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REVIEW

Spiritual care provision to end-of-life patients: A systematic literature review

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Abstract

Aim: To develop an understanding of how nurses provide spiritual care to terminally ill patients in order to develop best practice.

Background: Patients approaching the end of life (EoL) can experience suffering physically, emotionally, socially and spiritually. Nurses are responsible for assessing these needs and providing holistic care, yet are given little implementable, evidence-based guidance regarding spiritual care. Nurses internationally continue to express inadequacy in assessing and addressing the spiritual domain, resulting in spiritual care being neglected or relegated to the pastoral team.

Design: Systematic literature review, following PRISMA guidelines.

Methods: Nineteen electronic databases were systematically searched and papers screened. Quality was appraised using the Critical Appraisal Skills Programme qualitative checklist, and deductive thematic analysis, with a priori themes, was conducted. Results Eleven studies provided a tripartite understanding of spiritual caregiving within the a priori themes: *Nursing Spirit (a spiritual holistic ethos)*; *the Soul of Care (the nurse-patient relationship)*; and *the Body of Care (nurse care delivery)*. Ten of the studies involved palliative care nurses.

Conclusion: Nurses who provide spiritual care operate from an integrated holistic worldview, which develops from personal spirituality, life experience and professional practice of working with the dying. This worldview, when combined with advanced communication skills, shapes a relational way of spiritual caregiving that extends warmth, love and acceptance, thus enabling a patient's spiritual needs to surface and be resolved.

Relevance to clinical practice: Quality spiritual caregiving requires time for nurses to develop: the personal, spiritual and professional skills that enable spiritual needs to be identified and redressed; nurse-patient relationships that allow patients to disclose and co-process these needs. Supportive work environments underpin such care. Further research is required to define spiritual care across all settings, outside of hospice, and to develop guidance for those involved in EoL care delivery.

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KEYWORDS

communication, end-of-life care, holistic care, literature review, nurse–patient relationship, nursing care, palliative care, spirituality

1 | INTRODUCTION

The experiences associated with terminal illness can be physical, for example dyspnoea and nausea, but also emotional, for example depression, social, for example disconnection, and spiritual, which includes deep inner questioning and wrestling (National Institute for Health and Care Excellence [NICE], 2004). The spiritual domain within the biopsychosocial-spiritual whole is recognised as having increased significance for the terminally ill and those approaching the end of life (EoL). Unmet spiritual concerns or needs can lead to distress and unnecessary physical and emotional suffering (Edwards, Pang, Shiu, & Chan, 2010). Assessing spiritual needs and providing spiritual support is considered essential for quality EoL care: nationally (National Palliative and End of Life Partnership [NPEoLP], 2015), internationally (World Health Organization, 2018) and professionally (e.g. American Nurses Association, 2015; Nursing and Midwifery Council, 2018).

Nurses witness spiritual suffering first-hand and, through the nurse–patient relationship, are appropriately placed to provide spiritual care (SC; Clarke, 2013). Palliative and EoL guidelines highlight the importance of spirituality (Leadership Alliance for the Care of Dying People [LACDP], 2014; NPEoLP, 2015). Similarly, professional standards (NMC, 2018) and nursing theory (Biro, 2012; Clarke, 2009; McEvoy & Duffy, 2008) recognise the importance of the spiritual domain. However, nurses, and other healthcare professionals, are given little practical guidance on delivering spiritual care “at the bedside” (Holloway, Adamson, McSherry, & Swinton, 2011; Sinclair, Bouchal, Chochinov, Hagen, & McClement, 2012, p. 325). Of the biopsychosocial-spiritual domains, nurses, consequently, are least consistent and confident in caring for the spiritual domain (Biro, 2012). Nurses, in the United States (US) at least, provide spiritual care infrequently, but many do not conduct initial spiritual screening assessments (Taylor, Mamier, Ricci-Allegra, & Foith, 2017). Furthermore, 87% of advance cancer patients reported never receiving any spiritual care from nurses (Balboni et al., 2013). This may, however, be representative of the nurse–patient mismatch in spiritual care perceptions and expectations (Ross, 2006).

The confusion, a widespread “conceptual muddiness” (Taylor et al., 2017, p.30) surrounding spirituality and spiritual care, hinders nurse understanding, perceptions and provision (Ramezani, Ahmadi, Mohammadi, & Kazemnejad, 2014). According to Clarke (2009), postmodern definitions, seeking to separate themselves from religion, have incorporated existential elements and generated broad definitions causing confusion with psychosocial aspects. No universal definition could be generated by McSherry and Cash (2004) in their literature review, positing that this ambiguity hindered correct understanding and care for the spiritual domain.

According to Taylor et al. (2017), the definition of spiritual care is too broad; sometimes indistinguishable from basic nursing caring and psychosocial care (such as listening), and, thereby, impairing the ability to research it. They found spiritual care had become equated with the assessment and support of a patient's religion and, according to Selby et al. (2016), had relegated spiritual care to chaplaincy. Numerous spiritual perspectives within a multicultural society can further compound the complexity; spiritual care may differ by context, culture and situation (Ramezani et al., 2014). Gisberts et al., (2019, p.25) propose that spiritual care in palliative care:

Means that caregivers pay attention to spirituality, which includes hope. They try to be present, to empower and to bring peace to patients and patients' relatives. Spiritual care includes creative, narrative, and ritual work.

Despite the conceptual muddiness, spiritual care has long been considered to be part of a nurse's role (Ross, 2006). Nurses acknowledge their responsibility in providing spiritual care: 92.6% (3,722) agreed in the United Kingdom's (UK) largest national nursing survey on spirituality and spiritual care (McSherry & Jamieson, 2011). However, 79% agreed or strongly agreed that nurses do not receive sufficient training in this aspect.

This review is guided by a tripartite understanding of humans as comprising spirit, soul and body (Radmacher, Allen, & House, 1997; Weger & Wagemann, 2015): inseparable and integrated, shaping, influencing and comprising the whole person. When viewed as three concentric circles, traditionally *spirit*, as the central circle, enabled connection to the Divine (Radmacher et al., 1997) and has become identified as an individual's unique inner essence, energy and driver (McSherry, 2006) that enables connections to others (Clarke, 2013). *Soul*, the middle concentric circle, has traditionally been defined as the mind, will and emotions, and the *body*, the outer concentric circle, as the material (Weger & Wagemann, 2015) or physical corporal body (Radmacher et al., 1997), interacting with and interpreting the physical world (Clarke, 2013). Holistic nursing recognises the tripartite nature of humans, with health being balance and harmony between the elements, and disease being a lack of balance and harmony (Malinski, 2002).

Renetzky's (as cited in Ross, 1996, p.38) widely used definition of the spiritual dimension is used to guide this review:

The need to find meaning, purpose and fulfilment in life, suffering and death. The need for hope and the will to live. The need for belief and faith in self, others and a power beyond self or God as defined by the individual.

1.1 | Aim

The aim of this review is to develop an understanding of how nurses provide spiritual care to terminally ill adult patients, when spiritual need is potentially the greatest, by identifying the literature on nurses' experiences of providing spiritual care.

2 | METHODS

2.1 | Design

A systematic literature review was conducted, using Preferred Reporting Items for Systematic Review and Meta-Analyses (PRISMA) guidelines (see Appendix S1, PRISMA, 2019).

2.2 | Search strategy

Search terms were developed based on the key words in the research question, their synonyms and similar concepts found in relevant literature: "nursing care", "nursing intervention", "nurs*", "nurses", "spiritual*", "spiritual care", "spiritual comfort", "spiritual distress", "spiritual well-being", "spiritual support", "palliative care", "palliative", "terminal care", "end of life", "terminal", "terminally ill", "experience", "view", "perspective" and "thought". Medical Subject Headings (MeSH) and truncated keywords were used to search databases, combined using Boolean operators, AND/OR, see Table 1. Searches were limited to English language and adults.

Searches were conducted between September–October 2017, and updated in March 2019. Nineteen relevant databases were searched: (MEDLINE, Embase, PsycINFO, Social Policy and Practice (Ovid), CINAHL, ProQuest Nursing and Allied Health, ProQuest Dissertations and Theses Global, ProQuest SciTech Collection, Applied Social Sciences Index and Abstracts [ASSIA], ProQuest Sociological, ProQuest Social Science, ProQuest Biological Sciences, ProQuest International Bibliography of the Social Sciences, The Allied and Complementary Medicine [AMED], ATLA Religion, Web of Science, Cochrane Database of Systematic Review, Cochrane Trials and Anthropology Plus. Identified papers were imported to

Refworks for de-duplication and were screened based on inclusion and exclusion criteria (Table 2).

2.3 | Quality appraisal

Methodological quality was assessed using the Critical Appraisal Skills Programme (CASP) Qualitative Checklist (2017), by EB and NH. None were excluded from the review based on the appraisal because no tested or accepted method for excluding qualitative research exists (Thomas & Harden, 2008).

2.4 | Data extraction

A data extraction tool was developed to collect data on design, data collection and analysis, sample including ethnicity, setting and key findings. The first author extracted data, and this was checked by a second author.

2.5 | Synthesis

Framework synthesis (Sniltveit, Oliver, & Vojtkova, 2012) was conducted to organise the results into the tripartite understanding of humans as comprising spirit, soul and body. Findings within the framework were sorted into subthemes. Data that did not fit the conceptual framework were examined to identify further themes. Comments from non-nursing staff were not included in the synthesis. Coding strategies and subthemes were cross-checked between two authors to maximise rigour.

3 | RESULTS

3.1 | Search outcome

Database searching yielded 1,049 potential studies for review. Eleven studies were identified following the selection process shown in Figure 1, including two identified by hand-searching.

TABLE 1 Search terms

Population	Context	Context	Outcome
Nursing care ^b or nursing care	Spiritual ^a	Palliative care ^b or palliative care	Experience ^a
Nursing intervention	Spiritual care	Palliative	View ^a
Nurs ^a or exp nursing staff or exp nursing	Spiritual comfort	Terminal care ^b or terminal care	Perspective ^a
Nurses ^b or nurses	Spiritual distress	"End of life"	Thought ^a
	Spiritual well-being	Terminal	
	Spiritual support	Terminally ill ^b terminally ill	

^aDenotes truncation.

^bMeSH term exploded.

Inclusion	Exclusion
Adult patients	Family, carers, spouse or patients <18years
Registered nurses' perspective	Other perspectives: doctors, chaplains, nonregistered nursing staff, patients, family
Experience of spiritual care provision	Nurse's spirituality or personhood
Primary aim: spiritual care	Primary aim: not spiritual care Existential care Comfort care Hope Spiritual encounters Minor theme: spiritualcare
End-of-life, palliative or terminally ill patients	Not end-of-life or not palliative patients or not terminally ill
Primary research	Case reports, reviews, commentaries
Qualitative and mixed methods with rich qualitative data	Quantitative
Papers published in peer-reviewed journals	Unpublished theses, papers not published in peer-reviewed journals
English language	Not English language

TABLE 2 Inclusion and exclusion criteria

The 11 studies were qualitative in design, see Table 3, using the following methods of data collection: eight semi-structured interviews (one of which formed part of an ethnographic design), two descriptive surveys and one of recorded conversations. Of these, 10 reflected the views of hospice nurses and one, oncology nurses attending a conference. Of the 380 participants the following professions were represented palliative care nurses (363), oncology nurses (57), palliative care nurse consultants (10), hospice nursing assistants (2), and hospice volunteer, bereavement counsellor, medical officer, doctor; and priest (all 1). Four studies originated from the US, two from Australia and one each from New Zealand, Republic of Ireland, Uganda and the UK. Limited demographic and spiritual orientation was supplied. Apart from Kale (2011) whose participants were all "of Ugandan decent," three studies identified the nurses as Caucasian with an additional one identifying nurses by national identity/origin. Three studies (Kale, 2011; Keall, Clayton, & Butow, 2014; Minton et al., 2018; Pittroff, 2013) identified, and one (Belcher & Griffiths, 2005) implied the nurses' predominant religious/spiritual identify as Christianity. Carroll (2001) differentiated between nurses who have a belief in God/universe and those who are agnostic/atheists. Ellington et al. (2015) provided the religious/spiritual identity of the patient families as Christian or Mormon. One study (Minton, Isaacson, Varilek, Stadick, & O-Connell-Persaud, S., 2018) identified the researchers' religious heritage as Christian and one study (Pittroff, 2013) identified the researcher as a lay minister in a Christian denomination.

3.2 | Study quality

The studies varied in overall quality, three were rated *poor*, four *fair* and four *good* (Table 4). There were several major weaknesses; nine studies gave no information regarding the researcher-participant

relationship where possible power imbalances could introduce bias within data collection or analysis. The sample recruitment of five studies was judged *poor* and six *fair* due to their convenience samples possibly not generating the most appropriate data. Apart from the surveys, the sample sizes of the studies were small, ranging from 5–22 nurses.

3.3 | Findings

Results are organised into the tripartite conceptual framework: *Nursing Spirit* (a spiritual holistic ethos), *the Soul of Care* (the nurse–patient relationship) and *the Body of Care* (nurse care delivery). No new themes were identified from the data. These constituents portray the relational and spiritual caregiving process that imbues love, meaning and value which facilitates the discovery and processing of a patient's spiritual needs and stresses.

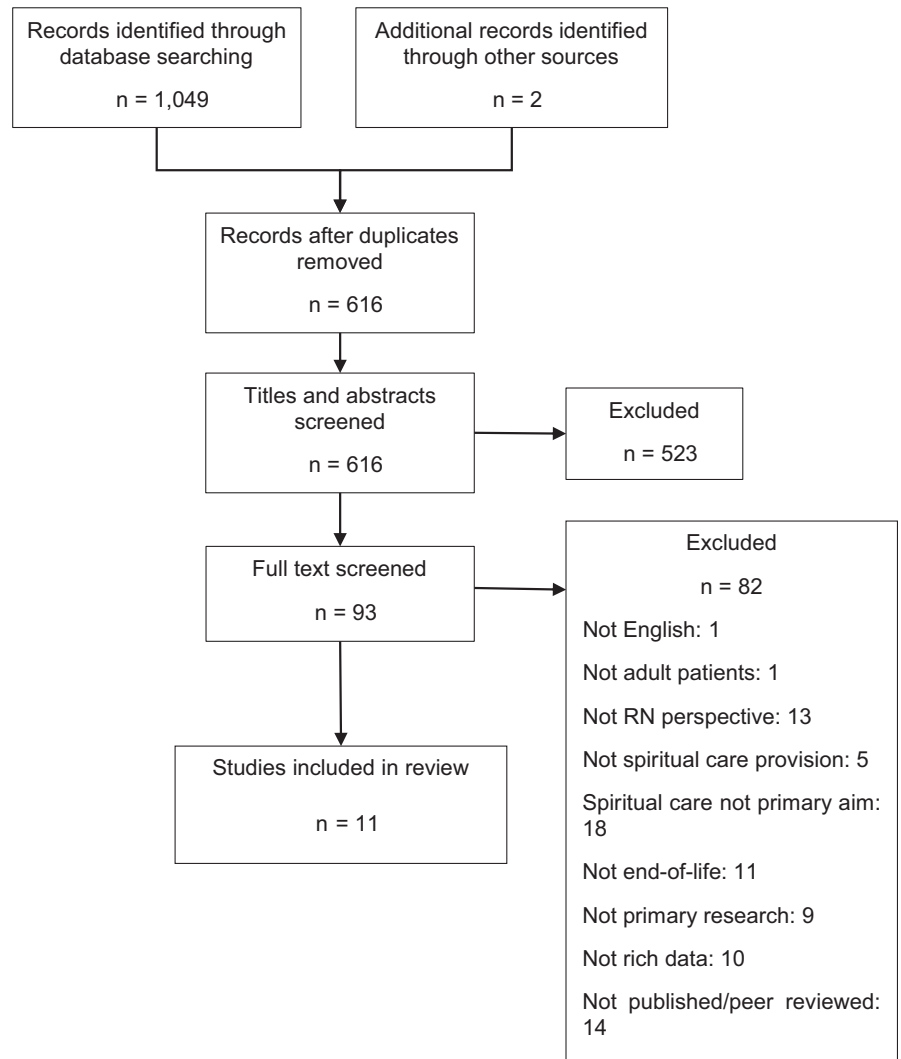
3.3.1 | Nursing spirit: a spiritual holistic ethos

This theme conceptualises the spirit, or the innermost essence and ethos, of the nurse who values and seeks to holistically care for the terminally ill as a whole person rather than viewing the biopsychosocial-spiritual domains separately (Clarke, 2013). This developed holistic ethos shaped and prioritised their care (Bailey, Moran, & Graham, 2009; Belcher & Griffiths, 2005; Carroll, 2001; Minton et al., 2018; Pittroff, 2013).

Spiritually integrated holism

Spirituality is considered to be integrated within all nursing care, influencing and infiltrating all aspects of an individual's biopsychosocial-spiritual being thus increasing the difficulty in its assessment

FIGURE 1 PRISMA flow diagram



and care (Bailey et al., 2009; Carroll, 2001; Keall et al., 2014; Walker & Waterworth, 2017). Physical pain, for example, was viewed as potentially having physical, spiritual and psychological components:

A young single father... went to theatre, open and close. He was riddled with cancer. His pain relief kept escalating without any effect. We sat down and talked... and got him to tell his story... and his needs for opiates actually decreased significantly (Keall et al., 2014, p.3201)

There was diversity in nurses' personally unique understanding of spirituality (Bailey et al., 2009; Belcher & Griffiths, 2005; Carroll, 2001; Kale, 2011; Pittroff, 2013; Walker & Waterworth, 2017; Wittenberg, Ragan, & Ferrell, 2017). This included concepts of transcendence, purpose, meaning and values, and related to, but different from religion (Bailey et al., 2009; Carroll, 2001; Kale, 2011); interconnectedness with ourselves, others and God/universe (Carroll, 2001; Kale, 2011); the inner self/essence (Carroll, 2001); and conversely equated with

religion in Uganda (Kale, 2011): "I guess it's [spirituality] that there's something greater than me, a power or life force" (Bailey et al., 2009, p.43), "My spirituality is the meaning I would give to my life," (p.43) and "Spirituality means the essence of my being" (p.44).

The synthesised findings suggest cultural religious context shapes nurse views on spirituality and care, such as the Ugandan study: "I think spirituality is the way somebody believes in God, how they relate to God, which... can relate to all areas that are surrounding one's life." (Kale, 2011, p.178).

Shaped and developed

Participants believed this integrated ethos to be developed and shaped first by personal understanding and practice of spirituality (Bailey et al., 2009; Belcher & Griffiths, 2005; Carroll, 2001; Kale, 2011; Minton et al., 2018; Pittroff, 2013; Walker & Waterworth, 2017; Wittenberg et al., 2017). One nurse frequently prayed for wisdom and discernment prior to meeting patients: "So to really ask questions, trying to pull out what's important to them" (Minton et al., 2018, p.178).

TABLE 3 Description of included studies

Author (year)	Sample, ethnicity and setting	Aim	Design, data collection, data analysis
Bailey et al. (2009)	22 nurses in specialist palliative care <i>No ethnicity information provided</i> One hospice; Catholic environment, Republic of Ireland	To identify and describe palliative care nurses' experiences of delivering spiritual care in an Irish context	Qualitative description Semi-structured interviews (tape-recorded), field notes Thematic content analysis
Belcher and Griffiths (2005)	204 hospice nurses $n = 194$; (95%) Caucasian; 9 states: 1 per region; U.S.A.	To determine the extent to which hospice nurses personally express spiritual values and integrate spiritual care into their role	Descriptive approach using qualitative techniques Previously used two-part survey: demographic data and 15 open-ended questions Descriptive statistics, thematic content analysis
Carroll (2001)	13 hospice nurses and 2 hospice nursing assistants <i>No ethnicity information provided</i> 1 hospice, U.K.	To find the meaning of spirituality and spiritual care through the direct experiences of nurses caring for patients with advanced cancer	Heideggerian heuristic phenomenological approach Semi-structured interviews (recorded), journal notes Thematic content analysis
Ellington et al. (2015)	5 nurses from 2 hospices caring for 7 patients with spouses/partners $n = 5$; 100% Caucasian; Patients' homes in 1 city, U.S.A.	To identify naturally occurring, spiritually relevant conversations and elucidate challenges for nurses in home hospice	Qualitative pilot study 33 digitally recorded conversations between nurse and patients and family caregivers on home visits Thematic content analysis using predefined spiritual care categories and definition of spirituality
Harrington (2006)	10 registered nurses and 1 volunteer, 1 bereavement counsellor and 1 medical officer <i>No ethnicity information provided</i> 1 hospice, Australia	To develop a better understanding of spiritual caring in relation to a previous masters' model	Qualitative interpretive ethnography Field notes from researcher following RNs and assisting in care, extensive setting descriptions, diary entries and documentation, interviews Four-phase thematic analysis
Kale (2011)	15 palliative care workers: 13 nurses, 1 doctor and 1 Catholic priest $n = 15$ (100%) Ugandan descent 3 hospices, Uganda	To examine how spiritual care is perceived in an African context	Exploratory phenomenological study Semi-structured interviews Thematic analysis
Keall et al. (2014)	20 palliative care nurses <i>No ethnicity information provided</i> Various practice locations, New South Wales, Australia	To investigate the facilitators, barriers and strategies that Australian palliative care nurses identify in providing existential and spiritual care for patients with life-limiting illnesses	Qualitative study Semi-structured interviews (digitally recorded): 10 in-person, 10 by telephone Inductive thematic analysis
Minton et al. (2018)	10 experienced palliative/hospice nurses 100% Caucasian 1 faith-based health system (5 rural, home-based, 5 urban, hospice) in South Dakota, USA	To describe experienced urban and rural palliative care nurses' communication strategies in providing spiritual care to patients and families at end of life.	Qualitative narrative descriptions from a larger multi-method study Semi-structured interviews (3 lead-in questions, audio recordings, field notes) Thematic analysis

Key findings	Overall quality rating
<p>Spirituality is considered a key attribute to care with each nurse having a unique, but common understanding. Nurse experience and intuition also play a significant role.</p> <p>A trusting nurse–patient relationship is needed for patient openness about needs.</p> <p>Complexities surround identifying, measuring and meeting spiritual needs. Time is viewed as essential.</p>	Fair
<p>Nurses had a strong personal spirituality related to church participation and were comfortable in spiritual caregiving.</p> <p>The hospice environment had helped to develop a strong sense of responsibility for spiritual care.</p> <p>Their knowledge base of spiritual care (SC) needs developed from hospice, some relationships, life experience and self-directed learning -- little from nursing education.</p>	Poor
<p>Nurses own exploration of spirituality aided their care and was viewed as integral to all aspects of care.</p> <p>Spiritual needs were difficult to assess; mainly identified by observation and patient communication. A trusting nurse–patient relationship is essential.</p> <p>Nurses met spiritual distress by providing space, presence, silence and physical care that fostered hope for a peaceful death.</p>	Fair
<p>99 spiritual-related, mainly brief dialogue over 22 visits; most frequently introduced (66%) and transitioned to another topic (48%) by nurses.</p> <p>Nurses' approaches varied: disclosing personal experience, sharing a personal belief, using open and closed-ended questions, checking for understanding, providing suggestions and active listening. Authors cited professional boundary issues.</p> <p>Key themes discussed: spiritual beliefs and rituals, family connections, spiritual comfort; closure and acceptance and spiritual distress.</p>	Good
<p>New model (<i>Their space</i>) generated: nurses and other professionals enter the patient's world to determine the needs through dialectic conversations, to care altruistically and to provide connection: the foundation of SC.</p> <p>The patient and family become central with the professional carers forming an outer ring. Spiritual caring is about accommodating the patient and family's world. Primary nursing enhances the nurse–patient relationship.</p>	Good
<p>Spirituality was significantly influenced by cultural perspectives and rarely distinguished from religion.</p> <p>SC included praying with those of different faiths and addressing existential, financial and practical needs, which may be particularly important in an under-resourced nation.</p> <p>Staff were comfortable with major religions, but uncomfortable with traditional indigenous beliefs, particularly witchcraft and cursing.</p>	Poor
<p><u>Facilitators:</u> The nurse–patient relationship; “walking alongside,” and practicing “presence.”</p> <p>Essential communication skills: active listening; being open, genuine and self-aware; allowing silence; showing compassion and empathy; body language.</p> <p>Nurse SC strategies: making appropriate referrals, maintaining realistic expectations, setting the scene for deeper conversations, taking counselling courses, documenting discussions for care continuity and spiritual conversation openers.</p>	Good
<p><i>Sentience</i> as primary theme with three subthemes: a) the nurse's willingness and courage to address deeper issues; b) being fully present when deeper issues surface; and c) having insight on how to proceed.</p> <p>Their ability and willingness differentiated their care from normal practices. Assessment was continuous and facilitated by their communication practices: simple questions, attentive to hints. Care goal was not to provide answers, but to support.</p> <p>These pivotal moments were seen as potentially transformative, easing spiritual distress.</p>	Good

(Continues)

Author (year)	Sample, ethnicity and setting	Aim	Design, data collection, data analysis
Pittroff (2013)	10 inpatient palliative care nurse consultants <i>No ethnicity information provided</i> Inpatient care, Midwest, U.S.A.	To explore how inpatient palliative care nurse consultants provide spiritual care and how they acquired these skills	Interpretive phenomenological study Thematic analysis Semi-structured interviews (recorded): 2 per participant
Walker and Waterworth (2017)	9 palliative care nurses 5 New Zealand, 3 British, 1 American-European 3 large hospices in culturally diverse populations, New Zealand	To explore palliative care nurses' experiences providing spiritual care to their patients who are facing a life-limiting illness	Qualitative, descriptive design Semi-structured interviews Thematic analysis
Wittenberg et al. (2017)	57 oncology nurses from 38 states; 61.4% from Western U.S.A. <i>No ethnicity information provided</i> One 2-day communication training course, U.S.A.	To explore the spiritual care experiences of oncology nurses to learn more about nurse communication involving spirituality	Qualitative, descriptive survey Summary of one account of patient and/or family communication about spirituality, including the nurse's response and whether the nurse shared his/her own spiritual beliefs Inductive, iterative thematic analysis

Second, this spiritually integrated ethos was shaped by personal life experiences of loss and illness (Belcher & Griffiths, 2005; Carroll, 2001; Ellington et al., 2015; Keall et al., 2014).

Cindy (nurse): 'Well, I've had surgery, chemotherapy, radiation. I understand the side effects, the feelings, the anxieties, and the fears. I think that just helps me relate to patients and the families... My illness also strengthened my faith, because I had a lot of prayer at that time, I was baptized at that time. So I think I kind of went through a transformation during my cancer treatment that increased my faith and strengthened it (Pittroff, 2013, pp.4-5)

Thirdly this ethos was shaped by professional care experiences and development (Bailey et al., 2009; Belcher & Griffiths, 2005; Carroll, 2001; Keall et al., 2014; Pittroff, 2013; Wittenberg et al., 2017). The hospice setting was considered significant in developing this ethos, particularly nurse confidence and competence (Belcher & Griffiths, 2005). Inadequacies of the nurses' education programmes were identified, with many of the participants in the study by Belcher and Griffiths (2005) and all from Pittroff's (2013) having undertaken self-directed studies, counselling courses or attended conferences. Only participants in Harrington's (2006) study found their education in spiritual care to be of only limited importance due to all team members willing to offer spiritual care.

I did a 3 day (an expert in grief counselling) course that really opened my eyes. I went from a nurse that

wanted to fix things to letting things unfold (Keall et al., 2014, p.3202)

Finally, the bi-directional nature of the nurse-patient relationship was considered to further develop a nurses' caring capacity and ability (Pittroff, 2013; Wittenberg et al., 2017).

3.3.2 | The soul of care: the developing nurse-patient relationship

This spiritually integrated essence or ethos of the nurse permeates and thus influences the "soul of care": the nurse's thinking, will and desire to provide truly holistic care. This motivates the nurse to connect, establish and develop a genuine nurse-patient relationship.

I take a deep breath outside of the room. I try to set aside wherever I've been and walk in that room calmly, sit down, make eye contact, and make it personal for them (Minton et al., 2018, p.177)

Connection, rapport, trust

All studies suggest spiritual caregiving is predicated on a developing patient-centred process, which seeks to know the patient holistically, prioritising and adapting all biopsychosocial-spiritual care accordingly. Participants identified the necessity of establishing a connection and/or rapport (Bailey et al., 2009; Carroll, 2001; Harrington, 2006; Keall et al., 2014; Minton et al., 2018; Pittroff, 2013; Walker & Waterworth, 2017; Wittenberg et al., 2017) and trust (Bailey et al., 2009; Belcher & Griffiths, 2005;

Key findings	Overall quality rating
<p><i>Humbled servants</i> describes the nurses' personhood and SC: a subject-to-subject stance, enabling mutual care. SC considered integral to holistic care; developed mainly through life experience, religious practice, nursing experience, continuing education, growing spiritual awareness and ability to accept without judging.</p> <p>Nurses' etiquette: hospitality, support, presence, nonjudgement and recognition of gift and grace. SC through ordinary acts: presence, courage, silence and touch.</p>	Poor
<p>3 main categories: recognition of spiritual distress, SC provision and documentation</p> <p>Spiritual distress: none used assessment tools but genuine questioning through nurse-patient relationship; difficult to define and detect; intuition used.</p> <p>SC provision regarded by all as an important nursing role and the nurse-patient relationship essential. SC: rapport; meaningful conversations; love and care through touch, gentleness and specialised individual care; appropriate referrals; tailored to the patient; a nurse's own spirituality; meaningful touch and presence consciously given; sitting and suffering with the patient.</p>	Fair
<p>Communication about spirituality primarily initiated by patients, commonly at end of life (EoL) or when experiencing spiritual distress; engaging in these conversations with patients was considered essential to quality EoL care.</p> <p>About 1/3 shared own personal spiritual/religious backgrounds; sharing experiences strengthened the nurses' faith.</p> <p>Nurse communication skills identified to develop nurse-patient relationship and facilitate spiritual discussions, resulting in positive patient engagement.</p>	Fair

Carroll, 2001; Kale, 2011; Keall et al., 2014; Pittroff, 2013; Walker & Waterworth, 2017) for deeper conversations triggered by death anxiety. The 20 palliative care nurses in Keall et al. (2014) study represented a cross section of years of experience, work, work location and spiritual beliefs; a majority prioritised building rapport, trust and the nurse-patient relationship for providing spiritual care.

The initial part is about rapport building.... and people can open up a little bit more each time...slowly over a number of visits you'll get to know who that person is (Keall et al., 2014, p.3199)

Phrases used to describe this process include "journeying with," "being with" or "standing alongside." Nurses come alongside to relate and support rather than focused on performing tasks (Bailey et al., 2009; Carroll, 2001; Harrington, 2006; Keall et al., 2014; Minton et al., 2018; Pittroff, 2013; Walker & Waterworth, 2017). "So there is only so much I can do. I can only walk beside it, I can't change it" (Keall et al., 2014, p.3200).

The studies suggest a nurses' caring manner and communication skills can facilitate this relationship. Key attributes nurses believed to enable spiritual caregiving include nonjudgementalism (Carroll, 2001; Harrington, 2006; Keall et al., 2014; Minton et al., 2018; Pittroff, 2013), empathy and acceptance (Belcher & Griffiths, 2005; Carroll, 2001; Harrington, 2006; Pittroff, 2013), respect (Belcher & Griffiths, 2005; Carroll, 2001; Walker & Waterworth, 2017) and compassion (Carroll, 2001; Keall et al., 2014; Walker & Waterworth, 2017). Participants believed showing compassion and empathy, by acknowledging the patient's circumstances and fears, strengthens the therapeutic relationship (Keall et al., 2016).

The New Zealand study (Walker & Waterworth, 2017, p.21), although small, described many of the nine palliative care nurses as having a strategy for developing connections with spiritual or humanistic patients by demonstrating a genuine desire to care and by identifying and respecting a patient's beliefs: "Spiritual care for me is identifying for the individual what is meaningful for them, what matters to them" and "I think spiritual care is respecting a person's belief system, no matter what that belief system is." None of the studies mentioned the need for or suggest strategies for patients with a different spiritual viewpoint from themselves although some studies mentioned nurse discomfort with patient or family beliefs or practices that differed from their own (Belcher & Griffiths, 2005; Carroll, 2001; Kale, 2011; Keall et al., 2014; Walker & Waterworth, 2017). In one U.S. study (Belcher & Griffiths, 2005) where 71% of respondents held regular religious practices, nurses reported experiencing discomfort or distress when attempting to care for and comfort patients who held distressing religious/spiritual views, such as not being forgiven by God, or who had no religious affiliation. Concern was also raised by nurses within the Irish hospice about the cultural and religious context of daily mass influencing patient choice (Bailey et al., 2009). Nurses within the Ugandan study (Kale, 2011) seemed to equate spirituality with religion and were comfortable in meeting the needs of Christians and Moslems, but not those of indigenous faiths.

3.3.3 | Body of care: the nurse care delivery

This spiritually integrated essence or ethos of the nurse permeates and thus influences the nurse's thinking and care delivery. This, in

turn, leads to the development of a genuine nurse–patient relationship where the nurse's practical expressions of care and professional skills lead to spiritually integrated, holistic care.

Meaningful care acts and interactions

Nurses give their care in a spiritual manner by conveying love, compassion and understanding through meaningful, consciously given, interactions and care acts (Bailey et al., 2009; Belcher & Griffiths, 2005; Carroll, 2001; Pittroff, 2013; Walker & Waterworth, 2017; Wittenberg et al., 2017), such as painting a patient's nails for a special occasion (Walker & Waterworth, 2017), playing special music or providing massage (Carroll, 2001). Meaningful, therapeutic touch was considered to give strength, life and love (Bailey et al., 2009; Belcher & Griffiths, 2005; Carroll, 2001; Pittroff, 2013; Walker & Waterworth, 2017; Wittenberg et al., 2017), and to ease fears and pain (Walker & Waterworth, 2017, 0.22).

I think it's how you carry out the physical care that gives the person the trust to open up to you, how you handle them, how you are gentle with them, the time you might take and when you are finished with the physical care you take the time to do it with the person and talk to them just to allow them the time and presence for that time ... I'm a nurse and there's the patient, but there's a person and I'm a person I'm here, I love this work so I just allow it to happen (Bailey et al., 2009, p.44)

For these nurses, such fully focused, meaningful physical care was viewed as something deeper that is spiritual because of the meaning given to and received by the patient.

Detecting spiritual needs: key communication skills and techniques

Observational skills (Bailey et al., 2009; Belcher & Griffiths, 2005; Carroll, 2001; Keall et al., 2014; Walker & Waterworth, 2017; Wittenberg et al., 2017) and intuition (Bailey et al., 2009; Carroll, 2001; Keall et al., 2014; Minton et al., 2018; Walker & Waterworth, 2017) were identified as enabling the nurse to detect patient behaviour change indicative of unresolved spiritual concerns or fears. Participants in Bailey et al.'s (2009) study identified that patients refrained from speaking about their spiritual concerns:

I just think somebody sleeping, somebody crying, somebody very cross, very withdrawn, very depressed and down, that is how they are dealing with their disease, their eminent decline or eminent death ... it's being aware when spiritual needs manifest themselves (Bailey et al., 2009, p.46)

Similarly, another nurses found that "sometimes you might meet someone and you just get the sense that they have this overwhelming pain, not a physical pain; a spiritual distress" (Walker & Waterworth, 2017, p.21).

The studies suggest spiritual assessment tools, such as FICA (Faith or Beliefs, Importance or Influence, Community, Address) and SPIRIT (Spiritual belief system, Personal spirituality, Integration with a spiritual community, Rituals and restrictions, Implication and Terminal events) (Holloway et al., 2011) are rarely used. This was raised by Walker and Waterworth (2017); five of the nine nurses were unaware of tools, and whilst one nurse used the Sources of Hope, Organised religion, Personal spirituality and practices, Effects on medical care and End of Life (HOPE) tool, she shared concerns about tools leading to a checklist approach which could dehumanise care. Around 80% of participants in one study questioned the ability to measure spirituality or use an assessment tool due to patient individuality (Bailey et al., 2009), whilst in another, "some" (undefined by researchers) participants stated they used a tool and some relied on the chaplain's assessment (Belcher & Griffiths, 2005).

There's no 'one' patient, they all have their own stories, some of them remarkable, but I don't know whether you can use a tool to bring forward the whole concept of spirituality. I think a tool would be a guideline, but I think we have to remember it's not for all our patients. (Bailey et al., 2009, p.46)

Detecting and assessing spiritual needs was considered complex by some because of the uniqueness of each patient, of the suffering involved, of the individual nurse and of their relationship (Walker & Waterworth, 2017). One nurse sensed spiritual distress when patients voiced, for example: "not making sense," "why me?," "why now?" (Walker & Waterworth, 2017, p.20). This complexity results in patient's spiritual needs not always being recognised and possibly being given inappropriate treatment (Walker & Waterworth, 2017).

I mean if we are not recognising it as spiritual distress then you just think they are agitated and often give them midazolam. I think we don't always give it much thought (Walker & Waterworth, 2017, p.21)

Verbal and nonverbal communication skills, as discussed below, were considered necessary to initiate and/or facilitate spiritual discussions, enabling needs to surface and be discovered; these discussions were considered essential to quality EoL care (Wittenberg et al., 2017) and required revisiting (Minton et al., 2018). Nurses in the studies by Ellington et al. (2015) and Walker and Waterworth (2017) also considered it their duty to prepare patients for death and initiated sensitive conversations accordingly; this enabled practical decisions and uncovering hidden spiritual needs. Simple questions, such as "Is there anything bothering you, anything that you're fearful of?" were used iteratively to gently probe for any concerns (Minton et al., 2018, p.176). Keall et al. (2014) study also generated a list of opening questions. Recordings of community hospice nurses revealed spiritually related conversations; nurses initiated these conversations more often than patients yet were more likely to change the subject (Ellington

et al., 2015). Conversely, Wittenberg et al. (2017) found that patients or families were most likely to initiate spiritual discussions.

Verbal therapeutic communication skills were identified in all studies. These included asking questions (Belcher & Griffiths, 2005; Carroll, 2001; Harrington, 2006; Keall et al., 2014; Minton et al., 2018; Walker & Waterworth, 2017), clarifying responses (Bailey et al., 2009; Ellington et al., 2015; Harrington, 2006; Keall et al., 2014; Walker & Waterworth, 2017; Wittenberg et al., 2017), affirming and acknowledging fears, emotions, concerns and beliefs (Ellington et al., 2015; Keall et al., 2014; Minton et al., 2018; Walker & Waterworth, 2017), responding to patient-initiated questions (Ellington et al., 2015; Walker & Waterworth, 2017), and providing suggestions (Ellington et al., 2015).

A nurse described an encounter with a dying patient who denied any spiritual practices or needs, yet the patient elaborated poetically to the nurse on the meaning of a tree in a field he had plowed. The nurse recalled: "I listened. I encouraged him to explore the meaning of this spiritual experience which obviously brought him peace and protection" (Wittenberg et al., 2017, p.569)

The studies suggest that nurses responding to patient stress resulted in patient positive outcomes; Wittenberg et al. (2017, p.570) found 95% of the narratives reported positive "behavioural and emotional outcomes," such as a patient enabled to fall asleep, for patients and families when nurses engaged with them regarding "religious, spiritual or existential concerns."

Nurses sometimes shared from their own spiritual beliefs or background in response; about one-third of nurses reported doing so in Wittenberg et al.'s (2017) study. One nurse in Pittroff's (2013, pp.5–6) study cautioned against "self-disclosure" unless it served the patient's interests. An examination of recorded home visits noted some crossing of professional boundaries in this regard, but in the one cited example, the nurse shared the same faith as the patient/family (Ellington et al., 2015).

Attentive listening was reported as essential in identifying needs, facilitating discussions and creating a safe environment to process and voice concerns (Bailey et al., 2009; Belcher & Griffiths, 2005; Carroll, 2001; Ellington et al., 2015; Harrington, 2006; Keall et al., 2014; Minton et al., 2018; Walker & Waterworth, 2017; Wittenberg et al., 2017).

It's important to know, where the people you are caring for are at spiritually. It's important to stop and listen. To talk if need be. But sometimes it's just important to just be with the patient. You're not there to do things to a patient. You are there to listen. You are there to let them say things to you which they need to get off their chest (Walker & Waterworth, 2017, p.22)

Time/making time or appropriate timing for interventions was considered another key skill in allowing the opportunity to engage

in discussions about spiritual care (Bailey et al., 2009; Carroll, 2001; Ellington et al., 2015; Kale, 2011; Keall et al., 2014; Minton et al., 2018; Walker & Waterworth, 2017; Wittenberg et al., 2017): having time, for instance, to hold someone's hand at 4 a.m. for comfort (Bailey et al., 2009), to provide the meaningful care acts previously discussed and to build the nurse-patient relationship (Walker & Waterworth, 2017); taking time by slowing care and speech patterns that allow pauses (Wittenberg et al., 2017), which enables a patient time to process and "say something" (Minton et al., 2018, p.178); taking time to sit down or accept "an unwanted cup of tea to show you mean to stay awhile" (Keall et al., 2014, p.3202) and assisting patients and families with the timing of spiritual/religious interventions, such as when to call the priest (Ellington et al., 2015);

If the patient wants to talk at that point that is when you have got to talk, you can't leave it until tomorrow, because that window of opportunity might never come again (Carroll, 2001, p.91)

Time constraints were a clear challenge for spiritual caregiving (Bailey et al., 2009; Kale, 2011; Keall et al., 2014; Walker & Waterworth, 2017), and sometimes these "windows of opportunity" are lost.

We are opening more and more beds so you need to have the appropriate staff-patient ratio so you don't get lost in 25 dressings and 20 syringe drivers ... and we don't have time to sit and listen to people (Bailey et al., 2009, p.45)

The use of silence/silent presence was identified by participants (Bailey et al., 2009; Belcher & Griffiths, 2005; Carroll, 2001; Harrington, 2006; Keall et al., 2014; Minton et al., 2018; Pittroff, 2013; Walker & Waterworth, 2017; Wittenberg et al., 2017): "being with the individual in a physical, psychological and spiritual sense" (McSherry, 2006, p.156), which conveys "love and kindness" (Walker & Waterworth, 2017, p.22). Such *presence* enables patients to share and process fears and strengthens the nurse-patient relationship (Minton et al., 2018; Walker & Waterworth, 2017). The use of presence and time was seen as essential; "sitting with" and "witnessing" a patient's pain was considered to "create solidarity, comfort and enhance rapport" (Walker & Waterworth, 2017, p.22).

He came and he knew he was dying. For two nights the nurses had trouble because he was on his knees praying; to me he was trying to absolve himself. I spent a lot of the night with him; sitting next to him. It was horrible but I had to do it (Walker & Waterworth, 2017, p.22)

Documentation challenges possibly hindering team communication and continuity of care were considered (Carroll, 2001; Keall et al., 2014; Walker & Waterworth, 2017). Variability in team

TABLE 4 Summary of CASP critical appraisal

Study	Clear research aim	Qualitative methodology appropriate	Research design appropriate	Recruitment strategy appropriate	Data collection appropriate	Researcher-participant relationship considered	Ethical consideration	Data analysis	Findings: clear statement	Value	Overall rating
Bailey et al. (2009)	Good	Good	Fair	Poor	Fair	Poor	Fair	Good	Fair	Fair	Fair
Belcher and Griffiths (2005)	Good	Good	Fair	Fair	Poor	Poor	Fair	Poor	Poor	Poor	Poor
Carroll (2001)	Good	Good	Good	Poor	Fair	Poor	Poor	Fair	Fair	Fair	Fair
Ellington et al. (2015)	Good	Good	Good	Fair	Good	Good	Good	Good	Good	Good	Good
Harrington (2006)	Good	Good	Good	Fair	Fair	Poor	Good	Good	Poor	Good	Good
Kale (2011)	Good	Good	Fair	Poor	Poor	Poor	Fair	Poor	Poor	Fair	Poor
Keall et al. (2014)	Good	Good	Poor	Fair	Poor	Poor	Fair	Poor	Fair	Good	Good
Pittroff (2013)	Fair	Good	Fair	Poor	Fair	Fair	Fair	Fair	Poor	Fair	Poor
Walker and Waterworth (2017)	Good	Good	Good	Fair	Fair	Poor	Fair	Fair	Fair	Fair	Fair
Wittenberg et al. (2017)	Good	Good	Poor	Poor	Poor	Poor	Poor	Fair	Fair	Fair	Fair

members' documentation or completion (Keall et al., 2014; Walker & Waterworth, 2017), confidentiality concerns (Keall et al., 2014) and challenges in documenting or measuring this abstract, highly subjective domain were mentioned (Carroll, 2001; Keall et al., 2014) as well as the belief that such documentation was not read or valued (Walker & Waterworth, 2017). Several nurses believed that spiritual care documentation may enable evaluation of care and a patient's progress and even inspire other nurses or team members to consider using the same or different resources or approaches.

Documentation of spiritual wellbeing and care might inform or even give a measure for the nurse as to where that person is going. Is it getting better? Or is it getting worse?' Spiritual care documentation may also encourage the PCN [Palliative Care Nurses] to consider the use of additional spiritual care resources and do we need to ask another person to help us out? Maybe another person from the --multidisciplinary team (Walker & Waterworth, 2017, p.24)

Insufficient documentation may result missing essential information (Keall et al., 2014) and result in inadequate or inappropriate care.

Meeting specialised needs: practices and specialist providers

Spiritual care includes facilitating the patient's spiritual or religious practices; prayer, including offering prayer, was the most frequently cited practice (Bailey et al., 2009; Belcher & Griffiths, 2005; Ellington et al., 2015; Harrington, 2006; Kale, 2011; Minton et al., 2018; Walker & Waterworth, 2017; Wittenberg et al., 2017). In the Ugandan study (Kale, 2011), prayer was considered a universal language that could be initiated by and offered to anyone of any faith and was said at the end of each home visit. Within the context of a more secularised society, two nurses in the New Zealand study (Walker & Waterworth, 2017) participated in prayer: one offering, the other (described as nonreligious) listening, "It might be important for a person to pray. I'm not a religious person but I could sit with someone and listen to their prayers" (Walker & Waterworth, 2017, p.23).

I can remember having lengthy discussions with him, and praying with him. I felt that perhaps what he was asking for was the miracle of healing and what he was being given was the opportunity for the miracle of peace (Carroll, 2001, p.94)

Of interest, all nine respondents in Walker and Waterworth's (2017) study believed spiritual care extended postmortem; they continued to talk to and care gently for the patient as if he/she were alive and practiced personal spiritual practices such as opening a window for the soul, lighting a candle and praying.

I'll talk to them when I'm laying them out ... sometimes, if I go into the room after they have gone and

the rooms resting, I can still feel them ... I'd say something like, "Oh! I'm just going to open the window to let them out", I can still smell them, I can still feel them (Walker & Waterworth, 2017, p.24)

Referring patients to specialist providers, such as chaplains or social workers, was one approach used (Belcher & Griffiths, 2005; Carroll, 2001; Keall et al., 2014; Minton et al., 2018; Pittroff, 2013; Walker & Waterworth, 2017). This approach was viewed by many of the palliative care nurses as the priority strategy for meeting spiritual/existential needs in an Australian study (Keall et al., 2014). Referrals were considered a part of the collaborative and mutually beneficial team approach in hospice work (Belcher & Griffiths, 2005). One nurse reported that her working with the chaplain had enabled her to act as a substitute chaplain to families when he was unavailable (Pittroff, 2013).

I think they forget how vital it is [spiritual care]. You can't manage spiritual pain with midazolam. You need an expert. We have doctors on call but what about the other stuff? We need the chaplain; even if it's advice over the phone (Walker & Waterworth, 2017, p.23)

However, one nurse within Belcher and Griffiths' study (2005) did express the desire for all disciplines to recognise their ability to assist a patient spiritually without immediate referral to chaplaincy.

4 | DISCUSSION

The aim of this review was to develop an understanding on how nurses provide SC to terminally ill patients in order to facilitate good practice. For the terminally ill, nurses aim to holistically provide care that extends warmth, love and value to the patient and deepens the nurse–patient relationship through meaningful, loving and fully present care (Carroll, 2001). Such care is considered spiritual in itself and creates a spiritual nurse–patient connection. The professionals' use of therapeutic communication skills facilitates the discovery of and working through the unmet spiritual needs and stresses that may be negatively impacting the patient's well-being. These needs may require the nurse to assist in specific spiritual or religious practices or to seek other professionals for specialised care.

In this review, the nurses embraced a spiritually integrated holism (Carroll, 2001; Keall et al., 2014; Minton et al., 2018; Walker & Waterworth, 2017), which Holloway et al. (2011, p.32) describe as a "whole person-synergy." This caring-as-a-whole for a patient-as-a-whole worldview engenders his/her desire to "come along side," connect, know and holistically support a terminally ill patient. This finding contrasts somewhat with some literature that indicates the primary motivator for nurses arises from their developed personal self-, spiritual- and transcendental- awareness (Baldacchino, 2006) and from the desire to alleviate suffering (Giske & Cone, 2015). Although holistic care has long been advocated in nursing, medical care has fractionalised the individual biopsychosocial-spiritual

components and demoted spirituality (Baldacchino, 2006; McEvoy & Duffy, 2008). When compared to acute care nurses, palliative care nurses, comprising the majority of this review's participants, appear to better integrate the spiritual aspect (Ronaldson, Hayes, Aggar, Green, & Carey, 2012), thus truly caring for the patient as a whole (McEvoy & Duffy, 2008).

The bi-directional nature of the nurse–patient relationship was identified in this review. Spirituality is considered inherently relational and involves relationships with self, God, others and nature, and it is connection and relationships that gives patients meaning (Edwards et al., 2010). This underscores the essence of spiritual care, which is relational and patient-, not task-, focussed. Nurses in this review considered physical care given in a spiritual manner – that is, by conveying love, compassion and understanding through meaningful, consciously given, interactions and physical, practical acts – as spiritual care. Likewise, Sinclair et al. (2012) found that the manner of physical care could have a therapeutic effect, positively affecting a patient's well-being and spiritual domain when given in a manner conveying acceptance, respect, love and compassion. Spiritual care may be defined as any care that is "meaning-centred and therapeutic" (Ramezani et al., 2014).

Quality palliative care requires the "impeccable" assessment of patient's psychological, social and spiritual needs (WHO, 2018). The variability of definition (Edwards et al., 2010), the crossover between spiritual and psychological concerns and the complexity of nurses discerning spiritual concerns corroborates other findings and indicates the necessity of further research and education of nurses to clarify the concepts of spirituality, spiritual care, spiritual needs and appropriate assessment methods and skills. The informal nature of nurses' assessments in this review presents the possibility of missing a spiritual need and treating it inappropriately as a physical one. Impeccable assessment also implies appropriate documentation for team communication and continuity of care; however, this review highlighted the inconsistent nature of nursing documentation due to confidentiality issues, an insufficient language to express this subjective domain (Abbas & Dein, 2011), and the complexities in distinguishing spiritual causes of behaviour from physical or psychological ones (Edwards et al., 2010).

Although policies and guidelines necessitate spiritual care provision (e.g. LACDP, 2014), they provide no practical guidance on assessing or implementing such care. Whilst there is promotion of spiritual assessment tools in the US, the UK practice norm is based on the practitioner's ability to intuitively sense spiritual needs. Developed through experience, intuition forms a vital part of a nurse's decision-making ability (Stinson, 2017). However, provision of spiritual care training in nursing education is often lacking, meaning that nurses resort to undertaking self-directed learning, counselling courses or further professional development on an ad hoc basis (Belcher & Griffiths, 2005; Keall et al., 2014; Pittroff, 2013). This inadequate education can generate frustration when nurses are unable to alleviate spiritual suffering (Baldacchino, 2006). The multifaceted nature and complexity of processing these deeper needs may require referral to other professionals, such as chaplains, who have

the more advanced exploratory counselling skills and perhaps the emotional capacity to contain the patient's distress. Whilst nurses understand the need for referral (McSherry & Jamieson, 2011), many healthcare professionals simply pass off spiritual care to the pastoral team (Selby et al., 2016). Broadening multi-professional responsibility for spiritual care was, in fact, found to be the primary aim of spiritual care training (Paal, Helo, & Frick, 2015).

Holloway et al. (2011, p.35) suggest that competencies and standards were needed to enable registrants and practitioners to provide basic, nonspecialised SC; these included understanding its significance, identifying spiritual needs and the potential for and skills of effective interventions.

SC training may clarify and normalise SC, enabling nurses and other healthcare professionals to confidently support patients and communicate their care within the multidisciplinary team (Paal et al., 2015). Furthermore SC training can have a positive effect on participants' own spiritual well-being (Holloway et al., 2011).

Whilst educational developments and SC competencies may be yet to be defined and established, the nurses in this review demonstrated a willingness to enter another's world and pain and co-journey a patient's process. Whilst SC practicalities may yet to be established and may seem unattainable within the demands of every day nursing, Ross and McSherry (2018, p.79) have introduced a two-question spiritual/holistic assessment model (2Q-SAM): "What is most important to you now? How can we help?" The authors suggest that these two questions can enable nurses to provide SC or "care that is spiritual" (Ross & McSherry, 2018, p.80), by identifying and meeting a patient's foremost need at each nurse-patient encounter: whether the need is physical, psychological, social or spiritual at that time. The 2Q-SAM model may enable nurses to focus on what's truly important to the patient without the additional need of checklists, care plans or differentiating the domains; thus, empowering the patient and making care co-produced and truly person-centred.

4.1 | Strengths and limitations

To minimise bias from the researcher, the following methods were employed: a methodical, systematic approach in selecting the papers and rechecking the selections; critiquing the papers using a recognised critical appraisal tool; undertaking a thorough, methodical and iterative coding of themes and thematic analysis; maintaining a research journal; and verifying queries with the researcher's supervisor. Reflexivity was also practiced to reduce bias from a Judeo-Christian worldview and resulted in a second ordering of themes more representative of the results.

Application of the tripartite understanding of humans in the synthesis may have introduced bias; however, no new themes were identified from the data. This could reflect reviewer bias, that is that the reviewer overlooked themes grounded in the data, or it could be that the data confirm the conceptual framework.

A majority of the studies were conducted within a majority or all-Christian context, which influences a nurse's SC view. The

different research perspectives on spirituality between the US, UK and across Western Europe, combined with a lack of transcultural understanding on spirituality practice and experience, potentially inhibits SC in multicultural societies.

The review's focus on the palliative care nurse perspective reflects the potential bias across SC and nursing research. However, nurses in all settings potentially provide such care, and developing a broader understanding and practices applicable in all care environments is necessary for enabling nurses to provide SC for terminally ill patients.

5 | CONCLUSION

Spiritual needs, concerns and fears are known to increase at EoL, potentially escalating to spiritual distress and causing unnecessary suffering and pain. However, the spiritual domain is considered the least integrated, assessed and understood within nursing care. As the frontline carers, nurses face the immediacy of their patients' pains and struggles, and as caring, compassionate professionals, they are often responsible for holistically assessing and caring for them. However, disentangling the spiritual element from the whole and discerning and caring for spiritual needs is particularly complex. Nurses report deficiencies in their initial nursing education, require more training, understanding and professional guidance to identify and provide spiritually. Yet deficiencies lie in the system: a lack of an agreed nursing approach, evidence-based interventions and tools. Research is needed to clarify these subjects, to develop a consensus in SC and to reveal the lived experience of nurse provision in order to evaluate such care and train others. This systematic review sought to show the unique nurse perspective on spiritually caring for the terminally ill in any location. The spirit, soul and body of spiritual caregiving for palliative care nurses aligns with previous findings: SC is a relational spiritual caregiving process imbuing love, meaning and value to patients whilst facilitating the discovery and processing of spiritual needs. Further research is required to discover how non-hospice nurses are providing SC and whether hospice-type spiritual caregiving can be adapted to fit within mainstream care.

6 | RELEVANCE TO CLINICAL PRACTICE

Truly holistic nursing incorporates and integrates the spiritual domain of care, particularly for patients at the EoL. Individual practitioners, at all levels of experience and expertise and work environments, should be encouraged to develop their own awareness of, ability and remit to provide SC. SC should not be equated with religious accommodation, but borrowing from the palliative nurse ethos, nurses should realise they can provide focussed, meaningful care interactions that convey acceptance, understanding and compassion. Working within their level of competence, nurses can address these spiritual issues or seek further assistance from more advanced practitioners or professionals. Nurses' holistic assessments should consider the spiritual domain and its possible relation to any physical or

emotional pain and suffering. Nurses should not be afraid of broaching spiritual concerns, but be willing to have the conversation with the patient and/or family, be willing to develop their communication or therapy skills and be willing to seek further help.

If holistic care is the vision, then appropriate plans to progress us to this vision are required. More policies advocating holistic or spiritual provision are not the answer. A vision without the appropriate path to attainment only results in a superficial, hypocritical, holistic mantra that places yet another unrealistic expectation and frustration upon often-demoralised nurses who are already trying to meet too many goals.

CONFLICT OF INTEREST

The authors declare no conflict of interest in regard to this study.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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