ORIGINAL RESEARCH

Assessing the Frequency Nurse Practitioners Incorporate Spiritual Care into Patient-Centered Care

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ABSTRACT

Research indicates patient–centered care (PCC) has the potential to enhance patient outcomes and relationships within health care systems. Incorporating spiritual care (SC) into practice is 1 intervention nurse practitioners (NPs) can use to promote a PCC practice model and develop relationships and connections vital to SC. This descriptive study identifies a lack of education on SC as 1 barrier to incorporating SC in NP practice within a PCC model. Concepts for inclusion in education are suggested based on the findings.

Keywords: nurse practitioners, patient–centered care, spirituality, spiritual care
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Spiritual care (SC) has significant implications for nurse practitioner (NP) practice and patient care related to the evolving NP role in the United States health system and patient-centered care (PCC).[1,2] Both PCC and SC emphasize connections and relationships to promote high-level patient care to include patient preferences while supporting patient resources to achieve optimal health.[3,4] NPs are also positioned to contribute to system improvements and cost containment in US health care because of the increasing shortage of primary care physicians (PCPs) and the Affordable Care Act. As more individuals acquire insurance coverage under the Affordable Care Act, more PCPs will be needed.[1-3] NPs are uniquely placed to help fill this gap in primary care using SC within a PCC model based on their advanced education and skill set, sensitivity to mutuality within the nurse-patient relationship, and work within health care systems.[2,3]

BACKGROUND

PCC emphasizes responding to and including individual patient preferences and beliefs to inform clinical decisions.[3,4] This aligns with NP core competencies, which support education on the provider-patient relationship and the development of a trusting culture.[4,5] NP standards of care and education indicate NPs are able to provide PCC while incorporating the patient's spiritual concerns within a plan of care.[4-8]

Religiosity is often described as a communal journey in which members have shared traditions, rituals, and text, with aligned beliefs and values. Spirituality is different; it is often described as an individual journey, promoting relationships with self, others, the environment, and the sacred in order to find meaning and purpose in life.[8-10] It is expressed through one's values and beliefs as well as individual religious or spiritual practices and is the overarching umbrella under which religion is just 1 aspect.[11,12] However, SC is provided by others to support an individual's internal resources during health or illness, promoting healing and optimal health. It is provided through the interpersonal relationship with others.[9,13] Important concepts of SC include a healing presence, therapeutic use of self, patient-centered interventions, and a nonjudgmental attitude.[13,14] Practitioners with a sense of spiritual self-awareness tend to have a heightened awareness of others in need of SC and frequently are more comfortable in initiating related discussions.[13,15,16] Both SC and PCC promote a trusting provider-patient interpersonal relationship and encourage interprofessional collaborations.[13,17]

Practitioners from multiple disciplines identify SC as pivotal to patient care.[14,17-22] The literature supports being spiritually self-aware and being nonjudgmental as facilitating factors to providing SC.[22-24] However, many report several barriers to the provision of such care, including a lack of education, time, a supportive environment, and reimbursement.[15,22] However, SC provided within a PCC model has implications for improved patient well-being, adherence to plans of care, increased health-seeking behaviors, improved patient satisfaction, improved health care systems, and cost containment.[1,16]

This research will address how SC education increases the incorporation of SC into NP practice, focusing specifically on NPs' frequency of recognizing defined cues and behaviors of patients indicating spiritual distress and whether there was further follow-up by the NP once the cues and behaviors were identified. Differences and relationships in the data are addressed.

LITERATURE REVIEW

A lack of education regarding the provision of SC among health care providers has been highlighted in the current literature.[17,19,23,24] Using a qualitative review approach, Vermandere et al[16] identified barriers in the provision of SC among general practitioners (GPs), including a lack of formal training and discomfort in using SC language with patients. Moreover, the authors indicated that patients' willingness to discuss spirituality depended on the GPs' acceptance and respect of other spiritual practices and beliefs, spiritual awareness, and spiritual and cultural alignment within a patient-centered approach to care. Formal education in SC was identified as potentially assisting GPs in increasing the provision of SC, spiritual self-awareness, and PCC. Similar research conducted by Keall et al[23] using a qualitative approach also identified a skill deficit in the provision of SC among Australian palliative care registered and advanced practice nurses. Participants identified being unequipped to facilitate discussions regarding SC, stemming from a lack of education. They suggested further education for nurses as a strategy to ensure this patient concern was met.

Balboni et al[14] identified barriers in the provision of SC among nurses and physicians regarding end-of-life concerns. Seventy-four percent of nurses and 60% of physicians among this sample (N = 322) desired to provide occasional SC to patients; however, 61% of all respondents identified they lacked SC education, making such care difficult to implement. Other identified barriers to providing SC included personal and professional traits, higher religiosity and lower spirituality for nurses, being female, practicing greater than 11 years, and being non-Christian. This research also identified that 75% of nurses and 51% of physicians were less likely to have SC training. Increased education and training in SC may heighten one's own spirituality and spiritual awareness, facilitating and optimizing SC to patients as previously mentioned.

Using quantitative approaches, Zollfrank et al[21] and Attard et al[24] assessed SC education regarding educational interventions and an SC competency tool. The Clinical Pastoral Education for Healthcare Providers intervention implemented by Zollfrank et al taught SC skills to health care providers through this experiential process. Participants included nurses and physicians over a 5-year period. A pre-post methodology using descriptive statistics for analysis indicated participants had an increased frequency of providing both religious and spiritual care, discussing religious and spiritual concerns with patients, initiating religious and spiritual conversations, and praying more with patients. Moreover, participants felt significantly more confident in providing religious and spiritual care and using religious and spiritual language to facilitate such care.

Attard et al[24] assessed SC education and competency using the Spiritual Care Competency Scale. Participants included midwives and nurses from Malta who had participated in an SC study module and midwives who were not participants in this module. There were no significant differences in the means between nurse and midwife study module participants. However, significant differences in means between study module participants and nonparticipants were identified. This proposes that education in SC can potentially make a difference in the competency of providing SC.