1 Spiritual leadership and spiritual care in neonatology

SÍLVIA CALDEIRA RN, MSc[1] and JENNY HALL EdD, MSc, RM, ADM, PGDipHE[2]

[1]PhD Student, *Institute of Health Sciences, The Catholic University of Portugal, Lisbon, Portugal and* [2]Senior Midwifery Lecturer, *University of the West of England, Bristol, UK*

Correspondence
Jenny Hall
Faculty of Health and Life Sciences
University of the West of England
Glenside
Blackberry Hill
Stapleton
Bristol BS16 1DD
UK
E-mail: Jenny.Hall@uwe.ac.uk

CALDEIRA S & HALL J (2012) *Journal of Nursing Management*

Spiritual leadership and spiritual care in neonatology

Aim This article aims to explore spiritual care in the neonatal care environment in addition highlighting the importance of spiritual leadership of a health team in that context.
Background Neonatal care is an ethically demanding and stressful area of practice. Babies and families require spiritual needs to be recognized in the context of holistic care. Literature around spiritual leadership is explored to nurture workplace spirituality.
Evaluation Analysis of a range of sources provides a theoretical reflection on spiritual leadership and spiritual care in neonatal care settings.
Key issues The literature identifies that the carers should consider carefully on how care given may affect the infant and family. Themes relating to the baby's and family's spiritual needs and those of the staff in this area are identified. Spiritual leadership by the manager will provide support to the staff and help spiritual need to be met in this area of practice.
Conclusion Spiritual needs should be acknowledged within neonatal care whether these are of babies, families or the team itself.
Implications for nursing management Managers have responsibility to ensure that spiritual care is carried out for babies and their families and to care for the team as spiritual leaders.

Keywords: neonates, nursing management, spiritual care

3 *Accepted for publication*: XXX

JONM | Journal Name | Manuscript No. 12034 B | Dispatch: 12.10.12 | Author Received: | Journal: JONM | No. of pages: 7 | CE: Nivedha | PE: Devipriya

Introduction

The neonatal care unit is an intensive and demanding environment where newborn infants are constantly bordering on life and death. It is an area that provides challenges to those working within it or being a parent or relative visiting an ill or small neonate. Stress and anxiety levels may be high, requiring sensitive and specialist care. Ethically difficult choices are constantly being faced by both parents and carers (Stutts & Schloemann 2002a, Stutts & Schloemann 2002b, Challinor & Mifflin 2003, Carter 2004). Neonatal care is often focused on the physical needs of the infant alongside the emotional and psychological needs of the families. However for nurses and midwives there is an expectation that spiritual care will also be given in a holistic context (International Council of Nurses 2006, World Health Organization 2007, Nursing & Midwifery Council 2009, 2010) and that nursing leaders are also responsible for care for the staff (Caldeira *et al.* 2011). It has been discussed elsewhere that the spiritual nature of unborn babies should be recognized during pregnancy (Hall 2006). It is therefore appropriate to consider the newborn

DOI: 10.1111/jonm.12034

infant as a human being, to have a spiritual nature and requiring spiritual needs to be met. In addition, in the UK, many hospital trusts' neonatal care web pages include reference to pastoral and spiritual support for parents from professional spiritual advisors. It is apparent that neonatal staff should work in partnership with others in order to meet spiritual needs. It is also an important aspect of a leader's role to motivate nurses and other clinicians to include spirituality in practice; this is reflected in the time the leader invests in taking care of individual members of the team. Spiritual care is regarded as an aspect of the holistic approach to patient's spiritual needs and is a role within nursing care (Caldeira 2009). Spiritual needs are considered to be those related to meaning and purpose in life, hopes and beliefs, (McSherry 2006).

The role of spiritual leadership is an emerging concept in management that is of particular importance in health care contexts as ethical and spiritual workplaces because it is based on honesty, confidence, temperance, prudence, honour and compassion (Caldeira *et al.* 2011). Spiritual leadership is regarded as a transformative way to motivate staff to complete their role and to get the best outcomes, while at the same time staff gain a sense of fulfilment and happiness (Rego *et al.* 2007). Spiritual values are connected to an ethical attitude, respect for human beings and dignity. Neonatal care units are real contexts where these kinds of values maybe practised with babies, parents, family visitors or the staff.

The aim of this article is to explore the relevance of spiritual leadership and spiritual care in the neonatal care context in order to meet the needs of the baby, parents and family visitors and the staff who work there. The purpose is to enable managers to consider how to support the development of an environment where spiritual need is both recognized and appropriate care is given.

Spiritual care of babies

Each baby is an individual and should be treated as such in the context of their family, preferably with a 'family-centred' approach to care (Stutts & Schloemann 2002a,b, Howard 2006). Treating them as a 'condition' should be avoided at all costs. Individualized care should be enhanced through a holistic nursing assessment of an infant, which involves all aspects of need, including spiritual assessment. Spiritual assessment in the context of adult care 'should seek to elicit the thoughts, memories and experiences that give coherence to a persons' life' (Rumbold 2007). It is regarded as an ongoing process that takes account of any changes that occur. The vulnerability of the baby is enhanced through their inability to express their need, although staff may also be involved in assessing spiritual need of parents. The nurse should be anticipating what these needs may be and considering the value of each person. Promotion of self-worth and value is closely linked to spiritual wellbeing (McSherry 2006). Therefore, any care that relates to the dignity and worth of a person will potentially have an impact on their spirit.

Consideration of dignity is regarded as promoting the worth, value and autonomy of the individual (Royal College of Nursing 2008). A recent campaign in the UK focused on the need to increase awareness of the dignity of adult patients (Dignity in Care Campaign 2008). In addition a National Institute for Health and Clinical Excellence (NICE) clinical guideline (2012) has been created to aid improvement of adult care. Although geared to adults many of the quality statements created apply to the care of a vulnerable infant and their family. Further, a qualitative interview study (Baillie & Gallagher 2011) revealed care providers' strategies for dignified care involved recognizing vulnerability to loss of dignity, communication issues between staff, patients and families, improving the environment for the individual and enhancing privacy. These strategies have implications for care of the neonate.

The need for privacy, for example, is significant in the case where a baby is dying. Most neonatal care settings include incubators being situated in shared rooms. Promotion of spiritual wellbeing of the baby and family in this scenario should involve recognition of the need for privacy, away from the gaze of the visitors of other babies and excessive numbers of members of staff (Desai *et al.* 2002). Unnecessary exposure of the infant's naked body should also be avoided in the presence of others, unless required for treatment purposes. It is proposed that care which considers the environmental conditions and gentle practices will promote developmental and spiritual wholeness in the infant (Goldberg-Hamblin 2007, Desai *et al.* 2002). Evidence around fetal and infant memory (Verny & Kelly 1982, Piepper 1996, James *et al.* 2002, Renggli 2005, Mampe *et al.* 2009) should lead the carer to consider carefully care practices in the early weeks of life. It is known that preterm infants demonstrate consciousness and awareness of their environment (Lagercrantz & Changeux 2010) and should therefore be treated with the same respect as term infants. It is unclear what long-term spiritual effects there may be for babies who require neonatal

care, but it is known stress in the early days has potential to have effects into adulthood (Renggli 2005, Verny & Kelly 1982).

Within the neonatal care environment carers should recognize the differing situations they will encounter with infants. Infants may have been born preterm, be demonstrating critical and non-critical illness or ranges of disability. In each of these situations the worth and value of the infant should be promoted, with recognition of their potential as a human being with meaning and purpose. In many situations these babies are themselves the meaning and purpose of their parents' lives, therefore carers should recognize the significance of this baby to the parents. Appropriate touch and promotion of touch will aid the parents develop relationship with their baby (Schenk & Kelley 2010). In addition carers should promote love and hope through the care they give but also not raise hope in situations where complications are too severe. Honesty and truthfulness will aid parents to reach a position of acceptance where the infant will not survive.

Care of parents and families

A systematic review (Cleveland 2008) to establish the needs of parents in neonatal intensive care unit (NICU) environments, and care behaviours that helped, has shown that parents require: effective information from staff; assurance that their infant is 'being watched over'; contact with their infant; to be perceived positively by the staff; to have a therapeutic relationship with them; care that is individualized. In addition, emotional support, a welcoming environment, parent empowerment and education, and participation in care were identified as helpful. The differing needs of the fathers or partners in these situations are also to be recognized. A recent qualitative study highlights that fathers experience anxiety, feelings of helplessness, and fear of the unknown (Hollywood & Hollywood 2011). It is evident that the staff within this environment have a responsibility of care to the parents as well as the infants, and a requirement to recognize their needs.

The experience of having a pregnancy that has complications has been shown to have an impact on women's spirituality (Price *et al.* 2007). It is a stressful time for parents, involving fear and uncertainty and this continues should the infant require care on the neonatal unit. It is therefore appropriate for carers to recognize the spiritual need of parents within this environment. Spiritual care involves the 'pursuit of meaning for an infant's life and, perhaps, for the family's loss' (Carter 2004). This implies that a important role of the carer is to provide support and promote the relationship between the parents and the infant.

As already discussed, each baby is of significance and value as a human being and this should be promoted to the parents by what is said and the care that is given. It should be recognized that parents will have often experienced a difficult pregnancy and birth, or even multiple difficult situations in order to have this infant (Price *et al.* 2007) and will need to come to terms with the infant being unwell or needing special support. Carers should be aware of situations of spiritual distress (Rosenbaum *et al.* 2011,.) Spiritual distress is defined as a nursing diagnosis by Carpenito-Moyet (2008) as: 'The state in which the individual or group experiences or is at risk of experiencing a disturbance in the belief or value system that provides strength, hope and meaning to life'. For parents with unwell babies, stress, anxiety and fear may cause deep questioning of supportive belief structures. Within these situations the involvement of pastoral care workers may aid parents explore these questions and help them come to terms with the challenges they are facing.

It is recognized that pastoral care workers are valuable within the neonatal environment to support both parents and staff (Desai *et al.* 2002, Dunn *et al.* 2009). Further Catlin *et al.* (2001) suggest that NICUs should have a dedicated pastoral carer because of the intensity of need in the environment. Meeting of religious needs is a dimension of spiritual care that is frequently requested, with parents asking for prayer, to request religious sacraments or put some symbolic religious objects in the incubator. Although nurses should recognize parents' needs for personal expression of belief, it may be considered unethical to provide this kind of intervention if the individual nurses do not feel able to do so (Caldeira 2009). In these situations, the pastoral carer is the member of the team who may be the best resource for the parents' wellbeing and comfort.

A crisis state for a parent may be triggered through fear and concern about 'being a parent' in the environment. This crisis is a holistic state of suffering involving the physical, mental, social and spiritual dimensions of the person. The environment includes highly technological equipment that will be familiar to staff but not to visitors. Within this, the incubator is central as the focus of their attention. It could be regarded as a symbolic representation of a 'temple' by the parents – a sacred space in which their love,

meaning and purpose in life is focused and being cared for. Some parents feel distanced from this 'temple' and feel that only the 'priests' (the care staff) are allowed to enter. Often mothers describe to nurses that she feels as though, suddenly, her 'belly' has been transformed into a glass box where once she was the only one that the baby needs and now has become a viewer of the caring process. The infant is seen as 'set apart'. The parents long to touch but are unable to 'break in' (Schenk and Kelley 2010). Nurses may support these parents by stepping through this barrier and enable them to provide family belongings that will remove some of the mystique of the infant's space. Nurses can give back to the parents that feeling of parenthood and, at the same time, give back their meaning and purpose. In all situations evaluation of need and promotion of spiritual care requires sensitivity and preparation in order for a nurse to ensure that a total holistic approach has been taken.

There should also be recognition of cultural and religious differences that may lead to conflict between what the parents believe should happen in relation to the care of the baby and those of the staff. It has been stated that the more staff are able to recognize the difference in their own beliefs and those of the parents they will be 'better equipped' to deal with ethical dilemmas and conflicts (Stutts & Schloemann 2002a, b). A manager's role should therefore involve recognition of potential conflict and enabling an environment where discussion and debate around these issues can take place.

Spiritual leadership

Being a nurse means being committed to patient welfare but it is expected that nursing leaders should also care for the nursing team. Nurses are vulnerable and pervious to parents and babies suffering, and generally recognize their place in a spiritual care scenario (Catlin *et al.* 2001). In addition, it is seen that spirituality is an aspect of nursing care but it is also a workplace dimension (Caldeira *et al.* 2011). Workplace spirituality is related to meaning at work and the desire to be genuine in what individuals do and how they do it (Cacioppe 2000). Workplace spirituality is also defined as 'workplace opportunities to perform meaningful work in the context of a community with a sense of joy and of respect for inner life' (Rego *et al.* 2007). These authors found five dimensions of workplace spirituality that explain organisational commitment and self-reported individual performance: a team's sense of community, alignment with organisational values, a sense of contribution to society, enjoyment at work, and opportunities for their inner life. This is a transformational way to look at the workplace. Rather than a place where people earn money and develop a career, it is a place of fulfilment, inner development and opportunity for creativity.

Hospital settings are places full of suffering and questioning of the meaning of life, where people (patients and nurses) are constantly invited to reflect on their own life experience and journey. In this it may be suggested that these environments are authentic spiritual workplaces. The neonatal care environment has special significance because it is a place where life is just at its start. The moment most dreamed for and as a potential for joy for parents is at that place a moment of suffering. In this context, staff, both nursing and medical, are conscious of dealing with the suffering of both the babies and their families (Cadge & Catlin 2006). They are also aware of the 'hardest part', namely, dealing with baby's death and knowing at times that the technology being used is not going to save the baby. Nurses and other health-care providers are confronted by that suffering and their interventions must be effective to nourish that pain. Within a NICU environment some staff feel that their work and caring for critically ill infants and their families constitutes their purpose and meaning in life (Cadge & Catlin 2006). This sense of fulfilment promotes inner motivation to work and could positively influence outcomes.

Within this suffering atmosphere, it is important that nurses also feel they are being cared for by their leader. One author stated: 'As times grow more chaotic, as people question the meaning (or meaninglessness) of this life, people clamour for their leaders to rescue them' (Weathley 2003). Leaders need to recognize when difficult decisions in care are stressing staff and provide resources to support them (Stutts and Schloemann 2002a, 2002b). A leader who emphasizes the ethics at work, relationships and the balance between work and self is seen to be developing spiritual leadership (Wolf 2004). It is clear that spiritual leadership is broader than being a 'nice' leader. It implies an effective commitment to the organisation, the mission and the goals. Spiritual leadership is also related to enthusiasm, joy and kindness but also money, determination, a willingness to keep learning and other characteristics (Parachin 2005). A spiritual leader is effectively concerned about the whole team's wellbeing as well as each one individually – one who inspires, motivates and enables each carer to find meaning in work and life. Spiritual leadership will

recognize when staff require more education to support personal development and enable improved care for the infants. In the context of spiritual care Dunn *et al.* (2009) argue that there should be increased emphasis on education that promotes the nurses own spirituality, both in pre-registration and continuing education programmes. Others have demonstrated how educational sessions may help children's nurses provide spiritual care (O'Shea *et al.* 2011). From a leadership perspective, facilitating staff to attend educational sessions to promote spiritual care would therefore be of benefit.

Conclusion

The aim of this article has been to discuss issues around spiritual care in a neonatal unit context and highlight the need for leadership that facilitates a holistic approach. Within this environment nurses have responsibility to meet the needs of both babies and their families. It is a place of intense emotions related to life and death and exploration of meaning where the health team are all constantly confronted by hope and suffering. It is evident that nurses' responsiveness to the baby, parents and family must be broader than just attention to physical and psychological needs, and should include awareness of spiritual need as well. In order to do this staff need to have opportunities for education and debate relating to these issues. Recognition of multicultural expressions of faith and belief in relation to the infant should also be explored. Attention should be paid to ensuring that staff have dedicated time and space within the working day to discuss the needs of babies and their families.

Closer relationships and working with pastoral carers may enable these needs to be met to a greater extent. Although it is recommended that individual pastoral carers be attached to neonatal units (Catlin *et al.* 2001), this is often not the case and availability at the time of greatest need may be a challenge. If managers recognize the benefit of having dedicated pastoral support they can work towards achieving this for their area. Pastoral workers can be provided with a remit that also involves educating and supporting staff in providing spiritual care and facilitating ethical debate as required.

This review has also demonstrated that nurses must also be cared for so they can care for others. Spiritual leadership is a strategic role to motivate nurses to provide holistic, spiritual and human care in response to the respect and fulfilment they feel within the workplace. Through feeling cared for and respected by their leader they in turn will be more committed to institution goals, improve productivity and, most importantly, contribute to the best service that babies, parents and families expect from health services. The aim is that managers will provide spiritual leadership to humanize the caring team so that, in turn, they will provide humanized nursing care. Evidence demonstrates that good staff management has a positive effect on staff engagement, higher quality of care and improved outcomes for those being cared for (West *et al.* 2011). The implications for this are that managers require education and training that explores the concepts of a more holistic approach to leadership in the context of neonatal care, rather than purely management and business skills. A philosophy such as this should filter through from a health-care management structure where staff are seen as valued and of worth, inspired and supported by those around them.

It is evident from this review that limited research has been carried out on the spiritual needs of staff and parents in this area of practice and there has been little attempt to consider the spiritual needs of the infant. It is therefore an area where further exploration and debate may continue. Research should be undertaken to establish the spiritual needs of parents and babies in this environment alongside development of spiritual assessment tools. Further research should also identify the understanding of spiritual care by staff within this context. There is evidence that positive leadership traits may have an impact on patient outcomes (Wong & Cummings 2007). Further research is also required on the impact of spiritual leadership in this context on both staff and infants and their families. Instruments are available in the literature that measure spirituality in the workplace (Rego *et al.* 2007) and further quantitative and qualitative research questions nurses about their spiritual experience at work would be helpful to increase the knowledge about this phenomenon. Correlation studies would allow us to know if spiritual leadership and a spiritual workplace are influential in a family's sense of spiritual wellbeing.

Source of funding

Xxxxxxx.

11

Ethical approval

Xxxxxxx.

References

Baillie L. & Gallagher A. (2011) Respecting dignity in care in diverse care settings: strategies of UK nurses. *International Journal of Nursing Practice* **17**, 336–341.

Cacioppe R. (2000) Creating spirit at work: re-visioning organization development and leadership – Part I. *Leadership and Organization Development Journal* **21**, 48–54.

Cadge W. & Catlin E. (2006) Making sense of suffering and death: how health care provider's construct meanings in neonatal intensive care unit. *Journal of Religion and Health* **45** (2), 248–263.

Caldeira S. (2009) Spiritual care – prayer as nursing intervention. *Cuid'Arte* **3** (2), 157–164.

Caldeira S., Frederico M. & Gomes A. (2011) A new paradigm in nurses management – spirituality in the workplace. *Referência* **3**, 25–35.

Carpenito-Moyet L.J. (2008). *Nursing Diagnosis: Application to Clinical Practice*. Lippincott, Philadelphia, PA.

Carter B. (2004) Providing palliative care for newborns. *Pediatric Annals* **33** (11), 770–777.

Catlin E., Guillemin J., Thiel M. *et al.* (2001) Spiritual and religious components of patient care in neonatal intensive care unit: sacred themes in a secular setting. *Journal of Perinatology* **21**, 426–430.

Challinor Mifflin P. (2003). *Saving Very Premature Babies: Key Ethical Issues*. Books for Midwives, Oxford.

Cleveland L.M. (2008) Parenting in the neonatal intensive care unit. *Journal of Obstetric, Gynecologic, & Neonatal Nursing* **37**, 666–691.

Desai P.P., Ng J.B. & Bryant S.G. (2002) Care of children and families in the CICU: a focus on their developmental, psychosocial and spiritual needs. *Critical Care Nursing Quarterly* **25** (3), 88–97.

Dignity in Care Campaign (2008) Available at: http://www.dignityincare.org.uk/DignityCareCampaign/ accessed 6 March 2012.

Dunn L.L., Handley M.C. & Dunkin J.W. (2009) The provision of spiritual care by registered nurses on an maternal–infant unit. *Journal of Holistic Nursing* **27**, 1–28.

Goldberg-Hamblin S., Singer J.G., Singer H.S. & Denney M.K. (2007) Early intervention in neonatal nurseries: the promising practice of developmental care. *Infants & Young Children* **20** (2), 163–171.

Hall J. (2006) Spirituality at the beginning of life. *Journal of Clinical nursing* **15**, 804–810.

Hepper P.G. (1996) Fetal memory: does it exist? What does it do? *Acta Paediatrica Supplement* **416**, 16–20.

Hollywood M. & Hollywood E. (2011) The lived experiences of fathers of a premature baby on a neonatal intensive care unit. *Journal of Neonatal Nursing* **17**, 32–40.

Howard E.D. (2006) Family-centered care in the context of fetal abnormality. *Journal of Perinatal & Neonatal Nursing* **20** (3), 237–242.

International Council of Nurses (2006) *ICN Code of Ethics for Nurses*. Available at: http://www.icn.ch/images/stories/documents/about/icncode_english.pdf accessed 8 March 2012.

James D.K., Spencer C.J. & Stepsis B.W. (2002) Fetal learning: a prospective randomized controlled study. *Ultrasound in Obstetrics & Gynecology* **20** (5), 431–438.

Lagercrantz H. & Changeux J.-P. (2010) Basic consciousness of the newborn. *Seminars in Perinatology* **34**, 201–206.

Mampe B., Friederici A.D., Christophe A. & Wermke K. (2009) Newborns' cry melody is shaped by their native language. *Current Biology* **19**, 1994–1997.

McSherry W. (2006) *Making Sense of Nursing and Healthcare Practice*. Jessica Kingsley, London.

Meert K.L., Thurston C.S. & Briller S.H. (2005) The spiritual needs of parents at the time of their child's death in the pediatric intensive care unit and during bereavement: a qualitative study. *Pediatric Critical Care Medicine* **6** (4), 420–427.

National Institute for Health and Clinical Excellence (2012) *Patient Experience in Adult NHS Services: Improving the Experience of Care for People Using Adult NHS Services. Clinical Guideline 138*. Available at: http://www.nice.org.uk/nicemedia/live/13668/58284/58284.pdf accessed 6 March 2012.

Nursing and Midwifery Council (2009) *Standards for Pre-registration Midwifery Education*. Nursing and Midwifery Council, London.

Nursing and Midwifery Council (2010) *Standards for Pre-registration Nursing Education*, Nursing and Midwifery Council, London.

O'Shea E.R., Wallace M., Quinn Griffen M. & Fitzpatrick J.J. (2011) The effect of an educational session on pediatric nurses' perspectives toward providing spiritual care. *Journal of Pediatric Nursing* **26**, 34–43.

Parachin V. (2005) The ABCs of spiritual leadership. *Ministry Issues* **00**, 15–16.

Price S., Lake M., Breen G., Carson G., Quinn C. & O'Connor T. (2007) The spiritual experience of high-risk pregnancy. *Journal of Obstetric, Gynecologic, & Neonatal Nursing* **36** (1), 36–70.

Rego A., Pina ???., Cunha M. & Oliveira M. (2007) Eupsychia revisited: the role of spiritual leaders. *Journal of Humanistic Psychology* **48**, 165–195.

Renggli F. (2005) Healing and birth. *Journal of Prenatal and Perinatal Psychology and Health* **19**, 303–318.

Rosenbaum J.L., Renaud Smith J. & Zollfrank R. (2011) Neonatal end-of-life spiritual support care. *Journal of Perinatal and Neonatal Nursing* **25** (1), 61–69.

Royal College of Nursing (2008) *Defending Dignity: Challenges and Opportunities for Nursing*. Available at: http://www.rcn.org.uk/__data/assets/pdf_file/0011/166655/003257.pdf accessed 8 March 2012.

Rumbold B. (2007) Mental health and spirituality in later life. *Australasian Journal on Ageing* **26** (3), 149–150.

Schenk L.K. & Kelley J.H. (2010) Mothering an extremely low birth-weight infant: a phenomenological study. *Advances in Neonatal Care* **10** (2), 88–97.

Smith J. & McSherry W. (2004) Spirituality and child development: a concept analysis. *Journal of Advanced Nursing* **45** (3), 307–31.

Stutts A. & Schloemann J. (2002a) Life-sustaining support: ethical, cultural and spiritual conflicts Part 1: family support – a neonatal case study. *Neonatal Network* **21** (3), 23–29.

Stutts A. & Schloemann J. (2002b) Life-sustaining support: ethical, cultural and spiritual conflicts Part II: staff support – a neonatal case study. *Neonatal network* **21** (4), 27–33.

Verny T. & Kelly J. (1982) *The Secret Life of the Unborn Child*. Sphere, London.

Weathley M. (2003) Leadership in turbulent times is spiritual. *Frontiers of Health Services Management* **18** (4), 19–26.

West M., Dawson J., Admasachew L. & Topakas A. (2011) *NHS Staff Management and Health Service Quality: Results from the NHS Staff Survey and Related Data*. Department of Health, London.

Wolf E. (2004) Spiritual leadership: a new model. *Healthcare Executive* 18, 22–25.

Wong C.A. & Cummings G.G. (2007) The relationship between nursing leadership and patient outcomes: a systematic review. *Journal of Nursing Management* **15**, 508–521.

World Health Organization (2007) People-centred Healthcare: a Policy Framework. Available at: http://www.wpro.who.int/NR/rdonlyres/55CBA47E-9B93–4EFB-A64E-21667D95D30E/0/PEOPLECENTREDHEATLHCAREPolicyFramework.pdf accessed 6 March 2012.

Author Query Form

Journal: JONM

Article: 12034

Dear Author,
During the copy-editing of your paper, the following queries arose. Please respond to these by marking up your proofs with the necessary changes/additions. Please write your answers on the query sheet if there is insufficient space on the page proofs. Please write clearly and follow the conventions shown on the attached corrections sheet. If returning the proof by fax do not write too close to the paper's edge. Please remember that illegible mark-ups may delay publication.

Many thanks for your assistance.

Query reference	Query	Remarks
1	AUTHOR: WILEY-BLACKWELL: Article type OK?	
2	AUTHOR: is the running head OK?	
3	WILEY-BLACKWELL: Please supply date of acceptance.	
4	AUTHOR: Goldberg-Hamblin 2007 has not been included in the Reference List, please supply full publication details.	
5	AUTHOR: Verny & Kelly 1981 changed to Verny & Kelly 1982 to match ref list	
6	AUTHOR: Is the text OK now: This implies that.	
7	AUTHOR: Shenk & Kelley 2010 has been changed to Schenk and Kelley 2010 so that this citation matches the Reference List. Please confirm that this is correct.	
8	AUTHOR: Is the text OK now: Being a nurse means being committed to patient welfare	
9	AUTHOR: Is the text OK now: The neonatal care environment has special significance because it is a place where life is just at its start.	
10	AUTHOR: Does the following text make sense (something missing?): The moment most dreamed for and as a potential for joy for parents is at that place a moment of suffering?.	
11	AUTHOR: Please provide Ethical Approval and Source of Funding statements.	
12	AUTHOR: If there are fewer than 7 authors, please supply all of their names. If there are 7 or more authors, please supply the first 3 author names then et al. Please check and update all such references found in the list.	
13	AUTHOR: Goldberg-Hamblin et al. (2007) has not been cited in the text. Please indicate where it should be cited; or delete from the Reference List.	

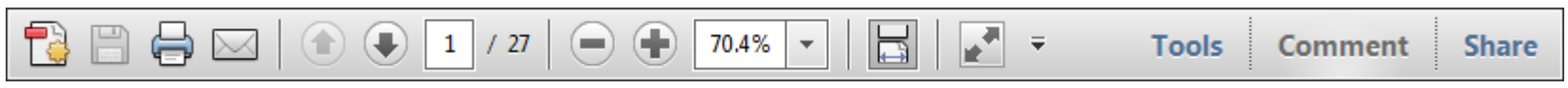
14	AUTHOR: Meert K et al. (2005) has not been cited in the text. Please indicate where it should be cited; or delete from the Reference List.	
15	AUTHOR: National Institute for Health and Clinical Excellence (2012) has not been cited in the text. Please indicate where it should be cited; or delete from the Reference List.	
16	AUTHOR: Please provide the given Names/initials for the author Pina for reference Rego et al. (2007).	
17	AUTHOR: Smith and McSherry (2004) has not been cited in the text. Please indicate where it should be cited; or delete from the Reference List.	
18	AUTHOR: Please provide the volume number for reference Wolf (2004).	

WILEY-BLACKWELL

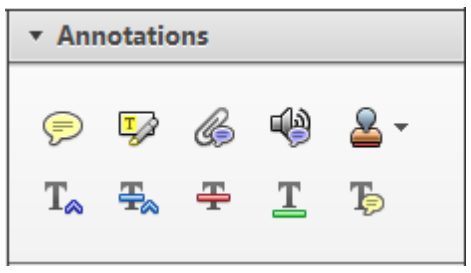
USING e-ANNOTATION TOOLS FOR ELECTRONIC PROOF CORRECTION

Required software to e-Annotate PDFs: Adobe Acrobat Professional or Adobe Reader (version 7.0 or above). (Note that this document uses screenshots from Adobe Reader X)
The latest version of Acrobat Reader can be downloaded for free at: http://get.adobe.com/uk/reader/

Once you have Acrobat Reader open on your computer, click on the Comment tab at the right of the toolbar:



This will open up a panel down the right side of the document. The majority of tools you will use for annotating your proof will be in the Annotations section, pictured opposite. We've picked out some of these tools below:

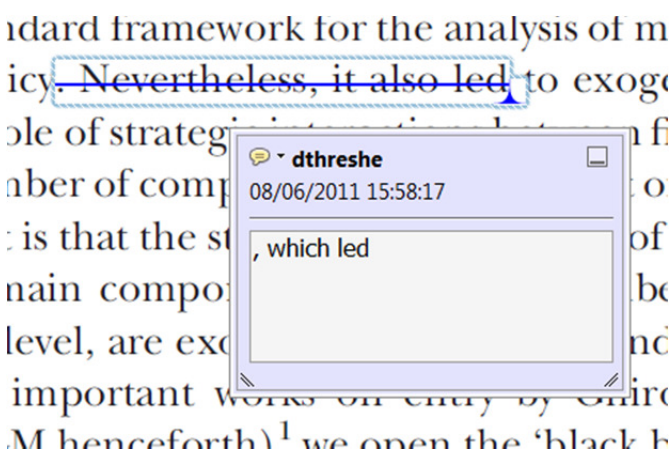


1. Replace (Ins) Tool – for replacing text.

Strikes a line through text and opens up a text box where replacement text can be entered.

How to use it

- Highlight a word or sentence.
- Click on the Replace (Ins) icon in the Annotations section.
- Type the replacement text into the blue box that appears.

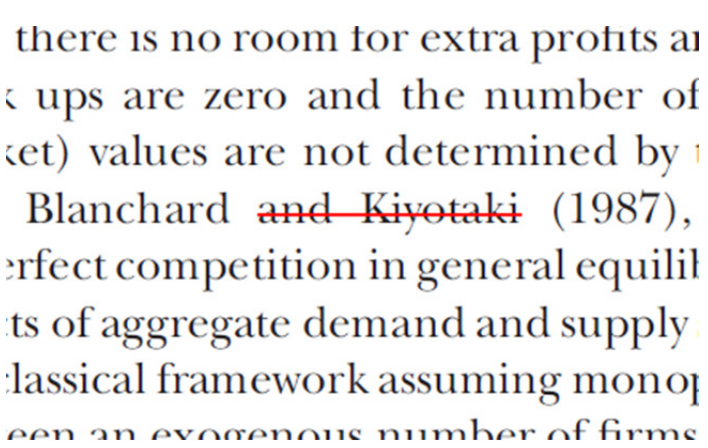


2. Strikethrough (Del) Tool – for deleting text.

Strikes a red line through text that is to be deleted.

How to use it

- Highlight a word or sentence.
- Click on the Strikethrough (Del) icon in the Annotations section.

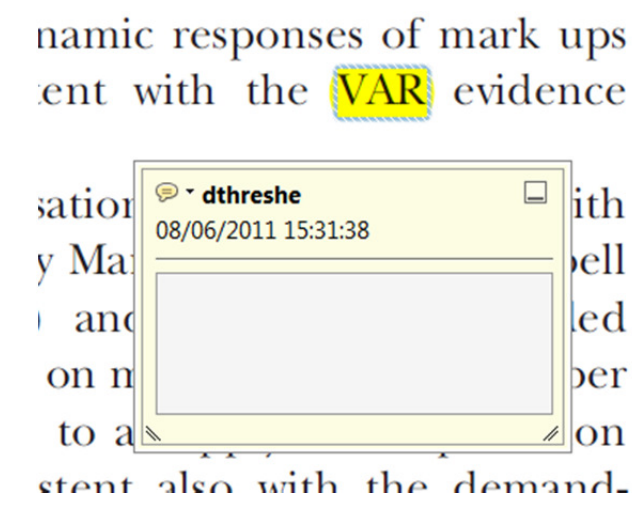


3. Add note to text Tool – for highlighting a section to be changed to bold or italic.

Highlights text in yellow and opens up a text box where comments can be entered.

How to use it

- Highlight the relevant section of text.
- Click on the Add note to text icon in the Annotations section.
- Type instruction on what should be changed regarding the text into the yellow box that appears.

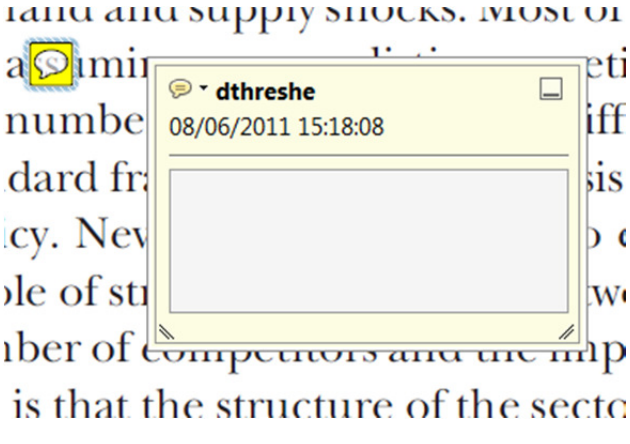


4. Add sticky note Tool – for making notes at specific points in the text.

Marks a point in the proof where a comment needs to be highlighted.

How to use it

- Click on the Add sticky note icon in the Annotations section.
- Click at the point in the proof where the comment should be inserted.
- Type the comment into the yellow box that appears.



WILEY-BLACKWELL

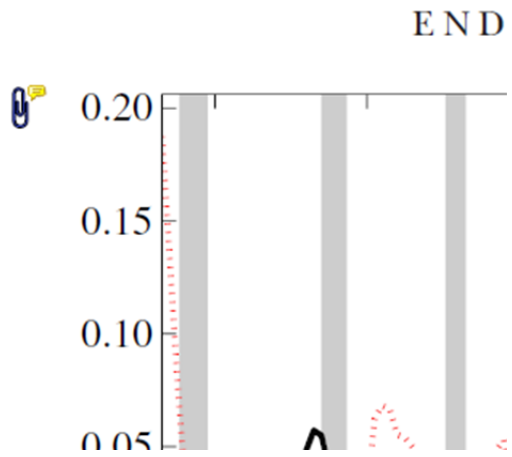
USING e-ANNOTATION TOOLS FOR ELECTRONIC PROOF CORRECTION

5. Attach File Tool – for inserting large amounts of text or replacement figures.

Inserts an icon linking to the attached file in the appropriate pace in the text.

How to use it

- Click on the Attach File icon in the Annotations section.
- Click on the proof to where you'd like the attached file to be linked.
- Select the file to be attached from your computer or network.
- Select the colour and type of icon that will appear in the proof. Click OK.

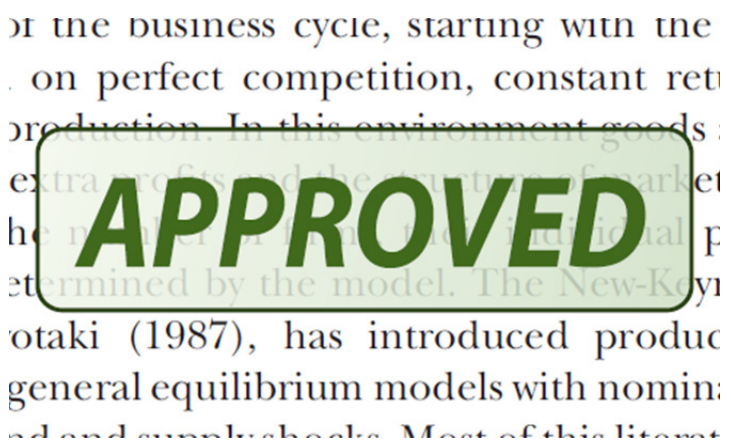


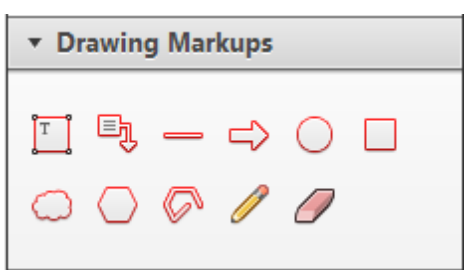
6. Add stamp Tool – for approving a proof if no corrections are required.

Inserts a selected stamp onto an appropriate place in the proof.

How to use it

- Click on the Add stamp icon in the Annotations section.
- Select the stamp you want to use. (The Approved stamp is usually available directly in the menu that appears).
- Click on the proof where you'd like the stamp to appear. (Where a proof is to be approved as it is, this would normally be on the first page).



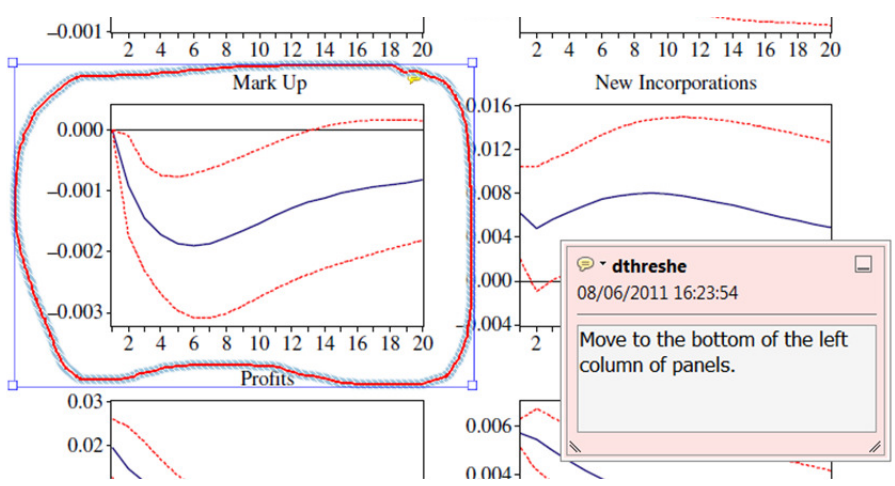


7. Drawing Markups Tools – for drawing shapes, lines and freeform annotations on proofs and commenting on these marks.

Allows shapes, lines and freeform annotations to be drawn on proofs and for comment to be made on these marks..

How to use it

- Click on one of the shapes in the Drawing Markups section.
- Click on the proof at the relevant point and draw the selected shape with the cursor.
- To add a comment to the drawn shape, move the cursor over the shape until an arrowhead appears.
- Double click on the shape and type any text in the red box that appears.



For further information on how to annotate proofs, click on the Help menu to reveal a list of further options: