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Nurses' Perception of Spiritual Care Practices Among Hospitalized Patients: A Basis for a Program

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ABSTRACT

Throughout hospitalization, patients place emphasis on health professionals to meet their spiritual and emotional needs. Since 1998, the National Inpatient Priority Index ranked emotional and spiritual needs as the patient's second priority. With evidence that shows the importance of spirituality in patient's health, nurses have a pivotal role in providing spiritual care. The purpose of this study was to examine the perception of nurses of spiritual care practice among hospitalized patients. The study used a descriptive research design to examine nurses' perception of spiritual care practices among hospitalized patients. The study was conducted among registered nurses (RN) working in Ghana. Convenient sampling technique was used to select 180 registered nurses. The study adopted and modified Nurse Spiritual Care Therapeutic Scale developed by Mamier and Taylor (2015). The results showed that the respondent's practices in terms of spiritual assessment were scaled as sometimes (M=3.12, SD=0.85). The respondent's practices in terms of spiritual support were scaled as sometimes (M=2.62, SD=0.88). The respondent's practices in terms of spiritual communication were scaled as often (M=3.55, SD=0.69). In examining the nurses' overall spiritual care practice, it was noted that the respondent's practices in terms of spiritual care were scaled at sometimes (M=3.12, SD=0.707). It can be concluded that spiritual care in terms of spiritual assessment and spiritual support was inadequate. Nurses provided adequate spiritual communication with the patients by actively listening to the patient's illness story. A program under the theme "Caring beyond the Physical" was developed to address the problem of spiritual care among nurses. It is recommended for administrators and clinical nursing educators to utilize this research and program in providing ongoing training for nurses in providing spiritual care. Secondly, further studies are recommended to be done to examine whether the personal profile has a significant difference in the use of spiritual care.

Keywords: Spiritual Care, Spiritual Assessment, Spiritual Communication, Spiritual Support, Nurses

INTRODUCTION

Throughout hospitalization, patients place emphasis on health professionals to meet their spiritual and emotional needs. Since 1998, the National Inpatient Priority Index ranked

emotional and spiritual needs as patient's second priority. (Gallison, Xu, Jurgens, & Boyle, 2012,)

The definition of health by the World Health Organization (WHO) puts emphasis not only on the disease but also incorporates spiritual health to enhance mental and social well - being. The North American Nursing Diagnosis Association and the Joint Healthcare Organizations Accreditation Commission also recognize the importance of spiritual care and directly influence that spiritual beliefs and support should be assessed and supported as necessary by all patients. (Kaddourah, Abu-Shaheen, & Al-Tannir, 2018,). The core of nursing is to holistically care for the patient. Thus, in their practice, it is necessary for nurses to evaluate and address spiritual needs.

According to Asare and Danquah (2017) in Ghana, the patient promotes spiritual involvement in the treatment of illness and healthcare. Health care providers ought not to reject the spiritual beliefs of Ghanaian patients but should use it to guide and facilitate the recovery of clients from disease. Patient's spiritual beliefs provide them with hope. This belief can, therefore, accelerate the recovery of disease when combined with Western treatment.

With evidence that shows the importance of spirituality in patient's health, nurses have a pivotal role in providing spiritual care. A study conducted in New York City explored nurses spiritual care practices using a convenient sample of 271 nurses. The study showed that 96% of the respondents believed that spiritual care is part of their nursing role, however, 48% of the participant did not participate in spiritual practices. Additionally, spiritual assessment was found to be inadequate. The study, therefore, concluded that proper spiritual assessment and communication skills are important components in spiritual care and spiritual care education should be given to nurses (Lepherd 2015).

There have been limited studies that investigated nurses spiritual care practices in Ghana. Subsequently, research on the subject has been mostly restricted to limited comparisons of factors that affect spiritual care among nurses. This, therefore, indicates a need to understand the various spiritual care practices that exist among nurses towards hospitalized patients. Specifically, it answers the following questions:

1. What is the extent of spiritual care practices in terms of:
    1) Spirituality assessment
    2) Spiritual Communication
    3) Spiritual Support
2. What program can be developed based on the results of the study?

Spirituality has often been described as a core element of human life as an essential component and ubiquitous dimension of the human condition. Spirituality is founded on several foundations from various religious traditions, spiritual stances, beliefs, cultures, and situations. Researchers have characterized the premise of spirituality in various ways, so it is difficult to reach a consensus because the idea could have several denotations. Nevertheless, the key attribute and characteristics of the idea are the need to find meaning and purpose in life. (Lepherd 2015)

A new concept of spiritual well - being has evolved over the last few years, aimed at bringing together the notions of spirituality and well – being. This new concept of spiritual well - being has a multidimensional perspective (Gouveia, Pais-Ribeiro, & Marques, 2012) and is sometimes deemed as a predictor of the quality of life and spiritual health status of patients. In addition, spiritual distress is a nursing diagnosis that has been mentioned in NANDA International (NANDA - I) since 1978 and is described as a state of suffering correlated with the significance of one's life, connected to one's self, towards others, to the world or to a superior (Caldeira, Carvalho, & Vieira, 2013).

Fisher (2016) explained that spirituality plays a key role in wellbeing, especially during times of crisis or severe illness, as it is fundamental and connects the biopsychosocial facets as an embedded whole. Though the concepts of spirituality and religion are mostly used synonymously, attempts have been made to distinguish between the two concepts, with a few commentators seeing spirituality as the broader, more comprehensive structure. The WHO (1990) expert committee on cancer pain relief and palliative care conceptualized spirituality as the aspects of human existence that supersede sensory phenomena. (Hodge, Salas-Wright, & Wolosin, 2014)

Similarly, Long Beach's Archstone Foundation, California, defined spirituality as aspects of human nature that allude to the way human beings pursue and convey purpose and meaning and the way they view their connection to the moment, to themselves, to others, to nature, and to the sacred. (Puchalski, 2001). In contrast, Hodge, Salas-Wright, and Wolosin, (2014) stated that religion is often seen as a mutual set of spiritual beliefs, practices, and rituals. Spirituality is, therefore, an individually experienced, universal concept expressed in the religion's organized, communal context.

In an investigation about patient satisfaction, Hodge, Salas-Wright, and Wolosin, (2014) utilized 4,112 adult patients over the age of 65 years, in a 12-month period from hospitals in

California, Texas and New England. The results showed that there was a significant relationship between meeting the patient's spiritual needs and patient's satisfaction.

Despite increasing acceptance of the significance of spirituality for health care, it remains difficult for nurses to assess spiritual needs (Smyth & Allen, 2011). The nurse must anticipate, respond to, and incorporate cultural and spiritual beliefs into patient care. Spiritual needs are described as needs and desires that individuals must find meaning, purpose, and value in their lives, but even individuals who may not have religion or beliefs that offer purpose and meaning to their life (Tirgari, Forouzi, Safarizadeh & Jahani, 2017).

Trying to meet the spiritual needs of the patient is part of daily nursing, but many nurses have difficulty conducting a spiritual assessment. This is particularly difficult when the patient has no indication of their religious preference or unfamiliar spiritual belief in the nurse. A spiritual assessment assists the nurse in planning holistic nursing care. Whether the nurse is unclear about the patient's spiritual belief or the patient has a spiritual belief unfamiliar to the nurse (Dameron, 2005).

Spiritual care has been described by Taylor (2008) as a stance that incorporates all aspects of a human being. Spiritual care is comparable to holistic care in which an individual's physical, psychological, social and spiritual components are taken. A detailed examination by Chan (2009) in a study showed that the higher the perception of the nurse's spiritual care, the more routinely the nurse's practices included spiritual care. Furthermore, the results showed that nurses can provide spiritual care by praying with or for the patient, reading sacred books, playing music and asking chaplain to speak to patient.

Within this context, Deal (2010) agreed that throughout the illness and spiritual crises nurses need to use these spiritual resources to give resilience to patients and families to cope. The author advocated that spiritual activities such as listening, silence and touch be incorporated. Other approaches that nurses can use to satisfy spiritual needs of patients include putting aside personal prejudice, acknowledging patient signals and verbal communication, making spiritual care resources including a private place for meditation and prayer, being compassionate, including patients and families in medical decisions.

A study conducted by McSherry & Jamieson (2011) 4054 British nurses revealed that participants had a diverse, encompassing knowledge of spirituality, acknowledging a wide range of spiritual beliefs. An immense majority of participants discovered that it is feasible to identify spirituality and spiritual care as fundamental nursing values or care principles. This aspect of care was seen by the nurses as a vital part of their role. The participants also conveyed

incompetency in spiritual care the researchers claimed that there seems to be an acknowledgment that there is a basic need to support the spiritual needs of patients regardless of one's personal belief. Outcome differences appeared to be related to age, gender, work experience, personal spirituality, personal factors.

Although the nurse has been recognized as the core member of the team whom patients communicate most often, spiritual communication is among the most difficult communications areas for nurses.

Wittenberg, Ragan, & Ferrell (2016) investigated nurses reported that spirituality communication was initiated primarily by patients, not family members, and spiritual topics often arose at the end of life or when patients encountered spiritual distress. The interactions of nurses identified the positive impact of spiritual discussions on the quality and benefit of patient care for families. Spiritual communication was characterized as an essential nursing role inpatient care, and nonverbal communication, listening, and discussion of patient emotions were highlighted as important and effective nurse communication skills during spiritual care conversations. It is apparent that during care patients want to discuss spiritual topics. Results of the study demonstrate the need to create a curriculum for spiritual communication and provide clinicians with training in spiritual care communication.

Several barriers to spiritual care have also been recognized, such as lack of education and preparation, and the understanding of the concept of spirituality has led nurses to perceive their incompetence towards spiritual care. In order to provide spiritual care, nurses necessitate competencies in three areas: self - awareness, spiritual dimension of the nursing process, and assurance and clinical expertise (Van Leeuwen & Cusveller, 2004).

METHODS

The study used a descriptive research design to examine nurses' perception of spiritual care practices among hospitalized patients. The study was conducted among registered nurses (RN) working in various hospitals in Ghana. Convenient sampling technique was used to select 180 registered nurses. For this research, the eligibility criteria specified: being a state-licensed registered nurse and providing direct patient care prior to the completion of the research study. The demographics of the 180 respondents showed that 98 (54.4%) were females and 82 (45.56%) were males. Secondly, 98(54.5%) had 0-4 years of work experience, 61 (34.1%) had 5-9 years' experience and 21 (11.4%) had 10 years and above of work experience.

The study adopted and modified Nurse Spiritual Care Therapeutic Scale developed by Mamier & Taylor (2015). The items of the tool identified 15 questions which were used to examine nurses' perception spiritual care practices among hospitalized patients, each of which is followed by a 5-point Likert-type scale anchored by Never 1, Rarely- 2, Sometimes - 3, Very often- 4, and Always- 5. All these Likert scales are based on Vagias (2006) Likert scale recommendation. Each table contains the scaled response and verbal interpretation as shown below

Table 1. **Scoring System Table for Spiritual Practice.**

Numeric Scale	Numerical Scale average Weight	Scaled Response
5	>4.2-5	Always
4	>3.4-4.2	Very Often
3	>2.6-3.4	Sometimes
2	>1.8-2.6	Rarely
1	>1-1.8	Never

A research assistant was utilized in the study. The research assistant was trained prior to the dissemination of questionnaires. All eligible registered nurses received a copy of the questionnaires from the research assistance. Additional measures were taken during this time to encourage RN participation. The RN was approached and the researchers explained the purpose and procedure of the study. Measures were put in place where RN had only a chance to answer only one questionnaire. RN who were willing to participate in the study were given a questionnaire to fill for about 20-25 minutes and the questionnaire was collected and sealed after completing the questionnaire. The study used the Statistical Package for Social Sciences (SPSS) version 23 to analyze the data. Descriptive statistics such as mean and standard deviation were used for the research question one.

RESULTS

Spiritual assessment was quantified using four questions. The respondent's practices in terms of spiritual assessment was scaled as sometimes (M=3.12, SD=0.85). In a critical analysis, I assess patient's spiritual beliefs towards health had the highest mean (M=3.27, SD=0.92) with the scaled response of sometimes. The lowest item was the assessment of spiritual challenges due to illness (M=3.00, SD=0.99) with a scaled response of sometimes. This is confirming Lepherd (2015) study that spiritual assessment is inadequate. This implies that nurses do not

provide adequate spiritual assessment all the time in patient's care. This would, therefore, cause inconsistencies in providing spiritual care due to the lack of understanding patient's spiritual needs.

Table 2. **Spiritual Assessment (N=44)**

	Mean	Std. Deviation	Scaled Response
I assess patient's spiritual beliefs towards health	3.27	0.92	Sometimes
I assess patient's religious practices towards health	3.16	0.91	Sometimes
I assess patient spiritual needs	3.05	1.16	Sometimes
I assess patient spiritual challenges due to illness	3.00	0.99	Sometimes
Spiritual Assessment	3.12	0.85	Sometimes

Spiritual communication was quantified using five questions. The respondent's practices in terms of spiritual communication was scaled as often (M=3.55, SD=0.69). In a critical analysis, I actively listen to my patient's story of illness the highest mean (M=4.39, SD=0.84) with the scaled response of always. The lowest item was I encourage patient to talk about their spiritual coping I (M=3.05, SD=0.94) with a scaled response of sometimes. This is confirming Wittenberg, Ragan, & Ferrell (2016) study that spiritual communication is suboptimal. This shows that spiritual communication as an aspect of spiritual care is practiced most of the time by nurses. This practice, therefore, implies that nurses believe that spiritual communication is a critical aspect in providing spiritual care.

Table 3. **Spiritual Communication (N=180)**

	Mean	Std. Deviation	Scaled Response
I actively listen to my patient's story of illness	4.39	0.84	Always
I encourage patient to talk about their spiritual concerns	3.39	1.17	Sometimes
I encourage patient to talk about their spiritual coping	3.05	0.94	Sometimes
I use therapeutic touch	3.46	1.02	Often
I provide a therapeutic presence of self	3.46	1.04	Often
Spiritual Communication	**3.55**	**0.69**	**Often**

Spiritual support was quantified using six questions. The respondent's practices in terms of spiritual support was scaled as sometimes (M=2.62, SD=0.88). In a critical analysis, I provide patient with quiet space the highest mean (M=3.36, SD=1.04) with the scaled response of sometimes. The lowest item was providing patient with chaplain (M=2.09, SD=1.01) with a scaled response of rarely. This confirms Lepherd, (2015) studies. This implies that nurses do not provide spiritual support to patients and, therefore, would cause ineffective care for patient's spiritual need.

Table 4. **Spiritual Support (N=180)**

	Mean	Std. Deviation	Scaled Response
I provide patient with quiet space	3.36	1.04	Sometimes
I offer to pray with my patient	2.66	1.20	Sometimes
I offer to read a spiritual passage with patient.	2.39	1.19	Rarely
I arrange chaplain to visit patient.	2.09	1.01	Rarely
I integrate patient spirituality into nursing care	2.91	1.16	Sometimes
I document spiritual care given	2.61	1.37	Sometimes
Spiritual Support	**2.62**	**0.88**	**Sometimes**

In examining the nurses' overall spiritual care practice, it was noted that the respondent's practices in terms of spiritual care was scaled at *sometimes* (M=3.12, SD=0.707). The highest-ranking aspect of spiritual care was spiritual communication scaled as *very often* (M=3.55, SD=0.6906), followed by spiritual assessment with a scaled response of *sometimes* (M=3.12, SD=0.848) and spiritual support scaled as *rarely* (M=2.67, SD=0.8808). This is consistent with McSherry & Jamieson (2011) that spiritual communication is the highest-ranked aspect used by nurses in providing spiritual care. This, therefore, implies that, in terms of nurses' overall spiritual care practices, it was suboptimal. Patients, therefore, do not receive an adequate level of spiritual care to address their spiritual needs when hospitalized.

Table 5. **Spiritual Care (N=180)**

	Mean	Std. Deviation	Scaled Response
Spiritual Assessment	3.12	0.848	Sometimes
Spiritual Communication	3.55	0.6906	Very Often
Spiritual Support	2.62	0.8808	Sometimes
Spiritual Care	**3.12**	**0.707**	**Sometimes**

DISCUSSION

The study examined nurses' spiritual care practices in terms of spiritual assessment, spiritual communication, and spiritual support. It was noted that that spiritual communication was practiced the most out of the other dimensions of spiritual care. This practice, therefore, implies that nurses believe that spiritual communication is a critical aspect in providing spiritual care. Secondly, in terms of spiritual assessment, nurses do not provide adequate spiritual assessment in patient's care. This would, therefore, cause inconsistencies in providing spiritual care due to the lack of understanding patient's spiritual needs. Nurses do not provide optimal spiritual support to patients and, therefore, would result ineffective care for patient's spiritual need.

The results of the study call for the need to provide a program to increase nurses awareness, knowledge, and skills in spiritual care that fosters the provision of holistic patient care. The seminar is under the theme "Caring Beyond the Physical", a one-day proposed program for nurses. It is recommended for administrators and clinical nursing educators to utilize this research and program in providing ongoing training for nurses in providing spiritual care. Secondly, further studies are recommended to be done to examine whether the personal profile has a significant difference in the use of spiritual care.

Conclusion

In this section, author present brief conclusions from the results of research with suggestions for advanced researchers or general readers. A conclusion may review the main points of the paper, do not replicate the abstract as the conclusion.

Not only do author write down the major flaws and limitations of the study, which can reduce the validity of the writing, thus raising questions from the readers (whether, or in what way), the limits in his studies may have affected the results and conclusions. Limitations require critical judgment and interpretation of their impact. The author should provide the answer to the question: is this a problem with error, method, validity, and or otherwise?

Writing an academic article is a challening, but very fulfilling, endeavor. Hopefully the guidelines presented here will enable you to write your first academic article with relative ease. Students, however, often underestimate the time required to produce a "poished" first effort. You cannot write a proper research article in a weeekend or even in aweek. It is, therefore, extremely important to allow yourself enough time –at least three to four weeks—to work on the successive draft.

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