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"Enablement"—Spirituality Engagement in Pre-Registration Nurse Education and Practice: A Grounded Theory Investigation

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Abstract: Historically, spirituality in nursing was considered a fundamental dimension, contributing to patients' wellbeing. Accordingly, nurses are expected to attend to the spiritual needs of patients as a part of holistic nursing care, and pre-registration nurse education (that is undergraduate nurse education) has a responsibility to equip them to fulfil this aspect of their role. However, the content of spirituality in nurse education programmes lack structure and consistency, hence further investigation into the value of such education and its transferability in clinical practice is needed. Data collection was by individual interviews with 13 pre-registration participants undertaking adult nursing between March 2012 and May 2014. Each interview was digitally recorded and transcribed verbatim. Through theoretical sampling, data collection and analysis occurred in a cyclical manner until theoretical saturation/sufficiency was reached. The participants' main concerns were: explaining spirituality, remembering spirituality education and content, and uncertainties about facilitating patients' spiritual needs; these combine to form 'having sufficient spirituality education to facilitate patients' spiritual needs'. The substantive theory of 'Enablement' (make possible) was constructed to explain how the participants resolved their main concern. This investigation reveals how the participants acquire and translate spirituality education to practice, so realising holistic care.

Keywords: pre-registration nurses; spirituality education; adult nursing; holistic care; qualitative research; grounded theory

1. Introduction

Spirituality is a worldwide phenomenon involving diverse beliefs and practices in different cultures, and historical accounts catalogue the connection between spirituality and care for the sick and poor of society (Bradshaw 1994). However, defining spirituality remains a conundrum, as it is subjective and means different things to different people (Young and Koopsen 2005; Barnum 2011), and similar difficulties are encountered in efforts to define spiritual care. Nevertheless, some healthcare professionals see these varied definitions positively, as they reflect cultural diversity and personal religious/non-religious beliefs and preferences (Pike 2011). Therefore, spirituality is important and necessary, particularly in times of illness (Van Leeuwen and Cusveller 2004; Weathers et al. 2015).

1.1. Definitions

Most definitions of spirituality include some common features, for example, Stoll (1989) defines spirituality as " ... a two-dimensional concept ... a continuous interrelationship between ... 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" (Stoll 1989, p. 7). Similarly, according to Weathers et al. (2015), "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" (Weathers et al. 2015, p. 15). Thus, spirituality occurs more naturally and may be private, in contrast to religiosity, which is the public practice of religion (Young and Koopsen 2005). However, spiritual care offered by nurses may support an individual's spirituality/religiosity. Consequently, nursing should acknowledge that the expression and meaning that individuals have about spirituality might differ considerably, based on personal values and convictions depending on their worldview. Furthermore, attention is drawn to a need for equal consideration to spirituality and spiritual care by nursing academics (Narayanasamy 2010; Mcsherry and Ross 2015).

1.2. Holistic Care

Spiritual care as a nursing responsibility is integral to providing holistic care (whole person care) and is exemplified within Watson's theory of human caring (Watson 1988, 1997, 2012). Watson 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. Furthermore, leading theorists in the nursing profession, such as Orem (1985) and Henderson (1966), believe it is not enough to focus on the disease episode in an individual's illness experience, but promote the delivery of total patient care without neglecting the spiritual dimension, thus emphasising holistic care. Moreover, together with the World Health Organisation (WHO)—a specialised agency of the United Nations supporting international health policies and strategies, there is a growing body of evidence supporting the link between the spiritual dimension and patients' wellbeing (WHO 2002; Visser et al. 2010; Krentzman 2013; Ivtzan et al. 2013; Ross et al. 2016). However, in spite of compelling arguments, and increased interest over the past three decades to support a move for nurses to be adequately prepared to meet patients' spiritual needs (Cone and Giske 2013; Jeong et al. 2016), this has not been fully realised.

Nurses in the United Kingdom (UK) are required to complete a three year course of study that includes theoretical education and clinical practice in various healthcare areas, as laid down by the Nursing and Midwifery Council (NMC) (NMC 2010). The aim is to prepare nurses that are competent in their professional role to practice in a holistic way. Furthermore, other countries have similar requirements for example, Canada—Olson et al. (2003), USA—(Nardi and Rooda 2011), Norway—Cone and Giske (2013), Singapore—(Tiew et al. 2013). A common feature that permeates nursing care involves meeting the patients' health needs as identified by assessment, including those of a spiritual nature. Furthermore, the International Council for Nurses (operated by nurses) work for quality assurance in nursing and highlight that spiritual care is important (ICN 2012). Accordingly, 'Fundamental Spiritual Care' (compassion, dignity, and respect) as well as other spiritual needs a patient may indicate as substantial to them should be facilitated. Therefore, significant aspects of spirituality and spiritual care should be made explicit in nurse education programmes. However, in reality, the spiritual care of patients receives little attention compared to other domains of patient care (Swinton 2001; Chan 2009; Caldeira et al. 2016); hence more research is needed not only into the effectiveness of pre-registration nurses' spirituality education, but also its translation and utilisation in clinical practice.

1.3. Spirituality Education

A systematic review of the literature relating to spirituality in nurses' pre-registration programmes (Lewinson et al. 2015) revealed that it is not only important for nurses to be spiritually aware

(Wallace et al. 2008; Giske and Cone 2012), but also to acquire competence in matters of spirituality and spiritual care (Van Leeuwen et al. 2008; Mcsherry et al. 2008; Barss 2012; Du Plessis et al. 2013) for the wellbeing of patients. Thus, nurses require adequate spirituality education for a better understanding of this concept, which goes beyond religion (Mooney and Timmins 2007), for on-going preparedness to respond appropriately with spiritual care in order to fulfil a vital part of their role in delivering holistic nursing care (Lewinson et al. 2015). Hence the purpose of Phase 1 of this investigation was to explore pre-registration nurses' spirituality education and its impact on clinical practice.

2. Method

2.1. Design

A constructivist grounded theory design (Charmaz 2006, 2014) was selected for this longitudinal qualitative investigation. Since the work of the original founders Glaser and Strauss (1967), different versions of grounded theory have developed (De Chesney 2015), one being Constructivist grounded theory (Charmaz 2006, 2009, 2014). This is a contemporary revision of the basic principles of classical grounded theory (Morse et al. 2009) but is flexible enough to acknowledge the researcher's values and the part they play in shaping the facts identified. 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, Charmaz (Charmaz 2006, 2014) 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. Further information relating to constructivist grounded theory can be found in 'Situational analysis: Grounded theory after the postmodern turn' (Clarke 2005).

2.2. Grounded Theory Process

Grounded theory involves five essential processes: (1) theoretical sensitivity; (2) theoretical sampling; (3) coding; (4) theoretical memoing; and (5) sorting. Therefore, through the cyclical and iterative process of constant comparison, the integration of these five processes during data analysis was achieved (see Figure 1).

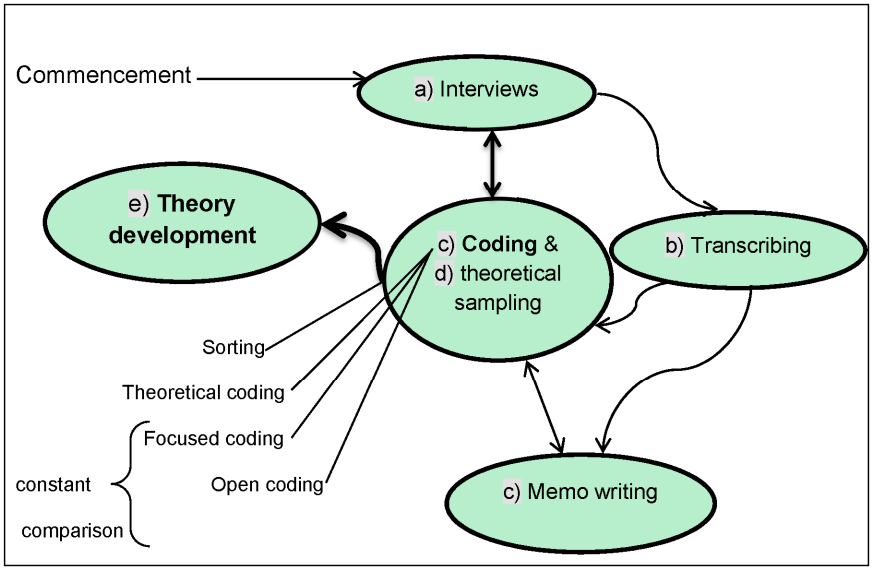

Figure 1. The process in developing grounded theory illustrates the process of data collection and analysis occurring in a cyclical pattern: (a) first interview; (b) transcribing; (c) coding and memo writing; (d) theoretical sampling for further interviews and constant comparison; (e) theory development.

As a result of these processes, the researcher eventually discovered the participants' main concerns relating to spirituality education and its practical value in the pre-registration nursing programme. Through the emergence of the main concerns from the data, the researcher was then able to construct a theory that explains how the participants resolved the same in everyday nursing practice.

2.3. Participants

This investigation was carried out at a university in the West Midlands, UK, and initially the participants (both male and female) were recruited by purposeful sampling. This was followed by theoretical sampling in the grounded theory tradition to ensure theoretical saturation/sufficiency (Glaser and Strauss 1967; Dey 1999, 2007). In total, 13 females participated in the investigation and attended individual interviews (three male students withdrew for unknown reasons).

The age range of the participants was 20–51+, and the participants had a variety of religious or non-religious beliefs. The inclusion criteria were students: (a) in adult nursing (this group is largest); (b) in their final year; (c) likely to seek employment locally (to take part in Phase 2 of the research); (d) different cohorts (to increase recruitment potential); and (e) located on either of the two campuses. The exclusion criteria were: other sectors of nursing, student nurses in years one and two, participants who for Phase 2 were unlikely to seek employment in a local National Health Service (NHS) trust, and 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).

2.4. Ethical Considerations

The university's Faculty of Health Sciences Ethics Panel granted ethical approval, and access was through the university's pre-registration nursing programme manager. In addition, ethical approval was gained from the local NHS trust, where the participants were likely to seek employment as newly qualified registered nurses, which was necessary at a later stage for Phase 2 of the investigation. All participants would volunteer and remain anonymous.

2.5. Data Collection

Data were collected while participants were allocated to various clinical practice areas, but the interviews took place in appropriate rooms on the university campus. These interviews for Phase 1 of the investigation were conducted at intervals from March 2012 to May 2014, lasting between 24 and 44 min. At the beginning of the data collection process, the use of an interview guide proved useful to open up conversation (Parahoo 2006, 2014), for example:

- What do you understand spirituality to be?
- In what ways do you think spirituality education in your nursing course prepared you to meet the spiritual needs of patients?
- How could you recognise if a patient has a spiritual need?
- In what ways have you met the spiritual needs of patients?

All data from individual interviews were digitally recorded, transcribed verbatim, subjected to analysis and coding by the author, then subsequently reviewed by the two supervising team members. The data collection process was directed by theoretical sampling which ultimately led to theory development.

2.6. Rigour

This longitudinal qualitative constructivist grounded theory investigation delivers the first-hand experiences of participants concerning their spirituality education and practice. The researcher faithfully presented the codes and categories that emerged from the data, resulting in findings that represented the perceptions and experiences of the participants, in keeping with empirical data. Additionally, the findings of this investigation were interspersed with supporting evidence from participants' excerpts

and professional literature. Therefore, the rigour addressed issues of trustworthiness and credibility, leading to the discovery of a substantive theory (Glaser and Strauss 1967).

2.7. Data Analysis

This process was ongoing from the first interview, as codes are actively constructed, by naming data that are identified as being significant to describe the participants' view (Charmaz 2006, 2014). The coding process involved subjecting the participants' transcripts to various levels of coding (see Figure 2). First, line-by-line coding was conducted which generated a number of meaningful codes; second, focused coding was carried out to reduce initial codes to the main categories; and finally, theoretical coding was done to relate main categories to the core category, and lead to an explanatory substantive theory.

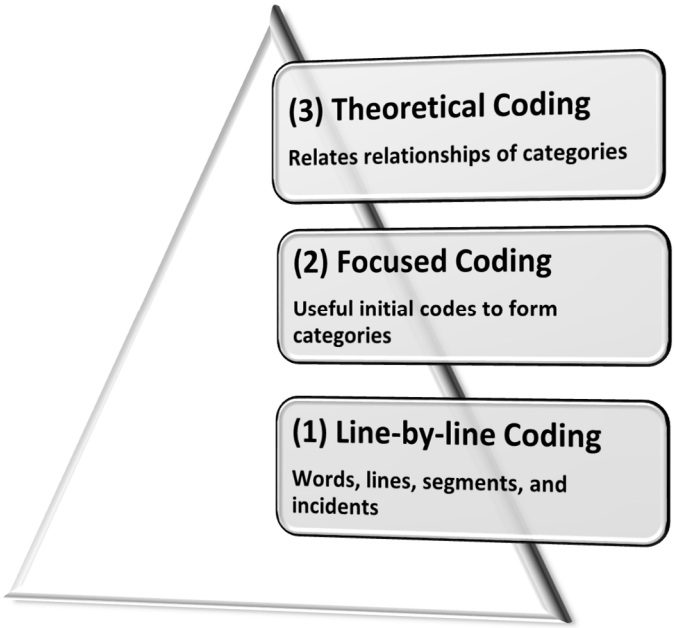

Figure 2. Three levels of coding for constructivist grounded theory.

Figure 2 shows the levels of coding that are applicable to constructivist grounded theory, displayed on a pyramid in ascending sequence. This shows the progressive order followed from line-by-line coding, through focused coding, and eventually theoretical coding.

2.7.1. The Main Concern

During the focused coding process, initially three main concerns were revealed: (1) explaining spirituality; (2) remembering spirituality education and content; and (3) uncertainties about facilitating patients' spiritual needs.

2.7.2. 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 (P = Participant):

> *I think it's a bit of everything really, a lot of the caring side of nursing. It doesn't necessarily need to be religious . . . .* (P3)

> *I think it's quite hard . . . to really clarify what spirituality is, so I think it's kind of up to you to make your mind up yourself.* (P4)

Revealed here are some uncertainties when trying to explain the broad concept of spirituality.

2.7.3. Remembering Spirituality Education and the Content

The main difficulty concerned the presence and content of spirituality education particularly in the first and second years of the nursing programme, for example:

> *Anything I can remember was from the third year*. (P6)

> *I think we had a couple of sessions, I don't know whether it was the first year . . . but I remember we definitely had dedicated sessions in the second and third year, but I can't remember back to the first—too long ago for me to remember*. (P7)

This inability of a number of participants to remember when spirituality education took place in the earlier years of their nursing programme and the actual content of the same concur with the findings in a study by Linda et al. (2015) whereby the research sample were unable to remember what, when, and how they learned spiritual care. However, in this investigation, information overload was given as one probable reason for such an occurrence, as expressed below:

> *I think when you are in the first year there's so much to take on board, it [spirituality] probably was there but not as much as in my third year . . . I don't really recollect the first year to be honest*. (P10)

However, the infinitesimal spirituality content in the overall curriculum, and its sometimes unobtrusive presence, compared to the more obvious representation of other subjects in the nursing programme is an important factor:

> *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]*. (P5)

However, this common occurrence of participants' inability to remember accurately when spirituality was covered in their nursing programme could also suggest the low priority given to this domain in nurse education. Nevertheless, even a limited amount of spirituality education has the potential to create an interest for further knowledge and understanding of the concept:

> *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 . . . .* (P6)

> Nevertheless, some participants were able to recognise aspects of spirituality in other topics:

> *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*. (P8)

> *One of the modules was very ethics based, so we did discuss spiritual beliefs and spirituality quite a bit in that particular module*. (P9)

The fact that participants remembered some spirituality education in their third year seems logical, being the most recent coverage of the subject. However, there is no denying their desire for more formal spirituality education.

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

> *I think as nurses we need more support and guidance and understanding what spirituality is and how we can help . . . I think it's something that needs to be looked at more often throughout the three years of training*. (P6)

Thus, a conclusion from Phase 1 is that spirituality education does not occupy a consistent recognisable place in the nursing programme. In addition, some participants had uncertainties about facilitating patients' spiritual needs.

2.7.4. Uncertainties Surrounding Facilitation of Spiritual Needs

In general, participants had difficulty describing how they had facilitated spiritual needs, and they were inclined to look for religious examples, whilst the integral nature of spiritual care is often contained in everyday nursing activities (Clarke 2013), and therefore not readily recognised (Golberg 1998). Nevertheless, spiritual care involvement can cause concern/uncertainties for students, as explained in the following:

> *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 . . . not go over the boundaries of what we should be doing as a . . . student nurse.* (P1)

The nursing student's 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 within professional boundaries, especially for fear of unfavourable accusations, if misunderstood by patients or colleagues, for example:

> *There was something in the media a while ago wasn't there about 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 and meeting their other needs—I think it's [spiritual care] something you should be able to do—but I don't know where the boundaries are.* (P2)

Clearly, there appears to be an element of cognitive dissonance in relation to spiritual care of a religious nature. However, some participants realised that attending to spiritual needs was included in a broader integral frame:

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

> *It's difficult to point out really . . . I couldn't maybe point out 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.* (P4)

So spiritual care can be unobtrusive within other nursing activities, and trying to identify specific examples could be difficult at times.

The data also revealed that the necessary caring aspects of respect, dignity, and compassion in good nursing practice were not readily recognised as being spiritual in nature by many participants. The realisation of this usually occurred after reflection on their everyday nursing care (Byrne 2002). In addition, the significance of, not just doing to, but being with patients (RCN 2011) is not always appreciated as a part of spiritual care, unlike the next example:

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

However, participants who had palliative nursing experience were in no doubt that spiritual care is prominent:

> *I spent a lot of time with palliative care . . . in that setting it [spirituality] was a very big part of the nursing care.* (P3)

> *I went to a hospice palliative care setting, . . . it kind of introduced to you that there is more about people's wants and beliefs and things, and it [spirituality] is highlighted how important it is to address those needs . . . from that I have been able to understand it in other areas of nursing.* (P12)

There is agreement that the spirituality education acquired as a result of palliative care experience was substantial; also, theory and practice came together in a rounded learning experience. In addition, the importance of the spiritual dimension for other patients is highlighted.

Throughout Phase 1 of this investigation no other healthcare situation with a specific focus on spiritual care was mentioned, which reflects the high priority given to spirituality in hospice and palliative care settings, but a majority of participants did not have this experience. As a result, this could suggest that spiritual care may be regarded as less important elsewhere, but another explanation is that it rises in priority for palliative and end of life patients (Puchalski et al. 2006; Healthcare Quality Improvement Partnership 2016).

The above three main concerns interrelate and combine to form one main concern (Glaser and Strauss 1967; Glaser 1978; Glaser and Holton 2004) of 'having sufficient spirituality education to facilitate patients' spiritual needs'.

3. Findings

3.1. The Substantive Theory

The main concern of 'having sufficient spirituality education to facilitate patients' spiritual needs' was challenging. However, "Enablement" (make possible) was the generated substantive theory that explained the participants' resolution of the same. "Enablement" had the greatest explanatory relevance and the ability to connect the main categories (Corbin and Strauss 2008; Gibson and Hartman 2014). Thus, "Enablement" became the appropriate behavioural strategy.

This strategy involved three main categories by which the participants based their endeavour to respond to facilitating spiritual needs: perceptions of spirituality and spiritual care, accruing spirituality education, and opportunities to provide spiritual care. Relevant supporting examples from transcripts are provided below.

3.2. Perceptions of Spirituality and Spiritual Care

The participants' perceptions of spirituality informed their understanding of spiritual need, which is a necessary prerequisite for supporting spirituality in patient care. Although the participants found it difficult at first, they conceded that spirituality was more than religion, and that it was very much perceived and experienced on an individual basis, for example:

> *I kind of believe that spirituality is not a particular religion, I say it's more your own personal beliefs . . . .* (P9)

> *I think spirituality is something that everybody feels or has, it's linked with who you are—your soul and your belief systems . . . .* (P11)

Here, efforts were being made to explain spirituality. Moreover, perceiving spiritual care opportunities was enlightening.

> *We do touch their spiritual life . . . nursing is already a spiritual job. Nursing patients you are already touching their spiritual life . . . treating your patient with dignity, compassion, and respect is also another way of showing spiritual care . . . .* (P13)

On reflection, participants could identify spiritual care in their everyday nursing practice. Accordingly, 'Fundamental Spiritual Care' in the form of respect, dignity, and compassion was important.

3.3. Accruing Spirituality Education

The word 'Accruing' used in the context of spirituality within nurse education programmes express the accumulation of various sources of information, and skills in this learning area. The amalgamation of formal and informal education such as innate qualities, life experiences, and the gaining relevant of skills in practice is necessary and adds value. Accordingly, spirituality education provides information and clarification to benefit nurses' holistic care. The following examples cover areas of formal and informal learning:

> *We had a very good, very informative lecture . . . I thought, wow! this is something really important, something that we need to cover . . . I don't think it was covered enough by any means . . . I went out thinking I really would like to follow-up and read some more . . . get a better understanding of it, something that I would like to look into further.* (P2)

> *Any spiritual care that I think I've picked up has all been . . . seeing other nurses and healthcare professionals you know go about this . . . or from personal experiences from family and friends.* (P6)

> *Perhaps it's an innate thing—being able to respond to peoples' spiritual needs and listening and that kind of thing.* (P7)

Nevertheless, participants acknowledged that the small amount of formal spirituality input received together with relevant life experience, innate resources, and any experiential learning, all contributed to their education in this area. However, they also recognised that knowledge and understanding of spirituality and spiritual care was an on-going process.

3.4. Opportunities to Provide Spiritual Care

The participants were keen to incorporate spiritual care within their everyday nursing activities. They felt challenged in this area at times, but this did not dissuade them from endeavouring to facilitate the spiritual needs of patients, for example:

> *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 you know, their other life . . . .* (P4)

> *I think just touching her hands and holding her hand when I went and spoke to her helped her . . . .* (P7)

All three main categories relating to "Enablement" (see Figure 3) will now be explained.

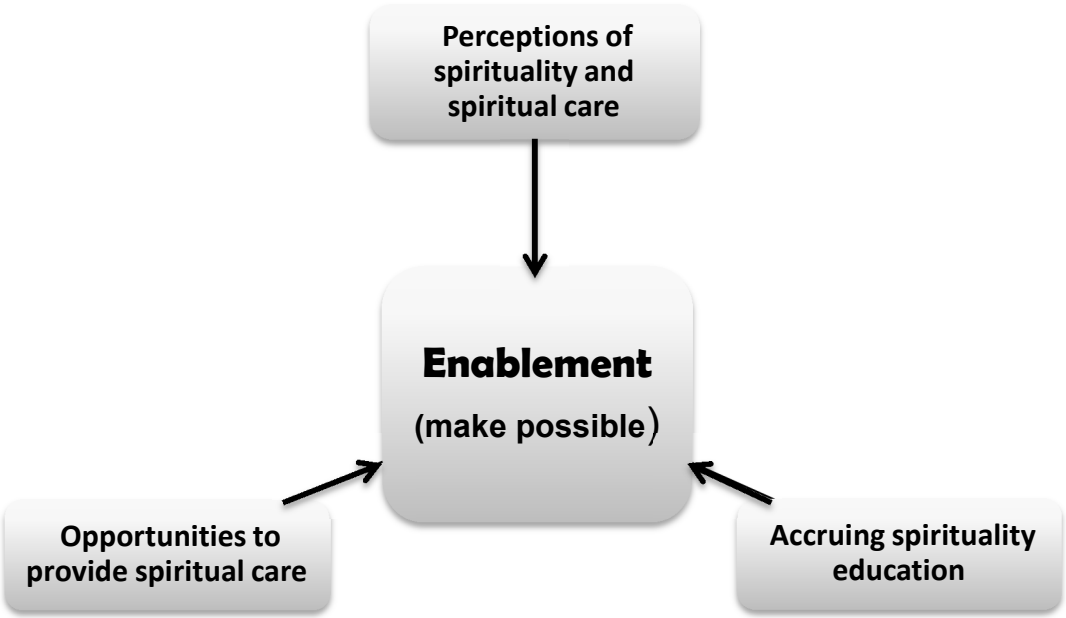

Figure 3. 'Enablement' related to main categories.

Figure 3 depicts the relationship between 'Enablement' and the three main categories, namely, 'perceptions of spirituality and spiritual care', 'accruing spirituality education', and 'opportunities to provide spiritual care'. 'Enablement' provides 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.

3.5. Perceptions of Spirituality and Spiritual Care and 'Enablement'

The participants' conceptual understanding of spirituality and spiritual care was a resource for potential utilisation in 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 (that is, 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'.

3.6. Accruing Spirituality Education and 'Enablement'

Spirituality education contributes to 'Enablement' formally through the nurse pre-registration programme and by the utilisation of informal sources such as life experience and innate resources. This personal reservoir of knowledge and understanding is available for equipping participants with sufficient resources to respond to patients' spiritual needs, within their competency. Knowledge and understanding also helps to furnish sensitivity (Callister et al. 2004), leading to more confidence to respond appropriately to the patient's spiritual agenda. As such, any lapse in memory in relation to formal spirituality education is compensated by accruing spirituality education from a variety of sources, in other words, accruing education for spiritual care giving.

3.7. 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 just a theoretical entity to its desired practical application. Callister et al. (2004) stated that the academic component of nurse education and clinical practice play a meaningful part in the development of a sensitive ability for nurturing the human spirit. This highlights the integral nature of spirituality and spiritual care. 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.

4. Discussion

This grounded theory investigation has shown that pre-registration nursing students are interested in matters of spirituality and want to engage in meeting the spiritual needs of patients in everyday nursing. However, it was important for the participants to acknowledge their personal perceptions of spirituality (Tiew and Creedy 2012; Ross et al. 2014) in order to develop an awareness of the spiritual needs of patients. Participants found the concept difficult to understand at first, but they conceded that spirituality was more than religion and that it was very much perceived and experienced on an individual basis; also, they were aware of the value spirituality may hold for some patients. In addition, after reflection, the participants realised that fundamental spiritual care is contained in everyday nursing practice when carried out with respect, dignity, and compassion. Such indirect development of spiritual awareness was discovered in a community placement study by Du Plessis et al. (2013), as opposed to direct academic input. Moreover, 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". Hence, spiritual care is embedded in nursing (Linda et al. 2015). Clarke (2013) also adds that spirituality in healthcare must be acceptable to people with a wide variety of beliefs and attitudes. However, Swinton and Pattison (2010) point to an unclear tendency in nursing literature for spirituality to be too inclusive, suggesting that good person-centred care would suffice. However, they concede that in times of illness people are more likely to think about the 'spiritual' regardless of how it is articulated. Thus, nurses' perceptions of spirituality are set to inform their understanding of spiritual need, which is a necessary prerequisite for supporting spirituality in patient care.

An important point gathered from the participants in this investigation is that they wanted more formal spirituality education, including guidance to identify and connect spirituality in other topics. Wright and Neuberger (2012) and Caldeira et al. (2016) both emphasise that spiritual care is a requirement for nurses, adding further support for adequate spirituality education in the pre-registration nurse programmes. However, there remains an unanswered question of how best to incorporate spiritual aspects into the student nurse curriculum (Greenstreet 1999) in order for nurses to practice in a holistic way as advocated by the NMC (2010). This again highlights the integral and sometimes covert presence of spirituality and spiritual care. Hence, spirituality and spiritual care education need to be clearly represented and 'joined-up' throughout the theoretical and practical components of pre-registration nursing programmes. In this way, although challenging, the holistic quest of nursing would be demonstrated in nurse education offering the impetus for transferability in everyday nursing care settings.

However, there is a counter argument that nurses should not be obliged to undertake spirituality education, as it could increase their discomfort about the topic (Paley 2008). Nevertheless, including this investigation, studies have shown that nurses are in favour of receiving spirituality education in order to adequately facilitate patients' spiritual needs (Mcsherry and Jamieson 2011). Furthermore, this investigation discovered that the main concern of the participants was 'having sufficient spirituality education to facilitate patients' spiritual needs'. The strategy available for resolving the same was the substantial theory of "Enablement", as participants became more open and receptive to various possibilities of learning to improve spiritual care for patients. This learning process cultivated a positive approach, which informed their aspirations and willingness to facilitate the spiritual needs of patients. Moreover, their clinical practice experience gave them the opportunity to demonstrate acquired knowledge and skills for delivering spiritual care. Thus, the unique feature of this investigation established the transferability of spirituality education from a variety of sources into actual patient care.

5. Limitations of the Investigation

This was a small study representing the views of a homogenous group of participants in the UK that were followed in their final year as pre-registration nursing students. Furthermore, only students in adult nursing were chosen for this investigation, so it is not known whether the views of other nursing sectors may have some differences. Additionally, those who participated may have had a more positive opinion of spirituality and spiritual care. Another point of note was that all participants were female, and the reasons for the nonparticipation of recruited male students are unknown. Finally, the fact that the area where the investigation took place was semi-rural is to some extent not representative of the diverse nurse and patient population in the UK or internationally. Consequently, taking into consideration these various factors, the results of this investigation cannot be generalised, but the findings may have relevance to the development of nursing education internationally.

6. Conclusions

Globally, spiritual care is recognised as a fundamental dimension in everyday nursing, so nurses need to be adequately prepared to recognise and support this dimension of their role. Informal sources of learning in spirituality and spiritual care will always be complementary, adding value to any amount of formal education in this area, but a concerted effort is needed to integrate theory with practice for a more comprehensive learning experience. Nonetheless, the substantive theory of 'Enablement' illuminated a strategy available to the participants in this investigation to make progress in facilitating the spiritual within holistic nursing care. However, continued research in this area of nurse education is necessary in an effort to formally and consistently establish spirituality and spiritual care in pre-registration nurse programmes.

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References

Barnum, Barbara Stevens. 2011. *Spirituality in Nursing: The Challenges of Complexity*, 3rd ed. New York: Springer Publishing Company.

Barss, Karen Scott. 2012. Building Bridges: An Interpretive Phenomenological Analysis of Nurse Educatiors' Clinical Experience Using the T.R.U.S.T. Model of Inclusive Spiritual Care. *International Journal of Niursing Education Scholarship* 9: 1–15.

Bradshaw, Ann. 1994. *Lighting the Lamp: The Spiritual Dimension of Nursing Care*. London: Scutari Press.

Byrne, Marjory. 2002. Spirituality in Palliative Care: What Language Do We Need? *International Journal of Palliative Nursing* 8: 67–74. [CrossRef] [PubMed]

Caldeira, Sílvia, Amélia Simões Figueiredo, Ana Paula da Conceição, Célia Ermel, João Mendes, Erika Chaves, Emília Campos de Carvalho, and Margarida Vieira. 2016. Spirituality in the undergraduate curricula of nursing schools in Portugal and São Paulo-Brazil. *Religions* 7: 134. [CrossRef]

Callister, Lynn A. Clark, Elaine Bond, Gerry Matsumura, and Sandra Mangum. 2004. Threading Spirituality Throughout Nursing Education. *Holistic Nursing Practice* 18: 160–66. [CrossRef] [PubMed]

Carroll, Barbara. 2001. A Phenomenological Exploration of the Nature of Spirituality and Spiritual Care. *Mortality* 6: 81–98. [CrossRef]

Chan, Moon Fai. 2009. Factors Affecting Nursing Staff in Practising Spiritual Care. *Journal of Clinical Nursing* 19: 2128–36. [CrossRef] [PubMed]

Charmaz, Kathy. 2006. *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis*. London: Sage Publications Ltd.

Charmaz, Kathy. 2009. Shifting the Grounds: Constructivist Grounded Theory Methods. In *Developing Grounded Theory: The Second Generation*. Edited by Janice M. Morse, Phyllis Noerager Stern, Juliet Corbin, Barbara Bowers, Kathy Charmaz and Adele E. Clarke. Walnut Creek: Left Coast Press Inc.

Charmaz, Kathy. 2014. *Constructing Grounded Theory*, 2nd ed. London: Sage Publications Ltd.

Clarke, Adele E. 2005. *Situational Analysis: Grounded Theory after the Postmodern Turn*. Thousand Oaks: Sage Publications.

Clarke, Janice. 2013. *Spiritual Care in Everyday Nursing Practice: A New Approach*. Basingstoke: Palgrave Macmillan.

Cone, Pamela Meryl Heneise, and Tove Giske. 2013. Teaching Spiritual Care—A Grounded Theory Study among Undergraduate Nursing Educators. *Journal of Clinical Nursing* 22: 1951–60. [CrossRef] [PubMed]

Corbin, Juliet, and Anselm L. Strauss. 2008. *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. London: Sage Publications Ltd.

De Chesney, Mary, ed. 2015. *Nursing Research Using Grounded Theory: Qualitative Designs and Methods in Nursing*. New York: Springer Publishing Company.

Denscombe, M. 2014. *The Good Research Guide: For Small-scale Social Research Projects*, 5th ed. Maidenhead: Open University Press.

Dey, Ian. 1999. *Grounding Grounded Theory: Guidelines for Qualitative Inquiry*. London: Academic Press.

Dey, Ian. 2007. Grounding Categories. In *The Sage Handbook of Grounded Theory*. Edited by Antony Bryant and Kathy Charmaz. London: Sage Publications Ltd.

Du Plessis, Emmerentia, Magdalene P. Koen, and Petra Bester. 2013. Exploring Home Visits in a Faith Community as a Service-Learning Opportunity. *Nurse Education Today* 33: 766–71. [CrossRef] [PubMed]

Gibson, Barry, and Jan Hartman. 2014. *Rediscovering Grounded Theory*. London: Sage Publications Ltd.

Giske, Tove, and Pamela Meryl Heneise Cone. 2012. Opening up to Learning Spiritual Care of Patients: A Grounded Theory Study of Nursing Students. *Journal of Clinical Nursing* 21: 2006–15. [CrossRef] [PubMed]

Glaser, Barney G. 1978. *Theoretical Sensitivity: Advances in the Methodology of Grounded Theory*. San Francisco: Sociology Press.

Glaser, Barney G., and Judith Holton. 2004. Remodeling Grounded Theory. *Forum: Qualitative Social Research* 5. [CrossRef]

Glaser, Barney G., and Anselm L. Strauss. 1967. *The Discovery of Grounded Theory: Strategies for Qualitative Research*. New Brunswick: Aldine Transaction.

Golberg, Bernice. 1998. Connection: An Exploration of Spirituality in Nursing Care. *Journal of Advanced Nursing* 27: 836–42. [CrossRef] [PubMed]

Greenstreet, Wendy M. 1999. Teaching Spirituality in Nursing: A Literature Review. *Nurse Education Today* 19: 649–58. [CrossRef] [PubMed]

Healthcare Quality Improvement Partnership. 2016. *End of Life Care Audit—Dying in Hospital National Report for England 2016*. London: Royal College of Physcians.

Henderson, Virginia. 1966. *Nature of Nursing*. New York: Macmillan.

ICN. 2012. *The ICN Code of Ethics for Nurses*. Geneva: International Council of Nurses.

Ivtzan, Itai, Christine P. L. Chan, Hannah E. Gardner, and Kiran Prashar. 2013. Linking Religion and Spirituality with Psychological Well-Being: Examining Self-Actualisation, Meaning in Life, and Personal Growth Initiative. *Journal of Religion and Health* 52: 915–29. [CrossRef] [PubMed]

Jeong, J. O., H. S. Jo, and S. H. Kim. 2016. Effect of the Spiritual Care Module Education Program for Nurses. *The Journal of Korean Academic Society of Nursing Education* 22: 51–62. [CrossRef]

Krentzman, A. R. 2013. Why Is Spirituality Important? In *Taking Charge of Your Health & Wellbeing*. Minneapolis: Center for Spirituality & Healing.

Lewinson, Lesline P., Wilfred McSherry, and Peter Kevern. 2015. Spirituality in Pre-Registration Nurse Education and Practice: A Review of the Literature. *Nurse Education Today* 35: 806–14. [CrossRef] [PubMed]

Linda, Ntombizodwa S., Hester C. Klopper, and Deliwe R. Phetlhu. 2015. Students' voices on spiritual care at a higher education institution in the Western Cape. *Curationis* 32: 1–9. [CrossRef] [PubMed]

Mcsherry, Wilfred, and Steve Jamieson. 2011. An online survey of nurses' perceptions of spirituality and spiritual care. *Journal of Clinical Nursing* 20: 1757–67. [CrossRef] [PubMed]

Mcsherry, Wilfred, and L. Ross. 2015. Heed The Evidence on Place of Spiritual Needs in Health Care. *Nursing Standard* 29: 33. [CrossRef] [PubMed]

Mcsherry, Wilfred, Mark Gretton, Peter Draper, and Roger Watson. 2008. The Ethical Basis of Teaching Spirituality and Spiritual Care: A Survey of Student Nurses' Perceptions. *Nurse Education Today* 28: 1002–8. [CrossRef] [PubMed]

Mooney, Bróna, and Fiona Timmins. 2007. Spirituality as a universal concept: Student experience of learning about spirituality through the medium of art. *Nurse Education in Practice* 7: 275–84. [CrossRef] [PubMed]

Morse, Janice M., Juliet M. Corbin, Phyllis Noerager Stern, Barbara Bowers, and Adele E. Clarke, eds. 2009. *Developing Grounded Theory: The Second Generation*. Walnut Creek: Left Coast Press Inc.

Narayanasamy, A. 2010. Recognising Spiritual Needs. In *Spiritual Assessment in Healthcare Practice*. Edited by Wilfred McSherry and Linda Ross. Keswick: M & K Publishing.

Nardi, D., and L. Rooda. 2011. Spirituality-Based Nursing Practice by Nursing Students: An Exploratory Study. *Journal of professional Nursing* 27: 255–63. [CrossRef] [PubMed]

NMC. 2010. *Standards for Pre-Registration Nursing Education*. London: NMC.

Olson, J. K., P. Paul, L. Douglass, M. B. Clark, J. Simington, and N. Goddard. 2003. Addressing the Spiritual Dimension in Canadian Undergraduate Nursing Education. *Canadian Journal of Nursing Research* 35: 95–107.

Orem, Dorothea E. 1985. *Nursing: Concepts of Practice*. New York: Mcgraw Hill.

Paley, John. 2008. Spirituality and Nursing: A Reductionist Approach. *Nursing Philosophy* 9: 3–18. [CrossRef] [PubMed]

Parahoo, Kadar. 2006. *Nursing Research: Principles, Process and Issues*, 2nd ed. Palgrave Macmillian: Basingstoke.

Parahoo, Kadar. 2014. *Nursing Research: Principles, Process and Issues*, 3rd ed. Palgrave Macmillan: Basingstoke.

Pike, Joanne. 2011. Spirituality in Nursing: A Systematic Review of the Literature from 2006–2010. *British Journal of Nursing* 20: 743–49. [CrossRef] [PubMed]

Puchalski, Christina M., Beverly Lunsford, Mary H. Harris, and Rabbi Tamara Miller. 2006. Interdisciplinary spiritual care for seriously ill and dying patients: A collaborative model. *Cancer Journal* 12: 398–416. [CrossRef]

RCN. 2011. *Spirituality in Nursing Care: A Pocket Guide*. Edited by R. C. O. Nursing. London: RCN.

Ross, Linda A., Tove Giske, Wilfred McSherry, Aru Narayanasamy, Carmel Downes, Paul Jarvis, and Annemiek Schep-Akkerman. 2014. Student Nurses Perceptions of Spirituality and Competence in Delivery Spiritual Care: A European Pilot Study. *Nurse Education Today* 34: 697–702. [CrossRef] [PubMed]

Ross, Linda, Tove Giske, René van Leeuwen, Donia Baldacchino, Wilfred McSherry, Aru Narayanasamy, Paul Jarvis, and Annemiek Schep-Akkerman. 2016. Factors Contributing to Student Nurses'/Midwives' Perceived Competency in Spiritual Care. *Nurse Education Today* 36: 445–51. [CrossRef] [PubMed]

Stoll, R. I. 1989. The essence of spirituality. In *CARSON*. Edited by V. B. Spiritual Dimensions of Nursing Practice. Philadelphia: W. B. Saunders Company.

Swinton, John. 2001. *Spirituality and Mental Health Care: Rediscovering a 'Forgotten' Dimension*. London: Jessica Kingsley.

Swinton, John, and Stephen Pattison. 2010. Moving beyond clarity: Towards a thin, vague, and useful understanding of spirituality in nursing care. *Nursing Philosophy* 11: 226–37. [CrossRef] [PubMed]

Thomas, Jacki. 2015. Hospice Chaplains: Talking About Spiritual Care and Avoiding the Modern Day 'Inquisition'. *Journal for the Study of Spirituality* 5: 60–69. [CrossRef]

Tiew, Lay Hwa, and Debra K. Creedy. 2012. Development and Preliminary Validation of a Composite Spiritual Care-Giving Scale. *International Journal of Nursing Studies* 49: 682–90. [CrossRef] [PubMed]

Tiew, Lay Hwa, Debra K. Creedy, and M. F. Chan. 2013. Student nurses' perspectives of spirituality and spiritual care. *Nurse Education Today* 33: 574–79. [CrossRef] [PubMed]

Van Leeuwen, R., and B. Cusveller. 2004. Nursing competences for spiritual care. *Journal of Advanced Nursing* 48: 234–46. [CrossRef] [PubMed]

Van Leeuwen, René, Lucas J. Tiesinga, Berrie Middel, Doeke Post, and Henk Jochemsen. 2008. The effectiveness of an educational programme for nursing students on developing competence in the provision of spiritual care. *Journal of Clinical Nursing* 17: 2768–81. [CrossRef] [PubMed]

Visser, Anja, Bert Garssen, and Ad Vingerhoets. 2010. Spirituality and Well-Being in Cancer Patients: A Review. *Psychooncology* 19: 565–72. [CrossRef] [PubMed]

Wallace, Meredith, Suzanne Campbell, Sheila C. Grossman, Joyce M. Shea, Jean W. Lange, and Theresa T. Quell. 2008. Integrating Spirituality into Undergraduate Nursing Curricula. *International Journal of Nursing Education Scholarship* 5: 1–13. [CrossRef] [PubMed]

Watson, J. 1988. *Nursing: Human Science and Human Care, the Theory of Nursing*. New York: National League of Nursing Press.

Watson, J. 1997. The theory of Human Caring: retrospective and prospective. *Nursing Science Quarterly* 10: 49–52. [CrossRef] [PubMed]

Watson, J. 2012. *Human Caring Science: A Theory of Nursing*, 2nd ed. Sudbury: Jones & Bartlett Learning.

Weathers, Elizabeth, Geraldine McCarthy, and Alice Coffey. 2015. Concept Analysis of Spirituality: An Evolutionary Approach. *Nursing Forum* 51: 79–96. [CrossRef] [PubMed]

WHO. 2002. Whoqol—Srpb Field-Test Instrument. Available online: http://www.who.int/mental_health/media/en/622.pdf (accessed on 9 June 2014).

Wright, S., and J. Neuberger. 2012. Why Spirituality Is Essential For Nurses. *Nursing Standard* 26: 19–21. [CrossRef] [PubMed]

Young, Caroline, and Cyndie Koopsen. 2005. *Spirituality, Health, and Healing*. Boston: Jones and Bartlett Publishers International.