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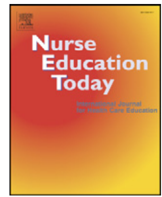

Nurse education and willingness to provide spiritual care

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SUMMARY

Background: Spiritual care is a critical part of holistic care, and nurses require adequate preparation to address the spiritual needs of patients. However, nurses' willingness to provide such care has rarely been reported. Hence, nurses' education, and knowledge of spiritual care, as well as their willingness to provide it require further study.
Methods: A convenience sample of 200 nurses participated in the study. Quantitative data were collected using a 21-item Spiritual Care Needs Inventory (content validity index = .87; Cronbach's alpha = .96).
Results: The majority of participants were female (96.5%, n = 193) between 21 and 59 years old (mean = 35.1 years). Moreover, the majority of participants had a Bachelor's degree (74.0%, n = 148) and 1–36 years of clinical experience (mean = 12.13 years). Regarding religious beliefs, 63 (31.5%) had no religious belief, and 93 (46.5%) did not engage in any religious activity. Overall, the nurses were willing to provide spiritual care, although only 25 (12.5%) felt that they had received adequate education.
Conclusion: The findings of this study indicate the need for further educational preparation in spiritual care for nurses. Specifically, additional teaching materials are required that are more directly related to spiritual care. Greater emphasis should be placed on different subject areas in school-based education, continuing education, and self-learning education according to the needs of nurses. Since spiritual care education needs policy support, in-depth discussions should take place regarding the approach and cultural environment for providing spiritual care in future nursing courses. Moreover, further studies should investigate barriers in providing spiritual nursing care to patients and whether they are the results of a lack of relevant knowledge or other factors.

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Introduction

Spiritual care is a critical area of holistic care and is generally considered as a part of the quality of care. Nurses require adequate preparation to address the spiritual needs of their patients (Timmins et al., 2015). Clinical nurses must attend to their patients day and night, and are responsible for maintaining holistic health and integrity of their patients. Holistic health involves patients' physical, psychological, social, and spiritual needs that are adequately met. Despite the requirement for nurses to provide spiritual care (Attard et al., 2014), relatively few studies have investigated nurses' willingness to provide such care and whether they have sufficient educational preparation if they choose to do so. Therefore, this study investigated clinical nurses' willingness to provide spiritual care and to examine whether the source of spiritual care education could affect their willingness.

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Background

The International Council of Nurses Code of Ethics for Nurses recognises the spiritual aspect of nursing care as a required duty of all nurses (International Council of Nurses, 2012). In addition, Florence Nightingale—the founder of modern nursing—emphasised the need for nurses to honour the psychological and spiritual aspects of patients to promote their health (Macrae, 2001). Because nurses are with patients throughout their daily practice, they are naturally in a position to safeguard their patients' wholeness and integrity (Chan, 2010). Nursing is a practice-based discipline that focuses on people; thus, caring for patients on a daily basis implies that spiritual care cannot be separated from caring for the person as a whole (Tanyi, 2002). Therefore, nurses have an active role in meeting the spiritual needs of their patients.

Literature Review

Rieg et al. (2006) emphasised that all people are spiritual beings with spiritual needs. Selman et al. (2007) conducted a literature review and proposed a model of spirituality comprising the following six

aspects: relationships; religious or nonreligious beliefs, practices, and experiences (e.g., faith in God); spiritual resources (e.g., meaning, purpose); outlook on life and self (e.g., hope, self-worth); outlook on death and dying (e.g., fears, death anxiety); and indicators of spiritual well-being (e.g., peace, feeling in control). Narayanasamy (2001) proposed the following eight spiritual needs: meaning and purpose; love and harmonious relationships; forgiveness; a source of hope and strength; trust; expression of personal beliefs and values; spiritual practices; expression of the concept of God or a deity; and creativity. Various spiritual concerns involved in nursing depend on personal expression of individual nurses to ensure that their provided care can meet patients' needs (van Leeuwen et al., 2006). McSherry and Jamieson (2011) conducted a large online survey on 4054 members of the Royal College of Nursing in the United Kingdom and the study revealed that the most crucial spiritual care needs, ranked according to frequency, were: (1) the need for a source of hope and strength, (2) the need to express personal beliefs and values, (3) the need for spiritual practice and expressions of the concept of God or a deity, and (4) the need for meaning and purpose.

Narayanasamy and Owens (2001) studied 115 nurses in the United Kingdom and found that the concept of spirituality and the role of nurses in providing spiritual care were confusing to nurses. Wu et al. (2012) studied 239 senior nursing students from 22 schools in Taiwan and noted that they were uncertain about the primary principles of spiritual care, such as listening, spending time with patients, respecting patient privacy and dignity, maintaining religious practices, and delivering care with kindness and concern. Timmins et al. (2015) explored the extent to which spirituality and spiritual care concepts were included in core textbooks in nursing education. They concluded that such texts must be strengthened through consistently applying and including spirituality and spiritual care in relevant instructional material. Wu and Lin (2011) found that adequate education could have a positive impact on how spirituality and spiritual care are perceived.

Spiritual care is a fundamental component of high-quality compassionate health care. Moreover, such practices are most effective only when they are recognised and reflected in the attitudes and actions of both patients and health care providers (Puchalski et al., 2014). McSherry and Jamieson (2011) argued that spiritual care is an integral and fundamental aspect of nursing care. Holistic nursing emphasises that spiritual care should not be overlooked (Brennan, 2013). In addition, spiritual care is concerned with the personal caring qualities and attributes of nurses, such as demonstrating care, compassion, cheerfulness, and kindness when communicating and interacting with patients, as well as respecting their privacy and dignity, and supporting them with their cultural and religious beliefs. Previous studies have shown that spiritual care enables patients to appreciate their life, achieve inner peace, and explore coping strategies that can help them overcome crisis situations (Kociszewski, 2003; Lundberg and Kerdonfag, 2010). Spiritual care is delivered through demonstrating care and respect, which can assist patients in regaining a sense of meaning and purpose in life, restoring their faith or trust, and finding hope, love, and forgiveness (Grant, 2004). Deal and Grassley (2012) posited that spiritual care includes various aspects of psychosocial nursing care, such as listening, demonstrating kindness, and treating patients with respect. It can also include organising assistance for patients from spiritual advisors (e.g., chaplains) or sharing spiritual practices (e.g., reading religious texts). Regarding the outcomes of providing spiritual care, Lundberg and Kerdonfag (2010) identified the three benefits of spiritual care as preventing disease, enhancing rapid recovery, and fostering composure. Spiritual care can be a source of strength and comfort for patients, and can alleviate their spiritual distress (Carson, 2011; Deal and Grassley, 2012). Nurses were also aware of the importance of liaising and collaborating with other health care professionals to support patients' spiritual care needs. McSherry et al. (2004) and Baldacchino (2008) also stated that cultural factors should be considered when providing spiritual care. Therefore, nurses must possess fundamental cultural knowledge related to providing spiritual care.

Methods

Design and Sample

The present study adopted a cross-sectional survey design, using convenience sampling, to solicit responses from eligible full-time registered nurses employed at a hospital in Taiwan. The study was explained to all nurses at various nursing department meetings. All on-duty registered nurses who took care of adult patients were invited to participate in the study. Questionnaires were distributed to eligible nurses and they were instructed to fill in the questionnaires and returned to the research assistant at their leisure. Based on a sample size estimation to obtain an effect size of 0.95, a minimum of 134 participants would be required (G Power Version 3.1) (Faul et al., 2009).

Table 1
Basic characteristics of the study participants ($N = 200$).

Variable	*n* (%)
Age (years)	
20–29	83 (41.5)
30–39	43 (21.5)
40–49	55 (27.5)
50–59	19 (9.5)
Mean ± SD (range)	35.1 ± 9.6 (21–59)
Clinical experience (years)	
1–10	117 (58.5)
11–20	31 (15.5)
21–30	42 (21.0)
31–36	10 (5.0)
Mean ± SD (range)	12.13 ± 10.02 (1–36)
Gender	
Male	7 (3.5)
Female	193 (96.5)
Education level	
Associate's degree	15 (7.5)
Bachelor's degree	148 (74.0)
Master's degree	37 (18.5)
Religious belief	
None	63 (31.5)
Have a religion	137 (68.5)
Buddhist	20 (10.0)
Taoist	39 (19.5)
Protestant or Catholic	13 (6.5)
Folk beliefs and others	65 (32.5)
Attending religious activities	
None	93 (46.5)
Yes	107 (53.5)
Regular	21 (10.5)
Occasional	86 (43.0)
Have attended a spiritual care course in nursing school	
Yes	139 (69.5)
No	61 (30.5)
Attended a spiritual care course in continuing education	
Yes	136 (68.0)
No	64 (32.0)
Source of spiritual care education (N = 193)	
School education	11 (5.7)
Continuing education	65 (33.7)
Self-learning education	7 (3.6)
School and continuing education	43 (22.3)
School and self-learning education	1 (0.5)
Continuing and self-learning education	36 (18.7)
School, continuing and self-learning education	30 (15.5)
Have received adequate education	
Yes	25 (12.5)
No	175 (87.5)

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