Titel

Spiritual care for older nursing home residents-healthcare professionals' experiences and suggestions for skills development

Abstract

Background: Providing spiritual care is recognized as part of a healthcare professionals' responsibility and an important part of whole-person care in nursing homes. **Aim**: To describe healthcare professionals' experiences with spiritual care provision and identify their educational needs concerning skills development within a nursing home. **Method**: Thirty-four healthcare professionals in a nursing home in Norway answered five open-ended questions. Analysis was undertaken using thematic analysis. **Findings**: Three themes were identified:1) *Understanding spiritual care as whole person care 2) Spiritual care must include matters of faith 3) Improving conversations and listening skills regarding spiritual needs*. **Conclusion**: Healthcare professionals' experiences of spiritual care varied; it included to religious rituals but was also described by the small things that make life worth living. Skills development areas were closely related to participants' understanding of spiritual care. Both theoretical knowledge and practical skills are needed, to discuss existential themes and communicate well with older residents.

Keywords: Healthcare professionals, educational needs, spiritual care, nursing home, long-term care, qualitative

Åndelig omsorg for beboere på sykehjem – Helsepersonells erfaringer og deres forslag til utvikling av ferdigheter

Sammendrag

Bakgrunn: Ivaretagelse av åndelig omsorg anses som helsepersonells ansvar og en viktig del av helhetlig omsorg i sykehjem. **Mål:** Beskrive helsepersonells erfaringer med ivaretagelse av åndelig omsorg i sykehjem, samt å identifisere deres utdanningsbehov og forslag til utvikling av ferdigheter knyttet til dette området. **Metode**: Trettifire helsepersonell i et sykehjem i Norge besvarte fem åpne spørsmål. Analyse ble gjennomført ved hjelp av tematisk analyse. **Funn**: Tre tema ble identifisert: 1) *Forståelse av åndelig omsorg som helhetlig omsorg, 2) helhetlig omsorg må inkludere tro* 3) *Bli god til å kommunisere og lytte til åndelige behov*. **Konklusjon:** Opplevelsen av åndelig omsorg spenner fra å be med beboeren til de små ting i hverdagen og læringsbehovene er tett knyttet til deltakernes forståelse. Utdanningsbehovene inkluderer teoretisk kunnskap og praktiske ferdigheter i å diskutere eksistensielle temaer og kommunisere med eldre.

Nøkkelord: Helsepersonell, læringsbehov, åndelig omsorg, sykehjem, langtidspasienter, kvalitativ

BACKGROUND

There are more than 38 000 older nursing home residents in Norway, and most are older than 80 years and have a long-term residency (1). While care for older people constitutes a large portion of the municipal health and care services, there is a shortage of qualified personnel and a mix of employees ranging from educated professionals to unqualified assistants (2). The majority of nursing home residents grapple with one or more life-threatening illnesses, thereby underscoring the heightened prominence and significance of spirituality for these residents (3). The overall level of competency on spiritual care might be low in nursing homes, thus, there is need of improved skills including how to provide spiritual care (4, 5)

Spiritual care is understood as addressing the spiritual dimension of the individual as part of whole-person care (6). Irrespective of their religious affiliations or life view, the preservation of a resident's spirituality stands as an equally integral facet of comprehensive nursing care, alongside the preservation of their social, physical, and psychological needs (7). Norwegian government documents, including white papers and official guidelines (8, 9) emphasize the importance of healthcare professionals supporting the spiritual and existential needs of older persons within the health and welfare sector. Despite this policy framework, research conducted in Norway revealed that healthcare professionals encounter challenges in delivering spiritual care (5, 10). Spirituality can be understood as "*the human search for strength, meaning, and goals, shared relationships, spiritual uplifts, quality of life, a relationship with God (a relationship with an abstract other), goodness*" (11). Spirituality is expressed in various ways within religious traditions or secular worldviews (12) and can be a fundamental dimension of life when interacting with others (13). Therefore, spirituality cannot be neglected in care (14).

Norway is a multicultural society, and Scandinavia is one of the most secularized places in the world (15). This study focuses on providing spiritual care. The researchers had to adopt a broad definition of spirituality while recognizing and being sensitive to the importance of the term existential. This is because the word "existential" in a Scandinavian healthcare context is often used interchangeably or instead of "spirituality" (16) because "existential" in a secular context seems more open than "spiritual "(17). Spirituality is conceived as a comprehensive concept that includes the existential dimension, however, the existential concept cannot exist independently, according to the model proposed by Nygaard, Austad (16). Consequently, the term "spirituality" and "spiritual care" are used in this study as the study sees to align itself within the nursing field. The choice is justified by the prevalence of "spiritual care" as the predominant term in international nursing literature (4, 10, 18).

Spiritual care for older people

In older people care services, being present and listening, providing touch, facilitating participation in social settings, and maintaining significant relationships can be understood as spiritual care and meeting residents' spiritual needs (18). This means that spiritual care is more than religiousness; it consists of what is meaningful in the older person's life. If a resident's spirituality is ignored, their dignity can be violated because they are not treated as whole persons (19).

Spirituality is vital for older people because connecting with one's inner self may provide peace, calm, wholeness, and health (18). Gautam et. al (20) found that residents value it when healthcare professionals addressed their spiritual needs. Nevertheless, residents report that their spirituality is not asked about in primary care settings (21). The working environment and the team's professional culture are essential in determining how healthcare professionals provide spiritual care, and there must be an openness for discussing spirituality (22). The professional culture in a Norwegian nursing home consists of different religious and cultural approaches due to immigration (23) while residents are mostly Norwegian. This diversity in the workforce is not discussed in nursing home departments (24). As healthcare professionals are not asked about their cultural or religious perspectives, the multiculturality is not utilized as a resource in the departments (24). Much research on spiritual care has been conducted within palliative care, but it remains lacking within the nursing home context (25-27). Previous studies highlight a lack of understanding regarding the nature of spirituality and spiritual care among patients in nursing home, particularly withing the context of dementia care (10, 20, 28, 29). Healthcare professionals in nursing home are thus pivotal in assessing and facilitating the spiritual resources and needs of patients (25).

Healthcare professionals' role as spiritual caregivers often becomes vital when residents encounter spiritual suffering (30). In nursing home settings, spiritual care is an important part of individualized whole-person care and this can be illustrated with the question "*what is important to you*?"(31). Furthermore, it is emphasized that in whole-person care, the caregiver must accept and understand the residents as unique human beings. Therefore, nurses and other healthcare professionals must both be able to recognize and meet residents spiritual needs irrespective of their own religious and spiritual attitudes (32). Therefore, healthcare professional must understand what spiritual care means, acknowledging and considering one's personal beliefs and needs are essential prerequisites for addressing spirituality (33) .

The challenge is that not all healthcare professionals in nursing homes understand what spiritual care includes (8). Therefore, expanding the evidence on spiritual care regarding educational needs

recognized by healthcare professionals in nursing homes is of great importance. The educational interventions that are needed vary, both hands-on training and targeted learning to raise awareness of spiritual care and how this can be integrated as a natural part of their whole-person care are seen as important (33, 34). In search for a broader understanding of spiritual care, a diverse group of healthcare professionals working in a nursing home were invited to share their experience and opinions. The research question for this study is:

How do healthcare professionals in nursing homes perceive spiritual care, and what are their educational needs regarding this dimension of care?

Theoretical Framework

The theoretical framework has been the *caritative caring theory* developed by Katie Eriksson (1943–2019), with roots in humanities with an hermeneutical epistemology (32) . The core of caritative theory is caritas, love, mercy, and compassion (35). As such, the human being can be understood as an indivisible entity of body, soul, and spirit (35). In this holistic view, the dignity and holiness of individual humans are also included (35).

METHOD

The overall methodology in this qualitative study is hermeneutical (36). This provided the opportunity to describe participants' understanding of spiritual care and educational needs in connection to the lens of Eriksson's Caritative caring theory (32). The authors represent both sexes and are trained nurses with varied experiences from care for older people, education, and research.

Recruitment and data collection

The setting is a Norwegian nursing home with 90 long-term residents. All personnel who worked bedside with residents; 107 in total, were invited to reply to five open-ended questions about spiritual care:

1) *How do you understand spiritual care?*
2) *Please, could you describe one time you provided spiritual care?*
3) *Please, could you describe one time a* resident *did not receive spiritual care?*
4) *What is your recommendation for an educational program in spiritual care?*
5) *What personal knowledge do you need to develop your spiritual care skills?*

The design of these questions was discussed prior to use by two of the authors, a group of nurses, a priest and leaders who were familiar with nursing home care. Based on the discussion, questions were revised and adjusted. Our preunderstanding based on the available evidence was that healthcare professionals understanding of spiritual care would be low (5, 10, 28, 29). Therefore, a definition of what spiritual care could contain was provided to them after answering question 1. Repeatedly in the healthcare literature those providing spiritual care feel that they require greater educational preparation to enable them to meet this role. Therefore, question 4 & 5 were developed to explore this. Due to the Covid-19 pandemic in 2020, the researcher could not inform the personnel face-to face about the study. Therefore, one nurse leader sent information to the personnel via e-mail with a link to the invitation to take part in the study electronically through the platform “Nettskjema”. Participants answered questions during their work-shift.

Participants

Thirty-four persons (31,7 %) agreed to participate: 32 women and two men (Table 1). Eight were registered nurses; 13 nurse assistants; four with other healthcare education (not specified); six unqualified assistants; one student; and two without health education (not specified). Participants held diverse life views: 14 identified as Christians, six as humanists, five as Muslims, and six as atheists, with three did not specify.

Insert: Table 1 – Overview of participants

Data Analysis

Analysis was done using the six phases of thematic analysis by Braun, Clarke (37). The first phase is *familiarization*, where we read and re-read the participants’ answers. This was done to gain a deeper understanding of the data material. In phase two all authors were involved in the open coding process. In accordance with the hermeneutical methodology, the researchers interpretations emerged through a dialogue with the text (36). In several meetings each authors individual understanding was discussed, and preliminary broad codes were created. The first author then re-read the whole material several times and in the third phase initial *themes were generated* based on the codes, see example in Table 2. Themes were *developed, discussed and reviewed* by all authors in the fourth phase. In phase five, themes were *redefined, named and defined* using a coding tree. In the sixth phase, the analysis of the data material was conducted with the research question in mind, ensuring that it was adequately addressed. All themes are displayed in Table 3.

Insert: Table 2 – Example of analysis

Ethical Considerations

All participants were informed about the study prior to providing written consent. Anonymity and confidentiality were safeguarded. The Norwegian Agency for Shared Services in Education and Research (Sikt) approved the study.

FINDINGS

The findings describe healthcare professionals' experiences with spiritual care and their perceived educational needs, see Table 3.

Insert: Table 3 – Themes

Understanding spiritual care as whole person care

Participants described their understanding of spiritual care and what this involved in the nursing home using a wide range of interpretations. While some participants described their understanding of spiritual care as making residents feel secure and considered it being an integral part of whole-person care, others highlighted the importance of listening to and respecting the residents. Some participants characterized spiritual care as encompassing everything done for the residents, from offering religious support to engaging in human contact within a compassionate relationship. Kristian wrote:

> *"Spiritual care is for the resident's well-being, and I facilitate security. The residents are looked after, and all their needs are safeguarded. Feelings of insecurity, shame and so on. To feel accepted."*

Participants understood spiritual care as a broad concept. Siri, described that it should extend as going beyond religion:

> *"How broad spiritual care is. It is ranging from small everyday matters to the greater events in life. Thus, for one resident having nail-polish on her toenails can be just as important as it is to speak with the priest for someone else.* "

Furthermore, Siri pointed to spiritual care as:

> "*To be seen and knowing that someone is there for you, and you are seen as a unique human being, regarding your good and bad sides, and respected for who you are.*"

Many participants considered spiritual care as more than religious needs. It could be about getting to know the individual residents and understanding what a person thinks about religiosity, but also other things that is meaningful to the person. A few participants thought of spiritual care as being connected to the person and his/her identity. As well as the environment one lives in and that we provide meaningfulness to the residents' lives through cultural and social activities. Johanne gave the following advice:

> "*I believe you need to break it down so everyone understands that spiritual care is not just religion, I think it will be easier to focus on spiritual care if everyone gets the understanding that there is so much more to it*."

According to some participants spiritual care could become clearer when residents were asked about what was important for them, related to individual needs. One example was to bring the resident out in the garden to let her smell the grass in the summer. It could also be to go to the hairdresser, creative art like painting, pedicure, go for a walk, tend the flowers in the garden, and so on. Anette wrote about how she used creativity to provide spiritual care:

> *"A resident was restless, sad, and upset. She was crying and felt that no one was there for her. I sat down with her, and we started to paint. The resident then got to express her feelings through colors. The resident smiled and seemed more at ease."*

The need for increased awareness of how spiritual care may manifest in a nursing home setting was emphasized by several participants, this underscores the importance of grasping the concept.
The findings support the need for knowledge to be able to provide spiritual care. Some participants were not familiar with the phrase "spiritual care" or what it encompasses. Ida, a participant with no healthcare education expressed:

> *"Knowing whether you provide spiritual care is hard when you do not know what it is."*

However, the nurse Johanne forwarded her opinion that healthcare professionals are unaware of that they provide spiritual care, calling it ordinary or just good care. Yet, Johanne recognized that healthcare professionals must have confidence to provide spiritual care to residents. Our understanding was that participants who were unaware of "spiritual" related it to religion and therefore described religious practices such as reading the bible, singing hymns or accompanying the resident to religious services. In addition, several other participants stated that spiritual care was simply about providing for religious rituals or related to death, exemplified through the importance

of holding the dying resident's hand. When participants described situations in which they provided spiritual care, they often made a special connection with the resident and gained a deeper understanding of who the person is. This connection could occur when they were doing activities together like singing. It was cherished when the personnel had time to sit by the resident near end-of-life, as described by Karoline:

> *"I had time to sit down and watch over a resident. I experienced meaning in being closely present with the resident. I listened when the resident was awake, and I promised to be there when she slept. I felt this gave her peace and security."*

Participants were asked to describe experiences where spiritual care was not provided. Only a few participants wrote such stories; these were describing the last days of life concerning residents with unmet needs or a nursing home priest who could not come. Spiritual care can be experienced as difficult to provide even though one try to be there for the resident. Maria described a very challenging patient situation:

> *"Extreme hearing difficulties, almost deaf. Dementia. Little language. Clearly anxious in the last phase of life. Hard to alleviate by medication. Personnel and next of kin are present, yet clearly anxious about death."*

Some participants also mentioned a lack of spiritual care provision due to shortage in time or capacity, or a perceived lack of competence in communication about spiritual issues. Helene wrote that it was so busy that they did not have time to focus on spiritual care. She also stated that she "*knew how to"* provide spiritual care, however she "*did*" not because of a lack of time. Overall, participants emphasized the importance of spiritual care in their interactions with residents. However, they acknowledge limitations in meeting residents wishes. Stories of a lack of spiritual care had one thing in common: participants empathized with the residents and understood their spiritual needs.

Spiritual care must include matters of faith

All participants associated spiritual care with how they, as caregivers, would like to approach the resident, how they behold all the needs of each resident and how they, as humans, connected with their resident. Situations where participants had provided spiritual care were described by most participants; a few participants wrote that they had never experienced providing spiritual care. Providing spiritual care situations emerged throughout the stories as being experiences filled with

love and compassion for their residents. However, it was evident that spiritual care often was perceived as responding to religious needs, as described by Sofia:

> *"Listen to and sing hymns with residents who are Christians. This pleased them greatly."*

Supporting religious needs was recognized as an integral aspect of spiritual care, and participants expressed a desire for additional education on how to meet various religious needs. To support the residents' philosophy of life and faith was important; it was evident in the following quote by Dina:

> *"I understand spiritual care as taking care of human beings regarding their faith and life view. Ask questions and encourage reflection on their faith if they wish to."*

Spiritual care was perceived as good care, and it should include supporting religious needs. As religious needs were expressed to be an important part of whole person care, many participants expressed a need for greater knowledge about different religions, rituals and what healthcare professionals' duties are in this area. Maria stated:

> *"Concretely "what to do", "what to say" as religion and spiritual care are diffuse themes (…). Therefore, I consider it very important that the teaching is quite straightforward and easy to understand."*

There were several participants who questioned healthcare professionals' responsibilities regarding religious support. Many participants wrote that facilitating visits from the priest was an essential task because they did not have the time to address the religious needs of their residents. However, the priest was also recognized as an important person for residents to talk to, irrespective of whether the conversation had a religious context. Masha wrote about how she utilized the different personnel in the care team when residents had religious needs because she felt unable to address this aspect of care:

> *"The resident asked me to read from the Bible. At the time, I did not want to read myself but called for help from a colleague I knew would like to do this, and the resident was very grateful."*

Masha's story portrays how one's colleagues can be supportive and that this part of spiritual care can be outsourced to others in the care team. Overall, participants wanted to learn more about how to engage with different individuals on the care team when it comes to religious care provision.

Improving conversations and listening skills regarding spiritual needs

What participants wanted to learn about was closely linked to their understanding of spiritual care. If participants perceived spiritual care as solely religious, they expressed a desire to learn more about this aspect. Communication skills was, however, mentioned as desirable to improve irrespective of how they viewed spiritual care. Participants described a need for knowledge about communicating with residents with dementia, especially when residents found it hard to converse and had troubles finding words or simply lacked talking skills. In some situations, it could also be the personnel themselves that were struggling to find what to say. The nurse Karoline suggested to teach about different cultures as well as to make a tool for conversations, as it can be hard to find the right words. She wished for:

> *"To be able to facilitate good conversations, or to become an even better listener. Tools for a good conversation would have been nice, in those cases where things stop".*

To become a better listener was a skill that several participants mentioned. One nurse stated that she needed more in-depth knowledge about communication and language in connection with spiritual care. According to Kristian the meaning of life, suffering, and death were often topics of conversation that he would encounter, and he suggested:

> *"If I were to be offered tuition in spiritual care, it is first and foremost to learn to comfort those* residents *who cannot tell about their ailments."*

He connected this to when residents were in pain and when he, as a professional, tried to understand why they had pain, and then he often ended up having existential conversations. Talking about existential issues was understood by several participants as an essential part of providing spiritual care, although such existential topics could be scary to touch upon as described by Stine:

> "*I've had many conversations with residents about the meaning of life and death. These are scary conversations to have, but they usually end up being nice conversations."*

Listening was connected to developing skills in how to communicate about existential issues, especially when death is imminent. Being able to converse about approaching death was acknowledged as important, both to listen and reflect with the resident about what happens after death. Many participants wanted to learn more about approaching death and to have practical training in communication. Kari, a nurse, suggested to improve her spiritual care skills:

"To talk about death with the residents. Bring up/talk about how they wish to die. Learn how to talk about life-prolonging treatment."

Overall, participants expressed their need for training in how to communicate about faith and death and how to ask existential questions in general. Several participants stressed that a spiritual care education should include clinical examples relevant to daily practice in the nursing home.

DISCUSSION

This study aimed to understand healthcare professionals' experiences with spiritual care provision for older nursing home residents, and skills development related to this dimension of care. Findings revealed that participants had very diverse understanding of spiritual care; it was portrayed as both praying with the residents, active listening, or attending to the small things in everyday life. This broad understanding of spirituality affirms that this dimension is a fundamental aspect of care (11). Fostering a meaningful life for each individual resident is in accordance with our findings, a significant part of spiritual care in a nursing home.

The healthcare staff in Norwegian nursing homes range from educated professionals to unqualified assistants (1). The diversity in staff members is also seen in their differences in religious and cultural backgrounds (23). This heterogeneous group of staff is responsible for frail residents in their final residency (2). Research has shown that close to end-of-life, spiritualty often becomes more significant (3). However, previous studies have shown that healthcare professionals do not know what spiritual care is or how to provide it in nursing homes (5). Thus, it is likely to assume there is a gap between what is expected and the care that is provided (8, 9). This study finds that the professionals working in this nursing home did engage in spiritual care, but due to their lack of language about the spiritual dimension, they had difficulties in expressing spiritual care provision. This was particularly evident in the participants without education; they proved spiritual care but were not aware of this themselves.

The common thread running throughout the findings was participants acknowledgment that whole-person care, which encompassed attending to religious concerns, held significant importance. This came to light in their stories describing giving spiritual care, whether it was through reading the Bible or singing hymns. It is interesting to consider this diversity as a potential strength within the workforce. Within the secular Norwegian context (15), we would like to point to that the nursing home workforce stands out for its diversity, with members not only originating from varied

backgrounds (1, 24) but also sharing a familiarity with and a recognition of the importance of religion. From our perspective, this diversity, coupled with a shared appreciation for religion, is a distinctive asset in the nursing home. This must also be acknowledged when educational programs are made. However, it must also be mentioned that the varied cultural mix can to some extent be a source of misunderstandings, due to language barriers, cultural differences, and varied understandings of the content of spiritual care.

This study provides a valuable contribution to the field by highlighting the need to build awareness about the concept of spiritual care. The findings demonstrate that healthcare professionals both *can* and *do* provide spiritual care as a part of their work. We question the utility of teaching spiritual care as something distinct from other types of care; instead, we believe that spiritual care is an integral aspect of providing comprehensive and excellent care for the entire human being; indeed, spiritual care is a vital part of good care or caring for the whole human being (5). According to Eriksson (6), one cannot provide professional care without caring for the whole human being, and each older persons' dignity and holiness. We will argue that even though the participants were not knowledgeable about spiritual care, if they provide care with dignity, the residents' spiritual needs will be met, because spiritual care goes beyond religious needs. Thus, we suggest that whole person care can be provided whether healthcare professionals recognized their caregiving as spiritual or just "good care". This resonates with previous findings from Norway (5).

The overall interpretation from the findings is that to improve conversations and listening skills was important and wished for. While the dignity guarantee states that existential conversations is something residents in nursing home should be offered (9), our findings indicate a deficiency in communication skills. Consequently, existential conversations were not always provided although the participants depicted this being a crucial aspect of healthcare professionals' role and their responsibility. The findings reveal that addressing existential questions and handling them was often challenging. As a result, some would refer the resident to the nursing home priest. This typically happened when existential questions were raised or a clear religious need was identified, aligning with previous studies (20). The participants recommended using clinical examples to inspire and enable them to recognize situations from daily practices in the nursing home. This aligns with other studies showing that hands-on training is important to learn about communication and spiritual care (33). Therefore, the findings reinforce that training in communication skill (both verbal and non-verbal) is essential and vital to enable spiritual care provision in the nursing home. However, leaders are responsible for how spirituality is attended to in the nursing home. Therefore, leadership is a crucial element in setting the agenda for spirituality and fostering a culture where spiritual care is

something that one can talk about (38). The focus of education should be on spiritual awareness, making healthcare professionals aware that spirituality is something they can address in their care of their residents (34).

In summary, to understand spiritual care as an integrated part of whole-person care might make this dimension more recognizable for all healthcare professionals working in nursing homes. However, professionals must keep in mind that whole-person care must include faith for those residents who belong to a religious denomination. It is crucial to take the diversity in the nursing home into account when designing educational programs in spiritual care, focusing on enhancing spiritual awareness and recognizing the indispensability of spiritual care for older residents in nursing homes. Our findings regarding what skills participant want to improve highlight the importance of targeted learning about spiritual care (34). Thus, continuing education is recommended to give healthcare professionals a broader understanding that spiritual care is not just about providing for religiousness (34). Due to the religious connotation the word "spiritual" has in Norwegian it is, however, important to describe spiritual care within the framework of whole-person care in a Norwegian context.

Methodological considerations

The number of participants is small considering the number for invited participants, as only 31,7 % responded. However, the content of the answers was rich as it which gave us a broad picture of experiences and opinions, and the study included healthcare professional with diverse cultural backgrounds and professionals both with and without education. Due to the Covid-19 restrictions, the researchers were not allowed to attend the nursing home to promote the study, and this we believe limited the number of participants. Covid 19 and work pressure can also be a reason for participants not responding to our invitation. However, given the involvement of a diverse group of participants, especially the inclusion of unqualified assistants, this study contributes with new insights with contribution from an underrepresented group of healthcare providers in research conducted in Norway. Open-ended questions online were chosen due to Covid-19 restrictions. Due to anonymity, we were unable to ask participants to provide feedback on the findings. The Consolidated Criteria for Reporting Qualitative Research (COREQ) was used to report the study (39).

CONCLUSION

Spiritual care is understood as an essential component of whole-person care in nursing homes, and it is evident that spiritual care cannot be neglected. Seeing the whole person and providing holistic care can be understood as spiritual care. Within a Norwegian context, it might be easier to help leaders and policymakers understand that providing spiritual care is extremely important for making

residents feel at home in the nursing home. However, it might be simpler to describe it using the term “whole-person care”. However, given the heterogeneous group that works in nursing homes, one cannot assume that all healthcare professionals understand what whole-person care and spiritual care entail. Therefore, targeted education focusing on communication, practical training, and education that teaches how to be aware of a resident’s spirituality in a nursing home, as part of providing whole-person care, is essential.

Further research is recommended to develop an education program for healthcare professionals working in nursing homes. The content of this program should include an in-depth and detailed understanding of what spiritual care is and how to provide it as a part of whole-person care in nursing homes. It should also address how to provide for the religious needs of residents, including what rituals and practices might be important for them. In addition, the program should provide practical, hands-on training on how to talk about existential themes and communicate with older people.

AUTHORS’ CONTRIBUTIONS

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