice.
- 2) Participants would appreciate more academic spirituality in-put in their nursing programme so that they are better equipped to support the spiritual dimension of their role.
- 3) Participants would also like more overt integration of spirituality education in all clinical areas.
- 4) Participants were endeavouring to deliver spiritual care within holistic nursing practice.

The implications of the findings from this investigation affect: 1) nurse education in terms of curriculum content, planning, and appropriate lecturer resources for delivering spirituality and spiritual care education, and 2) clinical areas, as nurses are required to care for patients holistically, 3) nursing's professional body (NMC)

in terms of clearer consistent directives for the inclusion of spirituality in nursing education and practice, and 4) suggestions for further research in this area. My recommendations on all these issues are as follows:

Recommendations for Nurse Education

To move forward with spirituality education in pre-registration nurse programmes, it would be pertinent to establish such education from year one to three. The rationale being that spirituality is an integral part of all aspects of nursing care. Nurse teachers need to adopt a joined-up approach to spirituality in the classroom and the clinical placement areas, so that nurses are more likely to make the necessary connections, and that spirituality is appreciated and normalised in all patient care. There is also a need for nurse teachers to be familiar with the relevant and appropriate content, as well as various methods of teaching spirituality, which may probably necessitate opportunities for staff development (Seymour, 2006). Seminars and/or on-line courses may be contributory in this respect.

Recommendation for Nursing Practice

Spiritual care should be recognised as a legitimate part of nursing practice which contributes to the wellbeing of the patient, and this entails awareness by all members of the nursing team that, FSC is a part of everyday nursing care, and therefore the responsibility of all healthcare staff. Staff development in this area would assist in this process, perhaps by offering relevant study-days or short courses.

Recommendation for nursing's professional body

At present the spiritual domain of healthcare is understated and inconsistent in various NMC documents such as 'Standards for pre-registration nursing education' (NMC, 2010a), and 'The Code' (NMC, 2015). Therefore, it would be helpful for the NMC in the UK to clearly present spirituality in a consistent way in their directives. This would reduce confusion and ambiguity for nurses about the importance and place of spirituality in healthcare, and support them to confidently deliver holistic patient care.

Recommendations for further research

A larger investigation covering all three years of the nurse pre-registration programme is an area for further qualitative research. This would capture information about spirituality and spiritual care in the early and middle years of nurse training as well. What is also of importance is to follow the same participants as Registered nurses to gauge transferability and sustainability of spirituality and spiritual care in practice. In addition, all branches of nursing should be included as well as a heterogeneous research population.

Furthermore, research involving a more cosmopolitan area may provide additional information. The practical placement experience is a vital part of nurse education (NMC, 2010a) and is applicable to all learning fields within pre-registration programmes. Therefore, research concerning the link between the theory and practice of spirituality education among mentors and their students would be useful. In addition, the impact of my newly developed theory could be tested with other professional groups and patients. Such areas of research would complement this present investigation, and contribute positively to raising the

profile of spirituality in the nursing. But more importantly, it has the potential to increase attention to spiritual care, so benefiting patient wellbeing.

Limitations

This was a small study representing the views of a homogenous group of participants that were followed from their final year as pre-registration students through to post-registration. Furthermore, only the adult branch of nursing was chosen to participate in this investigation, so it is not known whether the views of other branches may have been different in some way. Additionally, those who participated may have had a more positive opinion of spirituality and spiritual care. Thus, these results may only be applicable to the adult branch of nursing. Other points to note is that the area of the UK where the study was conducted was semi-rural, which to some extent affected the diversity now represented in the nurse and patient population when compared to metropolises such as London, Manchester, Cardiff, or Glasgow. So it would be interesting to know if a more cosmopolitan area would yield similar results.

Conclusion

This investigation set out to answer the question about pre-registration nurse education and its impact on clinical practice. Using a grounded theory method (constructivist version) this longitudinal qualitative investigation unearthed the participants' knowledge, understanding, and practice of spirituality and spiritual care. The theory of 'Continuing with Enablement for Efficacy' explained the resolution of the participants' overall main concerns, and demonstrated the

unique aspect of this investigation that, even a small amount of spirituality education carried from pre-registration was transferred and sustained post-registration in their practice. Thus, future increase of spirituality education in terms of time and content would be welcomed by nurses and result in more positive outcomes for patients' wellbeing. Spirituality and spiritual care is challenging for nurses. But understanding that this dimension of care operates at different levels, and that FSC is being delivered within their everyday nursing practice, is reassuring for the holistic practice of nurses.

The strong conclusion from this investigation is that spirituality education is appreciated, effective, transferable, and sustainable. Therefore, spirituality and spiritual care need to occupy a consistent recognisable place throughout nursing programmes to reduce ambiguities, and better equip nurses for the spiritual dimension of their role.

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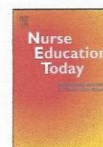
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Review

Spirituality in pre-registration nurse education and practice: A review of the literature

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SUMMARY

Spirituality is known to be an integral part of holistic care, yet research shows that it is not well valued or represented in nurse education and practice. However, the nursing profession continues to make efforts to redress the balance by issuing statements and guidance for the inclusion of spirituality by nurses in their practice. A systematic literature review was undertaken and confirms that nurses are aware of their lack of knowledge, understanding and skills in the area of spirituality and spiritual care, and desire to be better informed and skilled in this area. Consequently, in order for nurses to support the spiritual dimension of their role, nurse education has a vital part to play in raising spiritual awareness and facilitating competence and confidence in this domain. The literature review also reveals that studies involving pre-registration are few, but those available do provide examples of innovation and various teaching methods to deliver this topic in nursing curricular.

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Introduction

Spirituality as a concept is challenging, because the term is broad and ambiguous, covering religion and a variety of beliefs and values (Heriot, 1992; Golberg, 1998), hence, a plurality of definitions (van Leeuwen and Cusveller, 2004; NHS.Scotland, 2009). Spirituality is perceived as an integral part of every person (Willard, 1998; Meyer, 2003) which makes it subjective in nature. Moreover, Stoll (1989) describes spirituality as an interrelating two dimensional concept, the vertical concerns the relationship with the transcendent/God or supreme values that guide a person's life, and the horizontal refers to a person's relationship with self, others, and the environment. However, Swinton (2006), believes spirituality is still in the process of being enlarged, while Paley (2008a,b) says the concept is 'stretched'. Nevertheless, though spirituality may not sit comfortably within nurse education and practice due to a lack of direction for educators (Timmins and Neill, 2013), such education would clarify and enable a better understanding of the concept of spirituality within holistic care. However, there appears to be a contradiction because, despite the perceived lack of direction for nurse educators around the nature of spirituality and spiritual care, Ross et al. (2014) describe how there is a plethora of spiritual/religious

care guidance and policy that affirms that spirituality is an integral part of health care policy, practice and education.

Literature Search

A systematic review which employs a rigorous method of searching, critiquing and synthesizing the literature (Aveyard, 2010) was undertaken to gain insight into the position of the spiritual dimension within nurse education and practice. A narrative review was rejected as the search strategy is usually unfocused; also the method of appraisal or synthesis may be unclear. So using keywords: spirituality in nurse education, competence and holistic care, the data bases of BNI, CINAHL and MEDLINE were accessed. The inclusion criteria were, primary research using any method of investigation relating to spirituality in pre-registration nurse education; studies post-1992, when a seminal project believed to be the first of its kind in Britain, involving adult branch nurses was carried out by Linda Ross (nee Waugh) (Waugh, 1992); English language papers with abstract, and peer reviewed were accessed and retrieved. The exclusion criteria were, post-registration nurse education; editorials and discussion papers; books and book chapters; reviews and conference papers; and, non-English papers.

The search process included the time saving device of Truncation, denoted by an asterisk (*) or a dollar sign (\$) added to the root or stem of a word to find different endings. In addition, Boolean operators 'and' and 'or' were used to include specific terms. There was a duplication of a number of articles, which were subsequently removed.

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Table 1
Search history.

Keywords	BNI	CINAHL	MEDLINE
Spiritual* and education and student nurs*	Sourced 28 Selected 11 Discarded 17	Sourced 26 Selected 5 Discarded 21	Sourced 29 Selected 3 Discarded 26
Spiritual* and education and student nurs* research	Sourced 18 Duplicates 11 Discarded 7	Sourced 1 Discarded 1	Sourced 17 Discarded 17
Spiritual* and education and undergraduate or baccalaureate nurse	Sourced 12 Selected 6 Duplicates 2 Discarded 4	Sourced 142 Duplicates 2 Discarded 140	Sourced 104 Discarded 104
Spiritual* and education and undergraduate or baccalaureate nurse research	Sourced 12 Duplicates 8 Discarded 4	Sourced 14 Duplicates 2 Discarded 12	Sourced 14 Duplicates 1 Discarded 13
Spiritual* and education and nurs* and holistic care	Sourced 28 Selected 1 Duplicates 7 Discarded 20	Sourced 22 Duplicates 3 Discarded 19	Sourced 32 Selected 1 Duplicates 2 Discarded 29
Spiritual* and education and nurs* and holistic care and research	Sourced 12 Selected 1 Duplicates 6 Discarded 5	Sourced 6 Duplicates 1 Discarded 5	Sourced 22 Duplicates 3 Discarded 19
Spiritual* and education and nurs* and competence	Sourced 6 Selected 1 Duplicates 3 Discarded 2	Sourced 10 Duplicates 1 Discarded 9	Sourced 35 Duplicates 2 Discarded 33
Spiritual* and education and nurs* competence and research	Sourced 4 Selected 1 Duplicates 3	Sourced 6 Discarded 6	Sourced 22 Discarded 22

Relevant titles were then selected for viewing the abstracts to confirm suitability (Table 1).

The literature search returned 28 studies (Fig. 1) that met the inclusion criteria. Following a trend, most studies (13) originated from North America, and only 4 studies were carried out in the UK. Other papers came from Europe, South Africa and the Far East (Fig. 2 and Table 2). A quality appraisal of the selected papers was carried out (NICE, 2012) and the analysis led to the development of four main themes: 1) spiritual awareness, 2) spiritual assessment, 3) competence for spiritual care, and 4) spirituality content in pre-registration education programmes (Table 3).

Spiritual Awareness

Spiritual awareness appears to be a necessary prerequisite to meeting the spiritual needs of patients. It indicates sensitivity (Lemmer, 2002; McEwen, 2005), e.g. towards a patient's religious background,

attention to spiritual/religious conversations, also recognising spiritual cues in diverse settings (Narayanasamy et al., 2004; Giske and Cone, 2012).

In Canada, Pesut (2002) used a mixed methods study in a Christian University to investigate perceptions (awareness) of first year ($n = 35$), and fourth year ($n = 18$) nursing students' own spirituality and spiritual care giving. The participants answered three questions and completed a spiritual well-being scale devised by Paloutzian and Ellison (1982), to measure the quality of their spiritual health. Students rated themselves highly for both individual spirituality and spiritual care-giving, similar to Hoover (2002), and were aware that spirituality did not necessarily equate to religion. Furthermore, their strong sense of personal spirituality correlates with comfort in providing spiritual care (Taylor et al., 1999), but specific education provided a broader spiritual view and increased spiritual awareness.

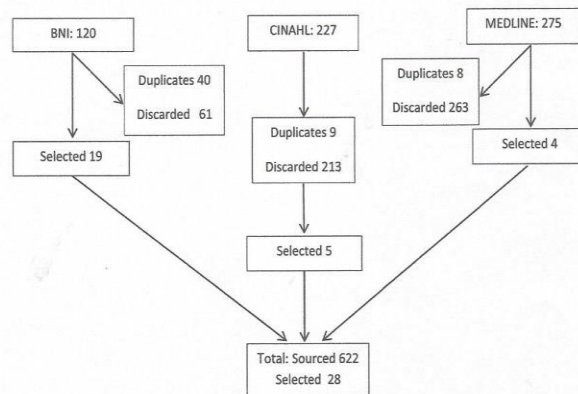


Fig. 1. Summary of selected studies.

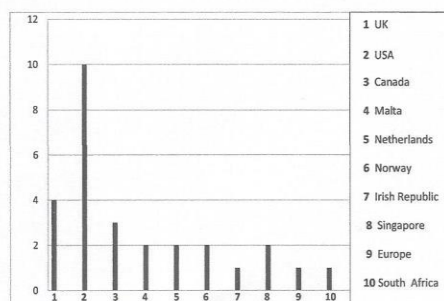


Fig. 2. Number of studies by location.

In order to increase senior nursing students' spiritual awareness, Baldacchino (2008a) provided a study unit on 'the spiritual dimension in nursing'. The 65 4th year participants were all Christians, and representative of the strong Roman Catholic affiliation accounting for (95%) of the Maltese population. Actioning Spirituality and Spiritual care Education and Training (ASSET) (Narayanasamy, 1999) was used for identifying the impact of the study unit. This model purports certain outcomes as a result of spirituality teaching: value clarification, sensitivity and tolerance, knowledgeable practitioner in the spiritual dimensions of nursing, competence in assessing spiritual needs, evaluating effectiveness of spiritual care, and positive nurse-patient spiritual integrity. The results demonstrated students' increased knowledge and awareness to definitions of spirituality and spiritual care. Students confirmed that facilitating patients' spiritual needs was central to holistic care.

The effectiveness of nurse educators to prepare students to provide spiritual care, was investigated by Meyer (2003), using 280 students from 12 mid-western nursing schools in the USA, 6 with a religious affiliation. Similar to Pesut (2002) there was no significant difference in relation to course content, but participants in religious institutions showed more religious commitment, and rated spirituality highly in their educational programmes. Suggestions are that there could be differences in the way that educational staff deliver courses and/or their spiritual conviction. Teaching staff that are comfortable with the language of religion, and spirituality are more effective in communicating its significance to their students (Catanzaro and McMullen, 2001; van Leeuwen et al., 2008).

Spiritual awareness and spiritual care in practice were the focus of a study in Singapore by Tiew and Drury (2012). Sixteen final year student nurses, from three educational institutions, were interviewed about definitions of spirituality and spiritual care, also spirituality education. The results showed: students' perceived that everyone has an innate spirituality, that spiritual awareness precedes spiritual assessment and spiritual care of patients. However, factors seen as influencing spiritual care were ambiguity surrounding spirituality and spiritual care, personal spiritual beliefs, and a paucity of pre-registration spirituality education. Furthermore, in support of the universality of spirituality, Tiew and Drury (2012) found that the Asian cultural perspective of these students was not a factor.

However, this was a small study and Tiew et al. (2013) went on to conduct a survey of 745 student nurses in Singapore to investigate perceptions of spirituality and spiritual care, using a spiritual care-giving scale (SCGS) (Tiew and Creed, 2012). They again found that building trust and spiritual awareness were pre-requisites for spiritual care, which concurs with McSherry et al. (2004). Participants also believed that spiritual care was vital for holistic nursing. However, Singaporean nurses are encouraged to be busy in clinical practice (Tiew et al., 2013,

p. 4), becoming more task-oriented, so spiritual care may be neglected. Consequently, the ward culture could either encourage or discourage spiritual care (Ross, 1997, p. 40).

du Plessis et al. (2013) in a qualitative phenomenological study in South Africa, engaged 18 final year psychiatric students in home visits within a faith community to gain experience in psychiatric community nursing. Both participants and families were of the Christian faith. It was recognised that during the practice experience, spiritual care occurred indirectly as part of their role in caring with respect, active listening and empathy, similar to suggestions by Clarke (2013, p. 98). Nevertheless, the researchers concluded that some spiritual needs might be overlooked.

Spiritual Assessment

According to McSherry (2010, p. 61) spiritual assessment is an enquiry about the health and well-being of an individual. And the NMC (2010) states that nurses must carry out comprehensive patient assessments including regard for spirituality (p. 18), and respond to these needs.

So a pertinent study by Hoffert et al. (2007), involving 38 1st year students looked into enhancing their ability and comfort level to perform spiritual assessment. The method involved, a seminar covering spirituality, religiosity, assessing and providing spiritual care, also a spiritual assessment tool developed by the researchers. The results indicated that the educational programme made a positive difference in students' knowledge, and comfort with performing spiritual assessment.

Conclusions drawn from Hoffert et al. (2007) are that spirituality is complex and perhaps intimidating, therefore, specific education and experience are required to build students' competence and confidence, a view supported by Greenstreet (1999) and Narayanasamy (1999). Furthermore, Baldacchino (2008a) suggests, a combination of knowledge and skills from a targeted course would embolden competence to deliver spiritual care. However, Meyer (2003) found that students' personal faith/belief contributed favourably to their ability to provide spiritual care.

Graham (2008) explored the preparedness of nursing students to assess patients' spiritual needs. This mixed methods study conducted in the USA, involved 24 participants from a Christian institution. The project employed O'Brien's (2008) spiritual assessment scale, a seminar covering religion and spirituality, assessing patient's spiritual needs and providing spiritual care, also an interview questionnaire. The results revealed that: Students' personal beliefs and affirmation from colleagues had a positive influence on their nursing care (Catanzaro and McMullen, 2001; Sawatzky and Pesut, 2005), and simple actions e.g. presence constitutes spiritual intervention (Jackson, 2004; Wallace et al., 2008). Furthermore, students recognised the importance of learning spiritual competence for spiritual care (van Leeuwen and Cusveller, 2004), and the necessity of assessing patients' spiritual needs (McSherry and Watson, 2002; Cavendish et al., 2004). However, participants felt that there was insufficient emphasis on spirituality in nursing education and clinical practice (Callister et al., 2004; McSherry and Jamieson, 2011).

Spiritual Competence

Nurses need to acquire relevant competences to practice as registered practitioners (e.g. Nursing and Board, 1997; DH, 1999; ICN, 2012; NMC, 2008, 2010). Moreover, van Leeuwen and Cusveller (2004) suggest that spiritual care is related to all facets of a nurse's competence, suggesting that it is not a stand-alone activity but an integral part of regular nursing care. Research relating to spiritual competencies in nursing and holistic care is sparse. However, Meyer (2003) suggests that the strongest predictor of perceived capacity to provide spiritual care results from a student's own personal spirituality, but targeted courses are believed to cultivate competence (Baldacchino, 2008a).

Table 2
Spirituality in nursing care papers.

Studies	Country of origin	Type	Sample size	Sample	Area of focus
Pesut (2002)	Canada	Mixed (survey & open questions)	53	Student nurses	Students' perceived well-being and spirituality, as well as their perceptions of spiritual nursing care and how these changed during 4 years of nurse education.
Lemmer (2002)	USA	Quantitative (survey)	250	Baccalaureate nursing programmes	How the spiritual dimension of nursing care is taught in baccalaureate nursing programmes.
Olson et al. (2003)	Canada	Qualitative (questionnaire)	18	Schools of nursing	The extent to which the spiritual dimension is addressed in Canadian undergraduate nursing curricula.
Meyer (2003)	USA	Quantitative (survey)	280	Student nurses	Impact of student's personal and environmental factors in nursing education on their perceived ability to provide spiritual care.
Kenny and Ashley (2005)	UK	Qualitative (questionnaire)	21	Children's nursing students	Children's nursing perspective on educational practice concerning spirituality in the nursing curriculum.
Seymour (2006)	UK (unpublished theses)	Qualitative (case study)	54	Student nurses	Evaluation of students' learning about spirituality in the classroom.
Mooney and Timmins (2007)	Republic of Ireland	Qualitative (focus groups)	100	Student nurses	Learning about spirituality through the medium of art.
Lovano and Wallace (2007)	USA	Quantitative (pre-test/post-test* SSCRS scale)	10	Undergraduate nursing students	Student nurse education course to enhance knowledge and understanding of spiritual care.
Hoffert et al. (2007)	USA	Quantitative (survey)	38	Baccalaureate nursing students	Enhancing the ability of nursing students to carry out spiritual assessment.
Baldacchino (2008a)	Malta	Qualitative (written assignment & self-reflection account)	65	Student nurses	Increasing students' awareness about the spiritual dimension in nursing care to enable them to implement holistic care.
Graham (2008)	USA (unpublished theses)	Mixed (*SAS Survey & interviews)	24	Senior nursing students	The preparedness of nursing students to assess their patients' spiritual needs after a 4 hour spirituality seminar.
McSherry et al. (2008)	UK	Quantitative (questionnaire)	135	Pre-registration nursing students	Ethical basis of teaching spirituality and the impact on students' perceptions and understanding of spirituality.
Purdie et al. (2008)	UK	Qualitative (focus groups)	6	Student nurses	Developing holistic caring skills particularly in relation to spiritual care.
Wallace et al. (2008)	USA	Mixed (*SSCRS pre-test/post-test & questions)	67	Undergraduate nurses	Evaluate students' spiritual knowledge and attitudes following integration of spirituality in the nursing curriculum.
Taylor et al. (2008)	USA	Quantitative (*DSE pre-test/post-test)	201	Baccalaureate nursing students	Efficacy of a self-study programme to teach nurses how to talk with patients about spirituality and identify learning factors.
van Leeuwen et al. (2008)	The Netherlands	Quantitative (quasi-experimental)	97	Student nurses	Evaluate the effectiveness of an educational course to develop competence in spiritual care.
van Leeuwen et al. (2009)	The Netherlands	Qualitative (peer-review groups)	39	Student nurses	Effects of peer-review discussion groups on developing competence in providing spiritual care.
Baldacchino (2010)	Malta	Qualitative (focus groups)	7	Undergraduate nursing students	Experiential learning for the delivery of spiritual care to clients in Lourdes.
Nardi and Rooda (2011)	USA	Mixed (survey & questionnaire)	86	Baccalaureate nursing studies	The nature of spirituality in senior baccalaureate nursing students.
Tiew and Drury (2012)	Singapore	Qualitative (interviews)	16	Student nurses	Student nurses' perceptions and attitudes relating to spirituality and spiritual care in practice.
Tiew et al. (2013)	Singapore	Quantitative (survey)	745	Student nurses	Exploration of final-year undergraduate students in Singapore in relation to their perspectives of spirituality and spiritual care-giving.
Cone and Giske (2013)	Norway	Qualitative (grounded theory)	19	Nurse teachers	Exploring teachers' understanding of spirituality and how they prepare undergraduate nursing students to recognise spiritual cues and learn to assess and provide spiritual care.
Giske and Cone (2012)	Norway	Qualitative (grounded theory)	42	Student nurses	To determine undergraduate nursing students' perspective on spiritual care and how they learn to assess and provide spiritual care to patients.
Barss (2012)	Canada	Qualitative (phenomenology)	4	Nurse teachers	Using the T.R.U.S.T. model to support caregivers in nurturing their own spirituality and offering patients opportunity to nurture theirs to promote well-being.
Burkhart and Schmidt (2012)	USA	Quantitative (survey)	59	Student nurses	To determine the effectiveness of a spiritual care educational and reflective programme on students' ability to provide spiritual care.
Costello et al. (2012)	USA	Quantitative (quasi-experimental)	52	Student nurses	A pilot study to determine if simulation is an effective method for instructing nursing students in the provision of spiritual care.
du Plessis et al. (2013)	South Africa	Qualitative (phenomenology)	18	Mental health nursing students	Students gained confidence implementing psychiatric nursing skills in home visits within a faith community, and spiritual care was provided indirectly.
Ross et al. (2014)	Europe	Quantitative (survey-pilot study)	618	Student nurses	A description of undergraduate nurses'/midwives' perceptions of spirituality/spiritual care, and their perceived competence in delivering spiritual care.

*SSCRS – Spirituality and Spiritual Care Rating Scale.

*SAS – Spirituality Assessment Scale.

*DSE – Daily Spiritual Experience Scale.

In the Netherlands van Leeuwen et al. (2008) using a quasi-experimental longitudinal study, investigated the effectiveness of nurse education to development of spiritual competence. Participants were 97 Christian student nurses from two Christian nursing schools; half were in the intervention group and the remainder in the control group. A questionnaire which included items from the Spiritual Competence Scale (van Leeuwen et al., 2007), was completed by participants before and after the research. No significant statistical difference in the students' self-assessed competencies was found at the beginning, but after six weeks the students in the control group differed positively in attitude towards patients' spirituality, spiritual care, and referral to professionals. However, at the conclusion of the study and four months later, the intervention group perceived themselves to be more competent, and this was attributed to the time that they had to internalise spiritual care needs. Nevertheless, perceived competence is questionable (van Leeuwen et al., 2008, p. 2778), as it could be an indication of increased self-confidence, therefore how best to measure spiritual competences needs to be addressed. The study further reinforces the suggestion that a nurse's own spirituality influences their awareness and competence to provide spiritual care, which concurs with Meyer's (2003) findings. Nevertheless, the clinical area is where theory is translated to practice, and competent skill levels are developed. Therefore, theoretical knowledge may become dormant without clinical follow-through.

van Leeuwen et al. (2009) also looked at developing student nurses' competence in providing spiritual care, using a qualitative analysis of reflective peer-review journals. The 39 senior students were from two Christian nursing schools in the Netherlands. Students' reflection showed increased spiritual awareness and development of confidence from involvement in clinical practice. However, they sometimes felt inadequate and afraid of saying the wrong thing when they were unable to answer patients' questions. Nevertheless, students felt content and encouraged to be engaged in spirituality conversations, but some thought that they had to suppress their own faith when supporting patients with different beliefs. This raises issues of conflict between personal convictions and professional practice, similar to findings by McSherry and Jamieson (2011).

An innovative two-week placement in Lourdes, with seriously ill and disabled people, was offered to six 3rd year adult branch students from a UK University (Purdie et al., 2008), to increase their holistic caring skills. The experiential learning relied on the role that experience has in the learning process, also focus groups gave students insight into the development of the nature of caring. Students emphasised that they had time to develop trusting meaningful relationships, which improved their listening skills, understanding of compassion and holistic care. Similarly, Baldacchino (2010) involved a group of 7 undergraduate students, on placement in Lourdes, and found that teamwork, holistic care, trustful nurse–patient relationships, and personal spirituality were developed. Although these two studies were very small, they suggest that students' competence to deliver spiritual care does not rest predominantly on classroom education.

To this end, Tiew et al. (2013) believe that individual reflection, spiritual guidance, experiential activities and in-depth discussion in the clinical setting, are more effective than mere class-based activities. Further support for experiential spiritual care learning comes from Catanzaro and McMullen (2001), who observed positive results, from teaching strategies in a community experience course. They concluded that, the home setting and affiliation with a religious congregation, promote an environment conducive to spiritual support.

Spirituality Content in Pre-registration Educational Programmes

The question of how best to introduce spiritual aspects into nurse education programmes remains mainly unanswered (Greenstreet, 1999), and Paley (2008b) argues that nurses should not be obliged to undertake spirituality education because it may increase their

discomfort about the topic. However, this view seems rather exclusive and narrow, as studies show that nurses are in favour of receiving spirituality education to equip them to meet the spiritual needs of patients in a better way (Baldacchino, 2008b; McSherry and Jamieson, 2011).

In the UK, McSherry et al. (2008) involved students across all branches of nursing, and looked into the ethical basis for teaching spirituality. During the 1st year of training, 135 students completed a questionnaire which incorporated questions relating to the ethics of teaching spirituality into the Spirituality and Spiritual Care Rating Scale (SSCRS; McSherry, 2000). The results showed that most students made links between spirituality and existentialism (meaning, purpose and fulfilment in life), and they felt that spirituality was relevant to everyone. However, students with more qualifications differed negatively in their opinion. Perhaps, the intangible nature of spirituality was overshadowed by the more tangible and scientific aspects of nursing. Additionally, participants felt that they had a right to their own views about spirituality, and that lecturers should not pass judgement.

Wallace et al. (2008) investigated the integration of spirituality education into the undergraduate curricula. The participants ($n = 67$) were involved in a spirituality course with classroom and clinical placement.

On the evidence of paired t-tests for pre and post-test scores using the SSCRS (McSherry, 2000), there was an increase in agreement that, spirituality is more than a belief and faith in God or a Supreme Being. This was attributed to the students' awareness of different ways of addressing spiritual issues, as indicated by Pesut (2002). There was less agreement that, arranging a visit from the hospital chaplain, or the patient's religious leader, constitutes provision of spiritual care.

Nonetheless, spending time with patients, giving support and reassurance, and enabling them to find meaning and purpose in their illness constituted spiritual care. In addition, listening to and allowing patients to discuss and explore their fears, anxieties and troubles, as well as respect for privacy, dignity and patients' religious/cultural beliefs, were considered to be spiritual care. These could be seen as fundamentals of nursing, and therefore integral in everyday nursing care (Clarke, 2013, p. 116). However, participants did not think that art, creativity and self-expression, had anything to do with spirituality, which runs contrary to research by Mooney and Timmins (2007). Furthermore, students thought that spirituality applied to atheists and agnostics.

In a qualitative exploratory descriptive design, Olson et al. (2003) looked into the extent to which the spiritual dimension is addressed by lecturers in 18 Canadian undergraduate nursing programmes. The 39 participant lecturers completed a questionnaire, in which 26 of them stated that the term, 'spiritual dimension', was not defined in their education programme. Nevertheless, lecturers found that spirituality could easily be integrated in their programmes, and were aware that such elements were already present, but undefined. The Olson et al. (2003) investigation was small, in terms of a national study for Canada, but revealed an awareness by some institutions that, spirituality needs to be included in their curricula.

Lemmer (2002) investigated 250 institutions offering baccalaureate nursing programmes in America, to explore how spirituality was being taught. Participants completed a 25 item Likert scale survey and a checklist, covering teaching on spiritual care. A subsequent Likert scale relating to attitudes that may influence teaching spirituality was supplemented with two open-ended questions.

The majority of programmes (81.5%) integrated spirituality throughout the curriculum, and some programmes (15.9%) delivered an elective spiritual care course. Most of the teaching was classroom based, and there was no significant difference in the amount of time assigned to the teaching of spirituality. In terms of attitudes, most lecturers believed that spirituality was a part of nursing care, and that it can be taught. The conclusion was that the teaching staff have an important part to play in nurses' understanding of their spiritual care role, which agrees with Catanzaro and McMullen (2001).

When considering the nature of spirituality in senior baccalaureate nursing students, Nardi and Rooda (2011) chose a mixed methods

Table 3
Four themes.

Theme	Study	Country of origin	Method	Sample size	Participants	Focus
Spiritual awareness	Pesut (2002)	Canada	Mixed	53	Student nurses	Students' perceived well-being and spirituality, as well as their perceptions of spiritual nursing care and how these changed during 4 years of nurse education.
Spiritual awareness	Baldacchino (2008a)	Malta	Qualitative	65	Student nurses	Increasing students' awareness about the spiritual dimension in nursing care, to enable them to implement holistic care.
Spiritual awareness	Tiew and Drury (2012)	Singapore	Qualitative	16	Student nurses	Perceptions relating to spirituality and spiritual care in practice.
Spiritual awareness	Tiew et al. (2013)	Singapore	Quantitative	745	Student nurses	A survey of final year nursing students to ascertain their perspectives of spirituality and spiritual care-giving.
Spiritual awareness	du Plessis et al. (2013)	South Africa	Qualitative	18	Student nurses	Students gained confidence in implementing psychiatric nursing skills in home visits within a faith community, and spiritual care was provided indirectly.
Spiritual assessment	Hoffert et al. (2007)	USA	Quantitative	38	Baccalaureate nursing students	Enhancing the ability of nursing students to carry out spiritual assessment.
Spiritual assessment	Graham (2008)	USA (unpublished thesis)	Mixed	24	Student nurses	The perception of student nurses, as to their preparedness to assess patients' spiritual needs.
Spiritual competence	Meyer (2003)	USA	Quantitative	280	Student nurses	Impact of student's personal and environmental factors in nursing education on their perceived ability to provide spiritual care.
Spiritual competence	Purdie et al. (2008)	UK	Qualitative	6	Student nurses	Developing holistic caring skills particularly in relation to spiritual care.
Spiritual competence	van Leeuwen et al. (2008)	The Netherlands	Quantitative	97	Student nurses	Evaluate the effectiveness of an educational course to develop competence in spiritual care.
Spiritual competence	van Leeuwen et al. (2009)	The Netherlands	Qualitative	39	Student nurses	Effects of peer-review discussion groups on developing competence in providing spiritual care.
Spiritual competence	Baldacchino (2010)	Malta	Qualitative	7	Undergraduate nursing students	Experiential learning for the delivery of spiritual care to clients in Lourdes.
Spiritual competence	Ross et al. (2014)	Europe	Quantitative	618	Student nurses	A description of undergraduate nurses'/midwives' perceptions of spirituality/spiritual care, and their perceived competence in delivering spiritual care.
Spirituality in pre-registration courses	McSherry et al. (2008)	UK	Quantitative	135	Pre-registration nursing students	Ethical basis of teaching spirituality and the impact on students' perceptions and understanding of spirituality.
Spirituality in pre-registration courses	Wallace et al. (2008)	USA	Mixed	67	Undergraduate nursing students	Evaluate students' spiritual knowledge and attitudes following integration of spirituality in the nursing curriculum.
Spirituality in pre-registration courses	Olson et al. (2003)	Canada	Qualitative	18	Schools of nursing	The extent to which the spiritual dimension is addressed in Canadian undergraduate nursing curricula.
Spirituality in pre-registration courses	Lemmer (2002)	USA	Quantitative	250	Baccalaureate nursing programmes	How the spiritual dimension of nursing care is taught in baccalaureate nursing programmes.
Spirituality in pre-registration courses	Nardi and Rooda (2011)	USA	Mixed	86	Baccalaureate nursing studies	The nature of spirituality in senior baccalaureate nursing students.
Spirituality in pre-registration courses	Taylor et al. (2008)	USA	Quantitative	201	Baccalaureate nursing students	Efficacy of a self-study programme to teach nurses how to talk with patients about spirituality and identify learning factors.
Spirituality in pre-registration courses	Mooney and Timmins (2007)	Republic of Ireland	Qualitative	100	Student nurses	Learning about spirituality through the medium of art.
Spirituality in pre-registration courses	Seymour (2006)	UK (unpublished theses)	Qualitative	54	Student nurses	Evaluation of students' learning about spirituality in the classroom.
Spirituality in pre-registration courses	Lovano and Wallace (2007)	USA	Quantitative	10	Undergraduate nursing students	Student nurse education course to enhance knowledge and understanding of spiritual care.
Spirituality in pre-registration courses	Barss (2012)	Canada	Qualitative	4	Nurse teachers	Using the T.R.U.S.T. Model to support caregivers in nurturing their own spirituality and offering patients opportunity to nurture theirs to promote well-being.
Spirituality in pre-registration courses	Cone and Giske (2013)	Norway	Qualitative	19	Nurse teachers	Exploring teachers' understanding of spirituality and how they prepare undergraduate nursing students to recognise spiritual cues and learn to assess and provide spiritual care.
Spirituality in pre-registration courses	Costello et al. (2012)	USA	Quantitative (quasi-experimental)	52	Student nurses	A pilot study to determine if simulation is an effective method for instructing nursing students in the provision of spiritual care.
Spirituality in pre-registration courses	Giske and Cone (2012)	Norway	Qualitative	42	Student nurses	To determine undergraduate nursing students' perspective on spiritual care and how they learn to assess and provide spiritual care to patients.
Spirituality in pre-registration courses	Burkhart and Schmidt (2012)	USA	Quantitative (survey)	59	Student nurses	To determine the effectiveness of a spiritual care educational and reflective programme on students' ability to provide spiritual care.
Spirituality in pre-registration courses	Kenny and Ashley (2005)	UK	Qualitative	21	Children's nursing students	Children's nursing perspective on educational practice concerning spirituality in the nursing curriculum.

study involving 86 senior nursing students from two American programmes. Most participants were Christian (79%). A spirituality scale questionnaire was used to determine the extent to which participants were aware of spirituality, also assessing patients' spiritual needs.

Most participants agreed that spiritual care was a basic part of nursing and that caring for the spirit is equally important as meeting other needs. Additionally, awareness of one's spirituality was an asset for supporting patients' spiritual needs, as indicated by Baldacchino (2008a). Overall, findings suggested that correct awareness of the spiritual needs of patients results in effective spirituality-based nursing care (Nardi and Rooda, 2011, p. 262).

Efficacy of a self-study programme to teach spiritual care was given attention to by Taylor et al. (2008). This was to enable nurses to talk with patients in a spiritually healing way, as well as investigate how such learning develops. Students used interactive workbooks to practice skills, test understanding or gain personal insight. It was found that students increased their attention to spiritual care, and were empathetic to patients' spiritual experience or spiritual pain, supporting the suggestion proposed by Bradshaw (1997) that spiritual care is more to be taught than taught.

Given that there is no concrete definition for spirituality, and the difficulties of teaching large groups of undergraduate student nurses, Mooney and Timmins (2007) in the Republic of Ireland devised a course to enhance students' engagement with the concept of spirituality. Students were given spiritual themes as prompts to select a piece of artwork in a gallery that they perceived as spiritual in nature. They then wrote the reason/s for their choice, and later discussed the same in a focus group.

The experience enabled students to: recognise spiritual dimensions of everyday life, see spirituality through others' impressions of art, develop a deeper awareness of the meaning of spirituality and realise that spirituality transcends traditional religions, and that spirituality enhances the nurses' role.

However, Seymour (2006) engaged 54 students in a qualitative case study, using a variety of classroom teaching methods to discover the value of nursing students' experiences of spiritual education. The course gave students the opportunity to discuss and explore the meaning of spirituality and spiritual care, and learn from the spiritual care experiences of their colleagues. This helped them to reflect on how they had met spiritual needs in the past. Students appreciated that the teaching increased their understanding of spirituality and spiritual care, but that providing this care could be challenging. Consequently, this course confirmed that spirituality and spiritual care can be learnt in a classroom.

In order to enhance the knowledge and understanding of spiritual care among student nurses, Lovanio and Wallace (2007) piloted a spirituality-focused project. The researchers selected 10 nursing students in their first clinical experience who had an interest in spirituality, and paired them with 10 residents in a faith-based care home. Pre-test/post-test evaluations using the SSCRS (McSherry, 2000) were completed. After the pre-test, students attended a 3-hour presentation about spirituality in nursing, and a weekly clinical conference, where they had the opportunity to discuss the definition of religion and spirituality, holistic nursing, and interventions that they implemented. The post-test revealed that the project broadened the students' concepts of spirituality, and reinforced the idea that spirituality can be taught.

In Canada, Barss (2012) studied the preparedness of nurse educators to enable nurses to provide evidence-based, non-intrusive spiritual care. The researcher developed a model consisting of: traditions, reconciliation, understandings, searching, and teachers (T.R.U.S.T.) (Barss, 2012, p. 2), to integrate spiritual care into holistic nursing practice. This phenomenology study involved 4 teachers. What transpired was that the participants felt that the T.R.U.S.T. model made it easier to build rapport with patients about spiritual matters. It also fostered confidence and consistency for student nurses to deliver spiritual care.

Employing grounded theory with 42 participants in Norway, Giske and Cone (2012) looked at how student nurses learn to assess and provide spiritual care. The participants' main concern was, 'how to create a professional relationship with patients and maintain rapport when spiritual concerns were recognised'. The students resolved this by, 'opening up to learning spiritual care' (Giske and Cone, 2012, p. 2006). This consisted of an interactive spiralling process of spiritual care involving: preparing for connection, connecting with and supporting, and reflecting on experiences. The researchers suggest that ongoing evaluation in relation to students' spiritual care in practice would encourage transformative learning (Giske and Cone, 2012, p. 2013).

A further study by Cone and Giske (2013) explored teachers' understanding of spirituality, and how to prepare undergraduate nursing students to recognise spiritual cues, and learn to provide spiritual care. This grounded theory project with 19 participants, found that 'Journeying with Students through Maturation' resolved their main concern. This involved raising awareness of the essence of spirituality, assisting students to overcome personal barriers, and mentoring students' spiritual care competency. The conclusion was that it is necessary to be explicit, with a continuous input throughout nursing programmes to prepare students to recognise and act on spiritual cues (Cone and Giske, 2013).

The paucity of literature on spirituality education in child branch nursing led Kenny and Ashley (2005) to conduct a qualitative study, using themes from spirituality in adult nursing. Twenty one child branch lecturers completed a questionnaire, and the answers were compared with conclusions from the adult literature. The similarities found were that spirituality and religion were interchangeable but that spirituality could be expressed through religion, individuals with a strong religious belief were more likely to engage in religious practices, spirituality was often recognised through emotional care, and spiritual care was often prioritised in death and dying circumstances. Emphasis was made that in children's nursing, the family were considered the 'main drivers' for recognising spiritual needs and realising spiritual care. Respondents felt that communication was the most important skill to have, while academically, seminars, lectures and directed reading were identified as desired learning for spirituality matters.

Discussion

From the literature review it is seen that only one study included all branches of nursing (McSherry et al., 2008), with the majority representing the Adult branch (the largest). However, this does not fully explain why the smaller branches of nursing internationally have not engaged more in the debate on spirituality in pre-registration education.

The numbers of qualitative and quantitative studies were fairly similar (13 and 12 respectively) with the rest (4) of mixed methods. However, most studies (18) engaged Christian students/Christian institutions which could introduce bias to the findings.

Nurses are required to carry out comprehensive assessments taking into account the patient's spirituality (WHO, 2002; NMC, 2010), but this activity may be challenging because of the ambiguous nature of spirituality (Narayanan, 2004; Pike, 2011).

The literature suggests that, spiritual awareness is necessary for spiritual assessment (Pesut, 2002; Baldacchino, 2008a; Tiew et al., 2013), and specific education on spirituality provides a broader view of diverse beliefs (Tiew and Drury, 2012; Wallace et al., 2008) and enabled students to grow in terms of sensitivity to their personal spiritual agendas (Baldacchino, 2008a).

Although Tiew et al. (2013) suggest that an understanding of spirituality and spiritual care did not necessarily influence practice, Hoffert et al. (2007) and Giske and Cone (2012) discovered that spirituality education enabled students to be more knowledgeable and comfortable performing spiritual assessments. In addition, Taylor et al. (1999) and

Graham (2008) found that students with a strong sense of personal spirituality felt comfortable and confident providing spiritual care.

Nevertheless for nurses to fulfil their role in delivering spiritual care, researchers such as van Leeuwen and Cusveller (2004) advocate competence in this area, and spirituality education appears to impact upon students' development of perceived competence for spiritual care (van Leeuwen et al., 2008), although some students felt a conflict between personal convictions and professional practice (van Leeuwen et al., 2009).

The need for spiritual care education is supported by the literature (Simsen, 1988; Ross, 1996; Maddox, 2001; McSherry et al., 2008; Baldacchino, 2011), nonetheless, it is challenging to raise awareness, develop competence and confidence for delivering spiritual care (Catanzaro and McMullen, 2001; McEwen, 2005). Research also shows that a variety of teaching methods should be considered for both classroom and clinical practice (Seymour, 2006; Mitchell and Hall, 2007; Mooney and Timmins, 2007; Taylor et al., 2008; Baldacchino, 2010), in order to enrich content and cater to different learning needs, for example, self-study spirituality programme (Taylor et al., 2008) and experiential spirituality education (Purdie et al., 2008; Baldacchino, 2010). However, experiential learning was limited to a small groups of students and had a religious bias, also there are cost implications of making this available to all students.

Although some institutions were aware that spirituality should be included in their curricula, this was not an established practice (Olson et al., 2003). Nevertheless, teaching staff have an important part to play in nurses' understanding of their role to deliver spiritual care (Lemmer, 2002; Cone and Giske, 2013), and nurses agree that spiritual care is a fundamental part of nursing and was as important as meeting other needs (Nardi and Rooda, 2011).

The review shows that students perceive that spirituality education enabled them to understand more about this concept and see that it goes beyond religion. Furthermore, they recognised that spirituality could be located in the everyday things of life, and now paid more attention to patients' understanding and expression of spiritual need. In addition, spirituality augmented their role as a nurse and they now reflect on the spiritual care that they gave. However, students realised that spiritual care could be challenging.

Conclusion

This systematic literature review affirms the spiritual dimension of nursing as an established concept, and nurses are aware of this aspect of their role. However, they require adequate education to fulfil this fundamental part of their role, in order to truly deliver holistic nursing care. Accordingly, more research is needed in the area of spirituality in nurse education, to raise awareness of spirituality and justify its consistent inclusion in programmes of nurse education. In addition, teaching content and strategies for the delivery of this topic need further exploration to offer other good ideas for nurse educators.

Even though education per se is important, the on-going preparedness of nurses to respond to spiritual care needs in practice is questionable, and needs to be investigated. This would give some insight into the theory–practice integration of spirituality, and demonstrate the long-term value and effectiveness of spirituality education. The benefits for nurses would be a contribution towards them achieving holistic care in everyday nursing practice.

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Initial Search History

Appendix 2

Keywords	BNI	CINAHL	MEDLINE
Spiritual* and education and student nurs*	Sourced 28 Selected 11 Discarded 17	Sourced 31 Selected 7 Discarded 21	Sourced 29 Selected 3 Discarded 26
Spiritual* and education and student nurs* research	Sourced 18 Duplicates 11 Discarded 7	Sourced 1 Discarded 1	Sourced 17 Discarded 17
Spiritual* and education and undergraduate or baccalaureate nurse	Sourced 12 Selected 6 Duplicates 2 Discarded 4	Sourced 142 Duplicates 3 Discarded 139	Sourced 104 Discarded 104
Spiritual* and education and undergraduate or baccalaureate nurse research	Sourced 12 Duplicates 8 Discarded 4	Sourced 14 Duplicates 2 Discarded 12	Sourced 14 Duplicates 1 Discarded 13
Spiritual* and education and nurs* and holistic care	Sourced 28 Selected 1 Duplicates 7 Discarded 20	Sourced 22 Duplicates 3 Discarded 19	Sourced 32 Selected 1 Duplicates 2 Discarded 29
Spiritual* and education and nurs* and holistic care and research	Sourced 12 Selected 1 Duplicates 6 Discarded 5	Sourced 6 Duplicates 1 Discarded 5	Sourced 22 Selected 1 Duplicates 3 Discarded 18
Spiritual* and education and nurs* and competence	Sourced 6 Selected 1 Duplicates 3 Discarded 2	Sourced 10 Duplicates 1 Discarded 9	Sourced 35 Duplicates 2 Discarded 33
Spiritual* and education and nurs* competence and research	Sourced 4 Selected 1 Duplicates 3	Sourced 6 Discarded 6	Sourced 22 Discarded 22

Appendix 3a

(Example) NICE Checklist for Qualitative Quality Appraisal

Study identification: author, title, ref. year of publication. <i>TITLE - Teaching on the spiritual dimension in care: the perceived impact on undergraduate nursing students</i>	Baldacchino, D. R. (2008)
Guidance topic: <i>Spirituality</i>	
Checklist completed by: <i>Lesline Lewinson</i>	
Theoretical approach: <i>Qualitative</i>	

1. Is a qualitative approach appropriate?	Appropriate ✓ Inappropriate Not sure	Comments: <i>Case study/seminar/reflective exercise seek to illuminate subjective experience.</i>
2. Is the study clear in what it seeks to do?	Clear ✓ Unclear Mixed	Comments: <i>The purpose of the study is discussed. Adequate reference to the literature.</i>
3. Study design How defensible/rigorous is the research design/methodology?	Defensible ✓ Indefensible Not sure	Comments: ASSET <i>Conceptual framework for identifying the impact of the study unit was appropriate to the research question.</i>
4. Data collection How well was the data collection carried out?	Appropriately ✓ Inappropriately Not sure/ Inadequately reported	Comments: Clearly described: <i>Observations, written work, seminar presentations. Examiners from nursing education and from clinical sector.</i>
5. Trustworthiness Is the role of the researcher clearly described?	Clearly described Unclear ✓ Not described	Comments: <i>? The researcher only actively involved in the classroom component of the research. Research explained and presented to the participants</i>

6. Is the context clearly described?	Clear ✓ Unclear Not sure	Comments: <i>Classroom studies, and caring for patients in the clinical areas.</i>
7. Were the methods reliable?	Reliable ✓ Unreliable Not sure	Comments: <i>The methods investigate what they claim, and the data were collected by more than one method.</i>
8. Analysis Is the data analysis sufficiently rigorous?	Rigorous ✓ Not rigorous Not sure/not reported	Comments: Explicit - <i>Case-study (40%) Academic write-up (60%) Voluntary reflection. Three themes.</i>
9. Is the data 'rich'?	Rich ✓ Poor Not sure/not reported	Comments: <i>A detailed and comprehensive understanding of participants' learning experience.</i>
10: Is the analysis reliable?	Reliable ✓ Unreliable Not sure/not reported	Comments: <i>Comprehensively reported. Examiners from nursing education and clinical sector.</i>
11. Are the findings convincing?	Convincing ✓ Not convincing Not sure	Comments: <i>Clear and coherent. Extracts from original data included. Appropriate referencing.</i>
12. Are the findings relevant to the aims of the study?	Relevant ✓ Irrelevant Partly relevant	Comments: <i>The findings presented were relevant to the aims of the study.</i>

13. Conclusions	Adequate ✓ Inadequate Not sure	Comments: <i>Clear and concise links between data, interpretation, and conclusions. Offers enhanced understanding of the research topic.</i>
14. Ethics How clear and coherent is the reporting of ethics?	Appropriate Inappropriate Not sure/not ✓ reported	Comments: <i>No details offered in the paper.</i>
Overall assessment		
As far as can be ascertained from the paper, how well was the study conducted?	++ ✓ + -	

(Example) NICE Checklist for Quantitative Quality Appraisal

Study identification: Tiew, L.H., Creedy, D.K., Chan, M.F. (2013)		
Study design: Cross-sectional survey		
Guidance topic: Student nurses' perspectives of spirituality and spiritual care		
Assessed by: Lesline P Lewinson		
Section 1: Population: Final-year student nurses		
1. Is the source population or source area well described? <ul style="list-style-type: none"> Was the country, setting, location, population demographics etc adequately described? 	++v	Comments:
	+	Three educational institutions in Singapore.
	–	
	NR	
	NA	
2. Is the eligible population or area representative of the source population or area? <ul style="list-style-type: none"> Was the recruitment of individuals, clusters or areas well defined (e.g. advertisement, birth register)? Was the eligible population representative of the source? Were important groups underrepresented? 	++v	Comments:
	+	Convenience sample of final-year nursing students.
	–	
	NR	
	NAv	
3. Do the selected participants or areas represent the eligible population or area? <ul style="list-style-type: none"> Was the method of selection of participants from the eligible population well described? What % of selected individuals or clusters agreed to participate? Were there any sources of bias? Were the inclusion or exclusion criteria explicit and appropriate? 	++v	Comments:
	+	Students on a diploma/degree programme.
	–	
	NRv	
	NA	
Section 2: Method of selection of exposure (or comparison) group		
4. Selection of exposure (and comparison) group. How was selection bias minimised? <ul style="list-style-type: none"> How was selection bias minimised? 	++v	Comments: Researcher addressed each student cohort.
	+	
	–	Response rate of 61.9% (n=745)
	NR	

	NA	
5. Was the selection of explanatory variables based on a sound theoretical basis? <ul style="list-style-type: none"> How sound was the theoretical basis for selecting the explanatory variables? 	++ ✓ + – NR NA	Comments: Study procedures were explained and questions taken.
6. Was the contamination acceptably low? <ul style="list-style-type: none"> Did any in the comparison group receive the exposure? If so, was it sufficient to cause important bias? 	++ + – NR ✓ NA ✓	Comments:
7. How well were likely confounding factors identified and controlled? <ul style="list-style-type: none"> Were there likely to be other confounding factors not considered or appropriately adjusted for? Was this sufficient to cause important bias? 	++ + ✓ – NR NA	Comments: Culturally relevant Spiritual Care-giving Scale (SCGS) developed by researchers.
8. Is the setting applicable to the UK? <ul style="list-style-type: none"> Did the setting differ significantly from the UK? 	++ + – ✓ NR NA ✓	Comments: Singapore – setting differs from the UK.
Section 3: Outcomes		
9. Were the outcome measures and procedures reliable? <ul style="list-style-type: none"> Were outcome measures subjective or objective (e.g. biochemically validated nicotine levels ++ vs self-reported smoking –)? How reliable were outcome measures (e.g. inter- or intra-rater reliability scores)? 	++ ✓ + – NR NA	Comments: Descriptive statistics; Pearson's product-moment correlation, t-test, and ANOVA, to test significant/association/difference on

<ul style="list-style-type: none"> Was there any indication that measures had been validated (e.g. validated against a gold standard measure or assessed for content validity)? 		the samples' average total SCGS.
10. Were the outcome measurements complete? <ul style="list-style-type: none"> Were all or most of the study participants who met the defined study outcome definitions likely to have been identified? 	++v + - NR NA	Comments:
11. Were all the important outcomes assessed? <ul style="list-style-type: none"> Were all the important benefits and harms assessed? Was it possible to determine the overall balance of benefits and harms of the intervention versus comparison? 	++v + - NR NA	Comments: <i>Students' perspectives of spirituality and spiritual care-giving.</i>
12. Was there a similar follow-up time in exposure and comparison groups? <ul style="list-style-type: none"> If groups are followed for different lengths of time, then more events are likely to occur in the group followed-up for longer distorting the comparison. Analyses can be adjusted to allow for differences in length of follow-up (e.g. using person-years). 	++ + - NR NAV	Comments:
13. Was follow-up time meaningful? <ul style="list-style-type: none"> Was follow-up long enough to assess long-term benefits and harms? Was it too long, e.g. participants lost to follow-up? 	++ + - NR NAV	Comments: <i>Cross-sectional survey</i>
Section 4: Analyses		
14. Was the study sufficiently powered to detect an intervention effect (if one exists)? <ul style="list-style-type: none"> A power of 0.8 (i.e. it is likely to see an effect of a given size if one exists, 80% of the time) is the conventionally accepted standard. Is a power calculation presented? If not, what is the 	++ + - NRv NAV	Comments:

expected effect size? Is the sample size adequate?		
15. Were multiple explanatory variables considered in the analyses? <ul style="list-style-type: none"> Were there sufficient explanatory variables considered in the analysis? 	++V + – NR NA	Comments: <i>Attributes for spiritual care, spirituality perspectives, defining spiritual care, spiritual care attitudes, and spiritual care values.</i>
16. Were the analytical methods appropriate? <ul style="list-style-type: none"> Were important differences in follow-up time and likely confounders adjusted for? 	++V + – NR NA	Comments:
17. Was the precision of association given or calculable? Is association meaningful? <ul style="list-style-type: none"> Were confidence intervals or p values for effect estimates given or possible to calculate? Were CIs wide or were they sufficiently precise to aid decision-making? If precision is lacking, is this because the study is under-powered? 	++V + – NR NA	Comments: <i>Mean values given for factors as in 4.2 above.</i>
Section 5: Summary		
18. Are the study results internally valid (i.e. unbiased)? <ul style="list-style-type: none"> How well did the study minimise sources of bias (i.e. adjusting for potential confounders)? Were there significant flaws in the study design? 	++V + –	Comments:
19. Are the findings generalisable to the source population (i.e. externally valid)? <ul style="list-style-type: none"> Are there sufficient details given about the study to determine if the findings are generalisable to the source population? Consider: participants, interventions and comparisons, outcomes, resource and policy implications. 	++V + –	Comments:



Faculty of Health/Faculty of Sciences

Student name:	Lesline Lewison
Title of Study:	Pre-registration nurses' spirituality education: The impact in clinical experience
Status of approval:	Approved

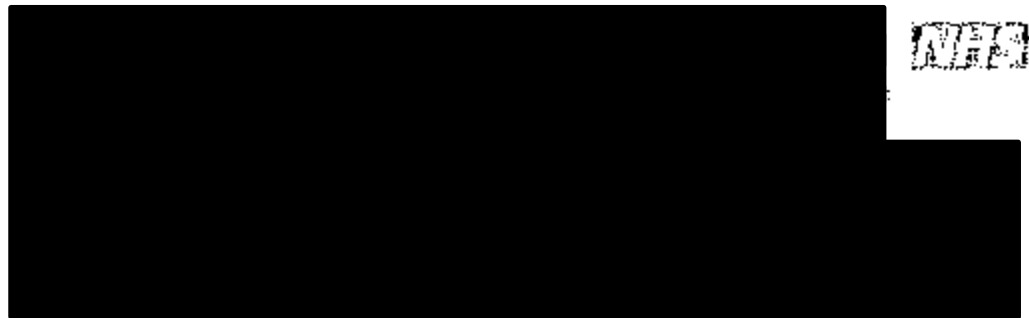
To whom it may concern,

The above project has been considered by the Staffordshire University Faculty of Health/Faculty of Sciences Ethics and IPR panel and has been approved.

A handwritten signature in black ink, appearing to read 'Vish Unnithan'.

Signed: Professor Vish Unnithan
Chair of the Faculty of Health/Faculty of Sciences
Ethics Panel

Date: 4th February 2013



Lesline Lewison
PhD Student
Faculty of Health
Staffordshire University

R&D Ref: Lewison001

26 March 2013

Dear Mrs Lesline Lewison,

Re: Pre registration nurses' spirituality education: The Impact in clinical experience

We have now received all the necessary paperwork for the above research, as listed on page 2. This letter gives this Trust's approval for your research.

Your research activity is now covered by NHS indemnity as set out in HSG(66)48. Your local reference number with us is **Lewison001** which should be quoted in any correspondence with this office.

Conditions of approval:

- Forward copies of any external or internal monitoring reports for the study to the R&D office.
- Send into the R&D office, monthly updates on patients recruited within the study, and formal notification of study completion or termination.
- Inform this office of any amendments to the study. Any changes to the study must first be notified to the R&D department, before being implemented at site.
- When your study has finished let me have a copy of any resulting publications for our records.

Trust web site: www.salford.nhs.uk

NON REG-LE-ER Version 1



Page 1 of 3

[REDACTED]

Subject: RE: Research

Dear Lesline

Thank you for supplying this information. As you have assured me that you have received ethical approval for your research and the methodology underpinning the research would not put additional stress on final year students. Therefore I am happy for you to approach 3rd year nursing student undertaking nurse education at Staffordshire University.

I would remind you that there are two intakes of students per academic year, one in September the other in March, so two cohorts of 3rd year student are accessible. In addition the course is delivered at two sites (RSH & BHL) so in effect you have access to 4 cohorts of 3rd year student nurses over the course of one academic year.

You may wish to consider if the level of study affect your findings as some will exit their award with level 6 qualification and others with level 5. You may wish to consider this when selecting your student population.

I would be grateful if you would inform me of planned completion date of your research and of any findings of the study.

Yours

[REDACTED]

Programme Area Manager - Pre Qualifying Health Professions

[REDACTED]

THE SPIRITUAL DIMENSION OF HOLISTIC NURSING CARE

A pre and post registration PhD project

Lesline P. Lewinson (Research student)

About me

- Background:
- Qualified nurse, Midwife, Health Visitor & Nurse Lecturer
- Post qualifying: A&E, CCU, ICU, Cardio Thoracic surgery, District nursing and Health Visiting.
- Nurse teacher: Hillingdon Health Authority, St Bartholomew's hospital, Northwick Pk and St Mary's, and recently at the University of Hertfordshire.
- Previous research: Department of Health - Broadwater Farm estate, Tottenham.

2

My Interest in the topic

- As a nurse I have professed to holistic nursing, but realise more attention tends to be given to the physical and psychological dimensions of health care.
- A few years ago during a seminar, a colleague commented on an assessment for a 'nurse return to practice course' in which the nurse briefly mentioned about attending to the spiritual needs of a patient. The reply my colleague gave was - 'perhaps this information would be more suited for a parish magazine'.
- I was surprised by this response and thought; what if the spiritual aspect of care was very important to the patient - and the nurse is not mindful to facilitate this need?
- As a result of the above response, researching the spiritual dimension of health became my passion!

3

RCN Spirituality Survey

- In 2010 the RCN commissioned Professor Wilfred McSherry of Staffordshire University to carry out a survey in order to ascertain members' perception of spiritual care.
- 4054 RCN members responded, and these are some of the conclusions:
- 95.5% of nurses identified patient/s with spiritual needs. However, only 92.2% felt they were able to meet their patients' spiritual needs.
- 89.9% confirmed that it was the patient who enable them to identify spiritual needs.
- 90% agreed that providing spiritual care can enhance the quality of nursing care.
- The findings of the survey also found that nurses with or without religious belief considered spirituality to be an integral part of their role. (RCN 2010)

4

Title - Pre-registration nurses spirituality education: the impact in clinical practice.

- **Aims of the investigation:**
- To investigate the extent to which spirituality in nurse education contributes to the practice of holistic nursing care.

5

Objectives of the project

- 1) To investigate the practical benefits of pre-registration final year students having spirituality education.
- 2) To follow-up the same participants after 6 – 8 months when qualified to ascertain theory-practice integration of spirituality education.
- 3) To discover the socialization processes that may affect sustained facilitation of spiritual needs.

6

Method of investigation

- A Qualitative study
- Interviews
- Modified Grounded Theory approach

• Data Collection:

1) Participants will initially consist of a convenience sample of final year pre-registration adult branch student nurses who have had some spirituality education as part of their course.

2) A follow-up of the same group of participants 6-8 months after qualification and working in the clinical setting.

[7]

Research

- **Part 1** - Collecting data from pre-registration nurses.
- **Part 2** - Collecting data from the same group of participants 6-8 after qualification and working as staff nurses.
- Comparisons between part 1 and part 2 will be made.

[8]

Expected outcomes

- 1) To ascertain the preparedness of pre and post qualified nurses to respond to patients' spiritual needs.
- 2) To identify ways in which practitioners could offer further support to nurses in the spiritual dimension of their role.
- 3) To discover additional information about spirituality education in pre-registration nursing courses.
- 4) To contribute to the literature relating to holistic nursing care.

[9]

Participants

- An invitation to participate in this research project
- **Details:**
 - Participant letter
 - Participant information sheet
 - Consent form
- The above details will be issued to you for your consideration and response over the next week.

• **THANK YOU FOR YOUR TIME!**

[10]

Dear student

My name is Lesline Lewinson, a PhD student in the Faculty of Health at Staffordshire University. I am informed that you have had some spirituality education in the pre-registration nursing programme, so I would like to recruit students who are willing to participate in my research study on spirituality in nursing practice.

Nursing practice aspires to holistic care which includes attention to body, mind and spirit, however, nurses are often occupied only with responding to patients' obvious physical and psychological needs.

Individual interviews will be arranged at your convenience to take place as final year students and 6-8 months post qualifying.

This research could provide useful information to help shape future spirituality education in nurse programmes. The research could also benefit patients as we find out how nurses may facilitate spiritual needs their practice setting.

Thank you for your time and consideration of this research study. Please read the participant information sheet; then sign the consent form if you are willing to participate.

Yours faithfully

Lesline Lewinson

PARTICIPANT INFORMATION SHEET

Title of Study

Pre- registration nurses' teaching in spirituality: The impact in clinical practice

Name of Researcher

Lesline P. Lewinson: PhD student – Faculty of Health at
Staffordshire University

I would like to invite you to participate in this research study to gather information relating to the possible impact on your clinical practice of having received spirituality education during your three year programme.

What is the purpose of the study?

Previous studies have shown that although nurses recognise that there is a spiritual dimension to their role, in practice, this aspect is mostly neglected and poorly understood. Therefore, having received input on spirituality in the nursing programme, it is useful to ascertain how this knowledge impacts upon your clinical practice within the context of providing holistic care.

What will I have to do?

You have been handed this information sheet to **help you decide** whether or not you wish to take part in this study which will take place during this your final year and 6-8 months after qualifying.

The individual interview sessions should last for about 1 hour, and you will be asked about meeting patients' spiritual needs in your clinical practice.

The researcher will seek your consent to record the interviews, and please be assured that ethical considerations and confidentiality will be maintained throughout. You do not have to take part in this study, but if you do agree to participate, you have the right to withdraw at any time.

What will happen to the research finding?

The findings of this study will form part of my PhD. Furthermore, the study may be shared at conferences and submitted for publication in relevant health care journals. Most of the data will be general and any quotes used will not reveal the identity of the participant. All data will be handled in accordance with the Data Protection Act 1998.

This work should be useful in informing nurse education and training programmes to meet in a better way the spiritual needs patients may have during their illness experience.

Exploring spiritual matters may be personal/sensitive so if additional support is needed please do not hesitate to contact Occupational Health, Counselling Service or Personal Supervisor.

A summary of the findings will be made available for you at your request.

Who has reviewed the study?

The study has been reviewed by the Faculty of Health Research Ethics Committee at Staffordshire University. They are an independent group of people.

What if there is a problem?

If you have any concerns about the study or need support after the interview, please speak with me. Alternatively, other contacts are my research supervisors [REDACTED]
[REDACTED] addition, the Dean of students and Occupational health.

Contact details: Lesline Lewinson (researcher) Mob: 07951 266 783
e-mail: leslinel@hotmail.co.uk

[REDACTED]

If you decide to take part, please complete your consent form and return it to me.

Appendix 10

CONSENT FORM: Version 4

03/06/2011

Centre Number:

Study Number:

Title of Project: Pre-registration nurses' teaching in spirituality: The impact in clinical practice

Name of researcher: Lesline P Lewinson

Please
initial box

1. I confirm that I have read and understand the information sheet dated 29/06/2011 (version 5) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason without my legal rights being affected.
3. I understand that the interview will be recorded and I consent to the recording and storage. I am aware that I can ask for the recording to be paused, stopped, or destroyed at any time.
4. I understand that relevant sections of my data collected during the study may be looked at by individuals from Staffordshire University from regulatory authorities where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.
5. I agree to take part in the above study.
6. I would like to receive a summary of the research findings.
7. I consent to excerpts of the interview transcript being published in your final thesis and publications

☐☐☐☐☐☐☐

Name of participant

Date

Signature

Name of person taking consent

Date

Signature

When completed, 1 copy for participant, and original for researcher file.

From: Lesline Lewinson [mailto:leslinel@hotmail.co.uk]

Sent: 06 January 2012 14:37

To: [REDACTED]

Subject: FW: Palliative care course

Sent again due to mistake in e-mail address.

From: leslinel@hotmail.co.uk

[REDACTED]

Subject: Palliative care course

Date: Fri, 6 Jan 2012 14:33:34 +0000

Dear Bob

My name is Lesline Lewinson and I am a PhD student in the Faculty of Health at Staffordshire University. My topic of resesarch concerns spirituality in nurse education, so as part of my background information I am interested to know the spiritual content in various nursing courses. To this end [REDACTED] informed me that you run the Principles and Practice of Palliative Care course, and basically I would be grateful if you would give me an overview of the course and indicate where spirituality is taught in the schedule of topics.

Many thanks

Lesline

The information in this email is confidential and is intended solely for the addressee. Access to this email by anyone else is unauthorised.

From: Lesline Lewinson [mailto:leslinel@hotmail.co.uk]
Sent: 20 February 2012 11:03
To: [REDACTED]
Subject: Information

Dear [REDACTED]

Thank you for the schedule of teaching previously sent to me with the topics identified where spirituality is included. I have visited the [REDACTED] campus and presented my proposed research to the 3rd year students in order to recruit volunteers to participate.

I will be visiting [REDACTED] again on the 7th March to do my 1st interview in the morning, and was wondering if you would be available for a brief chat regarding the content of your input in the above sessions.

Kind regards

Lesline

From: [REDACTED]
To: leslinel@hotmail.co.uk
Date: Mon, 20 Feb 2012 13:38:17 +0000
Subject: RE: Information

Hi Lesline,

Yes of course. I am around all morning and my office is at the back of the building. Seek me out and we can have a chat.

Regards

[REDACTED]

From: [REDACTED]
To: leslinel@hotmail.co.uk

Date: Wed, 11 Jan 2012 10:17:43 +0000

Subject: RE: Palliative care course

Hi Lesline,

I used to teach this subject a lot many years before [REDACTED] arrived and more recently [REDACTED] and it became funky. It was always the Cinderella subject that nobody knew how to approach, so I taught it on my palliative care modules and in the Pre Reg nursing programmes with some success. Unfortunately with a succession of revised curriculums and more seemingly 'important' priorities it got squeezed out the pre reg programme some time ago and in recent years I've not been able to teach it as a discreet subject either on my Principles and Practice module either for similar reasons.

I have published in this area and retain an interest, so my approach is to integrate spirituality and the issues inherent into discussion with other subjects. Notably, the sessions on grief and loss and end of life care priorities alongside communication skills and the nature of pain – as you can see from the timetable they feature quite heavily in the programme.

I hope that answers your questions and if you need any further information I'd be happy to help.

Regards

[REDACTED]

Researcher: Lesline P Lewinson

31/05/2011

INTERVIEW GUIDE

Study number:

Gender: ☐ Male ☐ Female

Age: ☐ 20 – 30 ☐ 31- 40 ☐ 41-50 ☐ 51 +

Ethnic origin:

Religious/non-religious belief:

Questions: The following will be used as prompts if required in initial interviews.

1. What do you understand spirituality to be?
2. What is spiritual distress about?
3. What is your opinion about all patients having a spiritual need?
4. In what ways do you think spirituality education in your nursing course prepared you to meet the spiritual needs of patients?
5. How could you recognise if a patient has a spiritual need?
6. What enables you to feel comfortable facilitating patients' spirituality?
7. In what ways have you met the spiritual needs of patients?
8. How do you cope with the variety of patient' spiritual values & beliefs?
9. What do you see as barriers to delivering spiritual care?
10. Which members of the multi-disciplinary team do you think should be involved in meeting patients' spiritual needs?
11. Why do you think spiritual care should/not be an important part of your nursing role?
12. Give examples of how your pre-registration spirituality education has had an impact on your clinical practice?

The Challenge of Spiritual Care in Practice for Student Nurses: A grounded theory study

Author: Lesline P. Lewinson RGN RM HV Dip HS MSc

Centre: Faculty of Health sciences

Staffordshire University



SPIRITUALITY IN PRACTICE

BACKGROUND

Historically spirituality has been a part of nursing practice, but nurses often find it difficult and sometimes uncomfortable to engage in meeting patients' spiritual needs (Ross, 2006), even though they acknowledge this as a part of their role (McSherry and Jamieson, 2011). Nevertheless, international, governmental and professional bodies continue to promote spirituality in health care e.g. (ICN, 2006, DH, 2009, NMC, 2010).

Therefore it follows that Pre-registration nurse education has a responsibility to prepare student nurses to be effective in all aspect of their role as qualified professionals. Furthermore, individualised holistic nursing care is highlighted within the nursing profession, but this cannot be fully achieved when the spiritual care of patients is not addressed, and as Burnard (1988b) asserts "to ignore the spiritual aspects of care is surely a gross omission (p 34).

The Nursing and Midwifery Code of conduct (NMC, 2008) states: "You are personally accountable for actions and omissions in your professional practice and must always be able to justify your decisions" (p2), which puts an onus on nurses to respond to the spiritual needs of their patients.

AIM

To capture the experience of Adult branch final year student nurses as they attempt to engage in spiritual care.

METHOD

10 final year adult branch nursing students were involved in this first phase of a qualitative longitudinal study. A modified grounded theory approach was adopted (Corbin and Strauss, 2008). This consisted of data collection individual interviews with the participants between March 2012 and January 2013 to collect data. The interviews were recorded and transcribed before being analysed using line-by-line open coding (Silverman 2010) for comparative analysis to reveal themes in order to generate theory.

RESULTS

The preliminary findings emerging from the first phase of this study revealed that: 1) participants had a broad concept of spirituality that encompassed religious and non-religious aspects.
2) They understood that spiritual care was a part of their role and not an option.
3) They were keen to engage in meeting patients' spiritual needs as appropriate when the opportunity arose. This occurred despite uncertainties and mixed opinions about their spirituality education.
4) Students found that spiritual care was prioritized in palliative and end of life care, but not so much in other clinical settings.
5) At times their life experience and personal religious/belief system were drawn on to enable them respond appropriately to a spiritual need situation.

Figure 1: Model showing aspects involved to effectively facilitate spiritual needs of patients



CONCLUSION

Student nurses were eager to practice holistic nursing care which includes the spiritual dimension, but were comfortable even though uncertain at times when giving such care. Furthermore, they desired to be competent and confident to address the spiritual needs of patients.

These preliminary findings will add support for the inclusion of spirituality within pre-registration nursing programmes; also highlight the need to integrate theory and practice.

Acknowledgements

Thanks to the students who volunteered for this study; my supervisors: [redacted] for their support and guidance; the help and assistance from clerical and other support staff at Staffordshire University.

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Contact:

leslinel@hotmail.co.uk

Appendix 14



Student Nurses Respond to Spiritual Care in Practice: A Grounded Theory Study

Lesline P Lewinson: May 2014

■ CREATE THE DIFFERENCE

2



AIM

To capture the experience of Adult branch student nurses as they attempt to engage in spiritual care



■ CREATE THE DIFFERENCE

3



■ CREATE THE DIFFERENCE




Pre-registration Spirituality Education

- The Nursing and Midwifery Council (NMC) emphasises holistic care (NMC, 2010b p11)
- The spiritual dimension is an integral part of holistic care
- Nurses need to be adequately prepared to meet patients' spiritual needs
- Nurses desire to be better equipped to meet patients' spiritual needs (McSherry and Jamieson, 2011)

■ CREATE THE DIFFERENCE

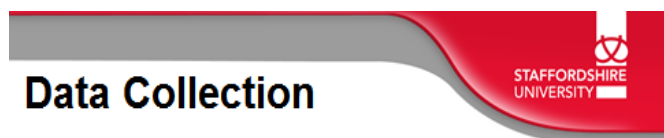
5



- **Participants:** A convenience sample
- 9 Adult branch **student nurses**
- 3rd year of training
- Recruitment: 

■ CREATE THE DIFFERENCE

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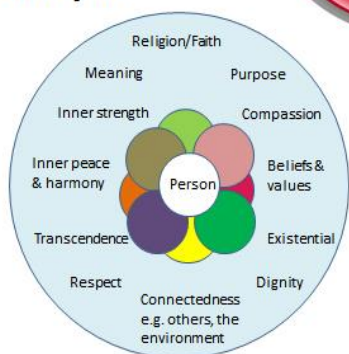


- Individual interviews (digitally recorded)
- Transcription of interview recordings
- Ongoing comparative analysis of data
- Theoretical sampling

■ CREATE THE DIFFERENCE

7

Spirituality is



■ CREATE THE DIFFERENCE

8

L Lewinson

Definitions

- A two dimensional concept: the vertical - a relationship with the transcendent/God or the supreme values that guide a person's life; the horizontal - a person's relationship with self, others, and the environment

(Stoll, 1989)

- The spiritual dimension seeks to worship something outside human control which sustains the person, especially in times of crisis - providing a source of strength

(Piles, 1990)

■ CREATE THE DIFFERENCE

9

Definitions

... the spiritual is a natural dimension of what it means to be human. The awareness of self, of relationship with others and with creation, the finitude of life, the search for meaning, for the transcendent, and the need to be acknowledged, accepted, valued and loved, are all parts of this dimension ... Many express these understandings and experiences through a belief system, by holding to a set of values, or through belonging with and participating in the life of a faith community.

(NHS, Scotland, 2009 Annex B p 5-6).

■ CREATE THE DIFFERENCE

10

Significance of spirituality to health care

- Spirituality is unique and subjective
- Spirituality can include religion
- Spirituality is universal and relevant to everyone
- Spirituality may be more prominent to a person during a crisis or illness

(McSherry, 2006)

■ CREATE THE DIFFERENCE

11

Students' understanding of spirituality:

- "the basis of someone's belief, it doesn't necessarily have to be religion ..." (p1)
- "I think it's something to do with the essence of somebody and what makes that person tick - whether it's religious or non-religious beliefs ..." (p7)
- "... I understand spirituality to be individual to a person ... I don't necessarily associate it with religious ... it's a whole variety of things" (p5)

■ CREATE THE DIFFERENCE

12

Continued

- "I think it's a range of all the experiences in your life ... spirituality is what makes a person individual ..." (p6)
- "... It's people's beliefs, whether they are religious or not, whether it's after-life type of thing. I'm vague on it, I haven't got a definite idea ..." (p2)
- "... I think it's hard to put your finger on anything really ... I think it's more about beliefs - anything that you believe ..." (p4)

■ CREATE THE DIFFERENCE

13



Holistic care

- "This holistic approach acknowledges the interplay of the mind, body and spirit where the whole is greater than the sum of the individual parts" (Ross, 2010)

Students' perception:

- "you cannot treat them holistically if you don't know that (spiritual) part of them ... it's very important ..." (p2)
- "Holistic means you think about ... all aspects of care ..." (p8)

Continued

- "... I think actually nursing staff do tend to forget the more holistic spiritual side of nursing care, they focus more on the physical ..." (p9)
- "They all go on about holistic care, but what does holistic care encompass really ... we focus a lot on interventions and how that directly affect the patient rather than the other side ... we keep promoting holistic care, but is it actually happening?" (p5)

Continued

- "... spirituality is one aspect of holistic care ... you try your best to provide holistic care but it's not always possible. I think as nurses that does annoy us at times because you want to provide the best possible care to every patient ..." (p6)
- "... we are supposed to be delivering holistic care ..." (p1)

Students' awareness of patients' spiritual need

- The literature clearly suggests that in order for nurses to respond to patients' spiritual needs, they must be spiritually aware (Catanzaro and McMullen, 2001, Lemmer, 2002, McEwen 2005)
- "... talking to a patient and finding out ... their body language might be a big factor ... looking outside the box rather than just on the inside box condition ..." (p5)

Continued

- "... every patient has a spiritual need – regardless of age or ethnic origin ... it's perhaps whether it's taken into account when they are in hospital ..." (p7)
- "... I think they do all have a spiritual need, but they may not recognise ... a spiritual need ... It's up to us nurses to help them decide what that is for them" (p8)



Continued

- "... I don't know how you'd recognise it ... You got to get to know ... the patient or they have got to start the conversation ... I don't quite know how you'd recognise it" (p2)
- "... the problem is you don't know as a person whether they would see it as a spiritual need ... I think it's quite hard to define the difference between a general and a spiritual need really ..." (p4)

■ CREATE THE DIFFERENCE

20

Students meeting spiritual needs

- "... always open to if anyone wants me to talk about ... spiritual needs ... trying to meet and help their needs but not go over the ... limitations and boundaries ..." (p1)
- "... I feel like in some respect I am meeting some spiritual needs of patients ..." (p5)



"being able to give them time and talk to them ..." (p3)

■ CREATE THE DIFFERENCE

21

Continued

- "I don't know that I have ... it's something I'm very weary of..." (p2)



- "... you know sometimes if you try and help people with spiritual needs you get sort of trouble for it in case you put your religion unto them - which is the problem" (p6)

■ CREATE THE DIFFERENCE

22

Continued

- "I think just touching her hands and holding her hand when I went in and spoke to her helped her ..." (p7)



- "... to me holding someone's hand as they die to me is as spiritual as it can get really ..." (p4)

■ CREATE THE DIFFERENCE

23

Continued

- "Palliative care ... taking them for a walk outside ... see the gardens, things like that really I know really help them ..." (p3)
- "... Just respecting peoples' beliefs ... making sure that they do have something in place to meet their particular values and beliefs" (p9)
- "... I think I've aimed to try my best " (p5)

■ CREATE THE DIFFERENCE

24

What are the students' main concerns?

- Preliminary findings:



1. Uncertainty about the content, recognition and receptiveness of the spiritual care they offer to patients.
2. Concerns about the low priority given to spiritual care in most practice areas.

■ CREATE THE DIFFERENCE

25

Continued

- *"... we don't do a huge amount on spirituality at university - we have the odd session here and there, but I think it's quite hard when you do have sessions to really clarify what spirituality is, so I think it's kind of up to you to make your mind up yourself..." (p4)*
- *"... there wasn't much in my training spiritual wise ... being in practice and working it out yourself a bit ... after experience and working with patients you seem to pick up quite a lot (p3)*

■ CREATE THE DIFFERENCE

26

How do students resolve their concerns?

- Preliminary indications:
- Mainly drawing on own knowledge and beliefs about spirituality and their life experience, as well as nurse education
- Delivering spiritual care to the best of their knowledge and ability, for individual patients within various clinical placements

■ CREATE THE DIFFERENCE

27

Final comment

- *"I don't believe it's (spirituality) dealt with, appreciated in the way it should be. A complete shake-up, it needs to be taken completely seriously ... I still see it as being important for the individual ... whether they are aware or not ..." (p2)*



■ CREATE THE DIFFERENCE

28

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■ CREATE THE DIFFERENCE

29



Spiritual care in the practice of student nurses: A Grounded Theory Study


Lesline P Lewinson: May 2014

■ CREATE THE DIFFERENCE

1

AIM

To ascertain how student nurses facilitate spiritual care in their practice, and the part played by nurse education



■ CREATE THE DIFFERENCE

2





■ CREATE THE DIFFERENCE

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1st Phase

- **Participants:** A convenience sample
- 10 Adult branch **student nurses**
- 3rd year of training
- Recruitment: [REDACTED]

■ CREATE THE DIFFERENCE

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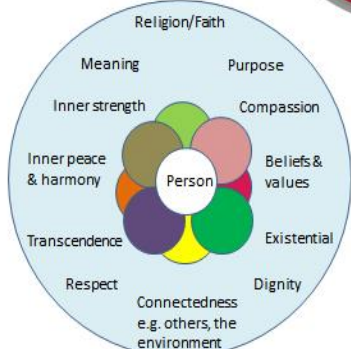
Data Collection

- Individual interviews (digitally recorded)
- Transcription of interview recordings
- Ongoing comparative analysis of data
- Theoretical sampling

■ CREATE THE DIFFERENCE

5

Spirituality is



L.P. Lewinson 14/05/14

■ CREATE THE DIFFERENCE

6

Definitions

... the spiritual is a natural dimension of what it means to be human. The awareness of self, of relationship with others and with creation, the finitude of life, the search for meaning, for the transcendent, and the need to be acknowledged, accepted, valued and loved, are all parts of this dimension ... Many express these understandings and experiences through a belief system, by holding to a set of values, or through belonging with and participating in the life of a faith community.

(NHS, Scotland, 2009 Annex B p 5-6).

■ CREATE THE DIFFERENCE

7

Significance of spirituality to health care

- Spirituality is unique and subjective
- Spirituality can include religion
- Spirituality is universal and relevant to everyone
- Spirituality may be more prominent to a person during a crisis or illness

(McSherry et al, 2006)

■ CREATE THE DIFFERENCE

8

Students' understanding of spirituality:

- *"I think it's a range of all the experiences in your life ... spirituality is what makes a person individual ..."* (p6)
- *"... It's people's beliefs, whether they are religious or not, whether it's after-life type of thing. I'm vague on it, I haven't got a definite idea ..."* (p2)
- *"... I think it's hard to put your finger on anything really ... I think it's more about beliefs - anything that you believe ..."* (p4)

■ CREATE THE DIFFERENCE

9



■ CREATE THE DIFFERENCE

Students' perception:

- *"... spirituality is one aspect of holistic care ... you try your best to provide holistic care but it's not always possible. I think as nurses that does annoy us at times because you want to provide the best possible care to every patient ..."* (p6)
- *"They all go on about holistic care, but what does holistic care encompass really ... we focus a lot on interventions and how that directly affect the patient rather than the other side ... we keep promoting holistic care, but is it actually happening?"* (p5)

■ CREATE THE DIFFERENCE

11

Pre-registration Spirituality Education

- The Nursing and Midwifery Council (NMC) emphasises holistic care (NMC, 2010b p11)
- The spiritual dimension is an integral part of holistic care
- Nurses need to be adequately prepared to meet patients' spiritual needs
- Nurses desire to be better equipped to meet patients' spiritual needs (McSherry and Jamieson, 2011)

■ CREATE THE DIFFERENCE

12

Students' perception of spirituality education

- "... we don't do a huge amount on spirituality at university - we have the odd session here and there, but I think it's quite hard when you do have sessions to really clarify what spirituality is, so I think it's kind of up to you to make your mind up yourself ... I don't think it prepared us very well ..." (p4)
- "... I don't think it did (pre-registration education) ... I did my spirituality course in a local hospice ..." (p5)

■ CREATE THE DIFFERENCE

13

Continued

- "... I don't think there is enough on the syllabus ... perhaps it's an innate thing being able to respond to people's spiritual need ..." (p7)
- "... I think it's mentioned a lot over the three years ... involved with cultural beliefs and stuff ... I wouldn't say we specifically have focus on spirituality." (p8)
- "... before I had education that (spirituality) wasn't really a focus ... having the education makes me realise that it's important ..." (p10)

■ CREATE THE DIFFERENCE

14

Continued

- "... there wasn't much in my training ... being in practice and working it out yourself a bit ... after experience and working with patients you seem to pick up quite a lot (p3)
- "... I don't think it's prepared us very well - not at all because from what I can remember we've only had one or two classes on spirituality and I think as nurses ... we need more support and guidance and understanding what spirituality is ..." (p6)

■ CREATE THE DIFFERENCE

15

Students meeting spiritual needs

- "... always open to if anyone wants me to talk about ... spiritual needs ... trying to meet and help their needs but not go over the ... limitations and boundaries ..." (p1)
- "... I feel like in some respect I am meeting some spiritual needs of patients ..." (p5)



"being able to give them time and talk to them ..." (p3)

■ CREATE THE DIFFERENCE

16

Continued

- "I don't know that I have ... it's something I'm very weary of..." (p4)



- "... you know sometimes if you try and help people with spiritual needs you get sort of trouble for it, in case you put your religion unto them - which is the problem" (p6)

■ CREATE THE DIFFERENCE

17

Continued

- "I think just touching her hands and holding her hand when I went in and spoke to her helped her ..." (p7)



- "... to me holding someone's hand as they die to me is as spiritual as it can get really ..." (p4)

■ CREATE THE DIFFERENCE

18

What are the students' main concerns?

- Preliminary findings:



1. Some ambiguity about the content, and delivery of the spiritual care, which affects facilitation.
2. The low priority given to spiritual care in nursing.

How do students resolve their concerns?

- Preliminary indications:
- Drawing on previous knowledge, their own spirituality or beliefs, also innate resources, as well as relevant content from the nurse education course.
- Delivering spiritual care to patients to the best of their knowledge and ability.

Final comment

- *"I don't believe it's (spirituality) dealt with, appreciated in the way it should be. A complete shake-up, it needs to be taken completely seriously... I still see it as being important for the individual... whether they are aware or not..." (p2)*



References & further reading

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Appendix 16

RCN education conference presentation: Nottingham 2015, (same as Appendix 14 pp. 378-382).

Also see letter in Appendix 18a (p.391).



Spirituality in pre-registration nurse education and practice: Grounded theory data analysis update

Lesline P Lewinson: July 2015

■ CREATE THE DIFFERENCE

1



To ascertain the impact of pre-registration nurses' spirituality education in clinical practice



■ CREATE THE DIFFERENCE

2



- Built on a symbolic interactionist theoretical perspective
- The researcher focuses on eliciting multiple meanings from the data (Charmaz 2000)



■ CREATE THE DIFFERENCE

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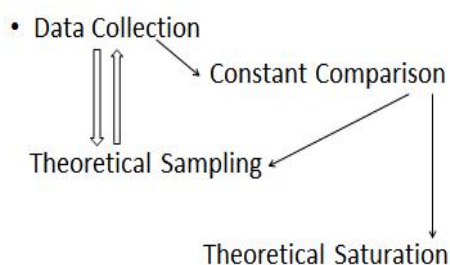


- Individual in-depth interviews
- Digitally recorded & transcribed contemporaneously
- 1st Phase & 2nd Phase data collection complete
- 1st Phase data analysis complete



■ CREATE THE DIFFERENCE

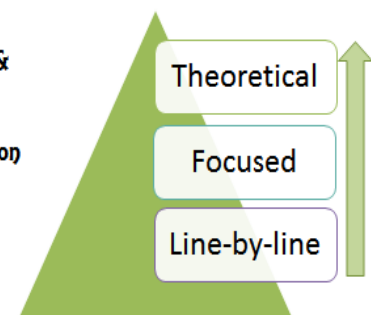
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■ CREATE THE DIFFERENCE



- Three stages of Coding
- Data managed and organised manually & NVivo 10 software
- Progressive reduction of the volume of data to be analysed



■ CREATE THE DIFFERENCE

LINE-BY-LINE CODING

- Grounded theory creates codes by defining what is seen in the data
- line-by-line coding is intense, fracturing the participants' verbatim data, to capture and examine their account (Corbin & Strauss, 2008)
- Participants' words describe their views, meanings, feelings and experiences

■ CREATE THE DIFFERENCE

Contd.

- The opportunity to, 'step back' and open up to all potential avenues of enquiry, to gain as full a picture as possible of what is going on
- Applying an open but critical view while comparing data with data
- Microsoft word (2010) 'review comments' tool used to carry out the initial 'line-by-line coding'

■ CREATE THE DIFFERENCE

FOCUSED CODING

- Pinpoints the most significant and or frequently occurring initial codes (Engward 2013)
- Large amounts of data are synthesised, integrated, and organised (Charmaz 2006)
- Words and phrases that contain a single unit of meaning are selected (Schreiber 2001) to generate **CATEGORIES**



■ CREATE THE DIFFERENCE

THEORETICAL CODING

- Sophisticated level of analysis which progresses from focused coding
- Adds precision and clarity to your findings
- Theoretical codes must earn their way into your grounded theory (Glaser 1978)
- Indicate possible relationships between categories
- Conceptualise how substantive codes relate and are integrated into a theory



■ CREATE THE DIFFERENCE

NEXT:

2ND PHASE DATA ANALYSIS



■ CREATE THE DIFFERENCE

Thank you for listening



■ CREATE THE DIFFERENCE

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Nursing Standard/Students

[REDACTED] 5/29/15

To: lplewinson@hotmail.com

Dear Lesline

I edit the careers and student pages in Nursing Standard and I was at the RCN education forum conference in Nottingham earlier this year and saw that you presented a session on how nursing students integrate spiritual care into their practice.

I am commissioning articles for a forthcoming special student supplement that will be published in Nursing Standard at the end of September in advance of the new academic year. This includes information and tips for students on preparing for their studies and first practice placements.

Spiritual care seems to be a great concern for all nurses presumably because patients want some acknowledgement of this in times of distress but guidance on how nurses should respond is unclear. I'm not sure how much preparation or opportunities there are for students to discuss such issues during their undergraduate studies.

I wondered if you might be interested in writing a short (700w) column about your study and how new students can think about spiritual care and its place in their practice. If so, I can send on a page brief, some pages published in last year's supplement so you can see what I'm looking for and details of our online submission process. The deadline for copy to arrive here is 1 July.

Maybe you would let me know what you think?

With kind regards

[REDACTED]

Careers Editor

[REDACTED]

W rcni.com

CAREERS STUDENT LIFE

Speaking of spirituality

Lesline Lewinson discusses how spiritual care – an essential but often overlooked area – fits into holistic practice



You do not have to be a religious person to meet the spiritual requirements of your patients.

As a nursing student, you can be sensitive to their needs by talking to them and being observant.

Historically, spirituality was always part of nursing practice, and it is still important today – although it is not mentioned as much as it could be. You may find that in your nursing course, spirituality is implied rather than directly identified, and incorporated into various topics, for example ethics.

Holistic care

Among other things, you will hear the term 'holistic care'. The Nursing and Midwifery Council requires all nurses to practise in a holistic way, which means attending to the physical, psychological, spiritual and social needs of patients.

But spirituality is, at times, overlooked in holistic care

because it is not a stand-alone aspect of nursing practice.

Spiritual care may appear ambiguous and challenging, and as a student you might feel uncertain about this aspect of care. It is helpful to remember:

- ▶ Spirituality is not necessarily about religion, but religion could play a significant part in spirituality for some patients. Nurses should be aware and respectful of patients' beliefs.
- ▶ Spirituality includes an appreciation of, or connection to, other people and the environment. It is unique to each individual and may be a source of faith, hope, peace, meaning, purpose in life and wellbeing.

- ▶ When someone is ill, their spiritual need may be more evident, and this should be reflected in their nursing care.

There are three elements of spiritual care that are fundamental to good nursing

practice, namely treating patients with respect, dignity and compassion. These three should go hand-in-hand throughout your nurse training and on every clinical placement.

Religious and cultural needs might be identified and expressed by a patient or their relative. Nurses may not be able to meet these needs themselves, but can make arrangements to enable them to be met – for example, a visit from the hospital chaplain or other spiritual leader, a reading from a sacred text, or privacy to allow a patient to pray. Family and friends can also play a significant part in addressing these needs.

Specific needs

Media reports have highlighted a number of failures in patient care in recent years. Attending to fundamental spiritual needs through holistic care in everyday nursing practice would go some way to addressing these failures.

Spirituality in nursing needs to be discussed more often, which will normalise the topic. In addition, relevant information about a patient's spiritual care should be recorded in their care plan and reported on in staff handovers. With this understanding, and the support of your mentor, you will be able to ensure your patients' spiritual needs are met **NS**

Lesline Lewinson is a former nurse lecturer currently studying for a PhD at Staffordshire University


Nurses do not need to be religious to meet patients' spiritual needs, says Lesline Lewinson (right)

RESOURCES

- ▶ Equality and Human Rights Commission – What is the Human Rights Act?
tinyurl.com/o5ilthnr
- ▶ Nursing and Midwifery Council – Standards for Pre-registration Nursing Education
tinyurl.com/oarxthj

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Student Nurses Learn Spiritual care in hospice and palliative care settings



Lesline Lewinson 2015

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Spirituality in nursing

- There is no question that spirituality is a relevant part of health care, but research has shown that this aspect of holistic care is given minimal attention in nurse education (Ross 2006)
- Nurses say that, spirituality is an important part of their caring activity for patients, furthermore, they desire to be better equipped (Baldacchino 2008, McSherry and Jameson 2011)

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My Doctoral Studies

- I am engaged in a 2 part qualitative longitudinal study, using a constructivist grounded theory method (concentrates on meaning) and in-depth interviews. Data were collected over three years - 2012-2015.
- My participants were a convenience sample of adult branch student nurses from 5 different cohorts over the three years, and from two different locations.
- I present a small part of the preliminary findings from my investigation.

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Learning spiritual care

"Caught or



- In the classroom - theoretical content is insufficient
- May be hidden in other topics e.g. ethics
- Selective placements -



■ HOSPICE & PALLIATIVE CARE

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Students' Verbatim Views

- I don't think we do enough, I don't think there is enough on the syllabus ...(P7)
- ... if it [spiritual care] had been addressed a lot sooner in my training, I would have recognised it a lot sooner ... and not wait until halfway through my training ... to look retrospectively at things to recognise that's what I was doing (P12)

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Contd.

- I think with some guidance and preparation within our training I would have dealt with that [spirituality] better ...
- Having it as a lecture is all very well but you just sit there and listen and maybe you participate a little bit - but you come out of that lecture room and you forget it ...
- You might have handouts ... but probably never refer to them again (P2)

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Contd.

- I think everything to do with the course and all of the caring aspects that we've gained from ... the classroom have helped me in practice (P3)
- ? spiritual care more caught rather than taught (Bradshaw 1997)



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Learning in practice

- my mentor ... was a link nurse for spirituality ... I think being able to work with her she kind of opened my eyes a little bit more to spirituality ... I had kind of done it before but it hadn't been highlighted as spirituality and spiritual care for a patient. ... I think for me personally when I am learning ... the practical side of being able to see it with a specific patient or in a specific area - that has helped me ... (P12)

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Hospice & palliative care settings

(Verbatim)

- I did my spirituality course in a local hospice ... I had no understanding as such, I had to sort of go and work on it and do the course (P5)
- the only time I have ever seen it is around palliative care - that's when nurses make more of an effort (P6)



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Contd.

- I did a placement in a hospice ... I found that they did it [spiritual care] really well ... (P7)
- Until I had that placement I didn't really address spirituality and spiritual needs, and it wasn't brought to my forefront until I went to a Hospice Palliative care setting ... I had a huge input in the palliative care (P12)



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Theory & Practice

- ... learning from clinical practice is an important aspect of it because that is where you really learn a lot of your practice, and yes that's good. But I think backup of knowledge from lectures, you know, that academic side, there should be that bit more knowledge coming from that side, so that you can sort of incorporate your knowledge in the clinical practice, you know - sort of bridge that gap between the two (P6)

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Student nurses learn that -

- Palliative care improves physical, psychological and **spiritual** wellbeing of patients and their families
- Student nurses do appreciate hospice & palliative experience for learning spiritual care



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Conclusions

- Spiritual care is part of the art of nursing and students need clinical experience to develop their reasoning and tacit knowledge (Greenstreet 1999),
- And real-life situations are important (Giske 2012)
- Spiritual care in nursing practice is reciprocal (Pesut 2002, Giske & Cone 2012)
- I suggest that spiritual care can be both taught and caught.



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Thank you for listening



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