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Spiritual care in nursing: an overview of the measures used to assess spiritual care provision and related factors amongst nurses

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Abstract. *Background and aim of the work:* Spiritual wellbeing has important implications for an individual's health and wellbeing. Whilst the provision of spiritual care and assessment of spiritual needs is a vital part of the nurse's role, literature suggests that nurses do not always engage in spiritual care with their patients or assess their spiritual needs. This review aims to ascertain wider reasons for this inconsistent spiritual care delivery by nurses to their patients. *Methods:* A review of the literature was conducted to identify instruments available relating to nursing professionals spiritual care and assessment. *Results:* 14 measures relating to spiritual care and assessment were identified covering the key domains of: 'Beliefs and values and attitudes around spiritual care,' 'Frequency of provision or extent to which they provide spiritual care or willingness,' 'Respondents' level of knowledge around spirituality and spiritual care,' 'Ability to respond to spiritual pain,' and 'Multiple Domains: beliefs and attitudes around spirituality and spiritual care, amount of preparation, training and knowledge, spiritual care practices, perceived ability and comfort with provision and perceived barriers to provision.' *Conclusions:* A lack of standardisation in the conceptualisation and assessment of spiritual care causes challenges in reviewing, however several themes do emerge. In general student and qualified nurses are aware of the importance of providing spiritual care and are hindered by a lack of education about how best to implement such care. The religiosity of individual nurses or their training institutions seems to be of less importance than training in spiritual care interventions. (www.actabiomedica.it)

Key words: spirituality, spiritual care and assessment, nursing

Introduction

There exists a lack of agreement around the definition of spirituality, indeed debate continues within the academic literature around the conceptualisation and definition of both spirituality and religiosity (1). Spirituality has been described as an umbrella term to denote the various meanings and interpretations of the term (2). Within nursing definitions of spirituality have been seen to include elements such as a higher power, feelings of connectedness, purpose and meaning in life, relationships and transcendence (3-5).

Regardless of the way it is defined or conceptualised spirituality is reported to contribute to the health and wellbeing of individuals (6). Spiritual wellbeing is associated with a number of positive outcomes including a greater tolerance of the emotional and physical demands of illness amongst patients (7) decreases in pain, stress and negative emotions (8), and lower risk of both depression and suicide (7). Patients who re-

ceive adequate spiritual care are also reportedly more satisfied with their hospital care and treatment (9).

The reverse appears true for unmet spiritual needs, with suggestion that when patients' spiritual needs are unmet there are seen to be lower levels of satisfaction with care received (10). Unmet spiritual needs appear to have a profound impact upon patient wellbeing (11). These adverse outcomes include reduced levels of quality of life, increased risk of depression and reduction in perceptions of spiritual peace (12).

Subsequently spiritual needs are acknowledged as being an important part of nursing care and assessment, and as such it can be regarded as a patient outcome. Indeed internationally there is growing emphasis on the importance of the spiritual needs of patients (13). Spiritual care is believed to be a major part of the nurse's role (14). This is consistent with the nurse's role as a multifaceted one, focusing on holistic care, incorporating the physical, psychological, social and spiritual needs of patients (15). Research has acknowledged that spiritual distress may occur at any time during the patient's journey and as such nurses should be prepared to provide spiritual care whenever it is needed including via the provision of a spiritual needs assessment (16). It has also been found (17) that nurses were both more likely to provide spiritual care and to contact specialist spiritual carers than physicians.

Despite this, there is evidence that spiritual needs and assessment are not always well engaged with by nursing staff, with suggestion in the literature that engagement with the spiritual needs of patients does not consistently occur (18). A variety of reasons may contribute to this, with the literature proposing various contributors including time pressures (19) and fear around the reaction of the patient to their attempts to aid with spiritual care (20). Cultural and religious differences may also affect ability to provide spiritual care, research (21) has found differences in knowledge of and training in spiritual care between Taiwanese and Mainland Chinese nurses. There is also said to be confusion amongst nurses about their role in spiritual care and assessment (22) a lack of clear definition over spiritual care as well as confusion over spiritual distress can act to make nurses less likely to deliver spiritual care to their patients (14). A perceived lack of skill in the area of spiritual care and of under preparation (23) and lack of confidence may also contribute (1). Indeed nurses often report the need for additional training provision in this area (e.g. 23).

This review intends to outline what measures have been used to examine spiritual care and assessment by nurse health professionals and explore what the literature using these methods tells us about how to increase the quality and quantity of spiritual care delivery.

Method

Searches were conducted using Nursing & Allied Health Database and Science direct databases.

Within the Nursing & Allied Health Database the words 'spirituality' and 'tools or measures or assessment or instruments or scales' and 'nursing' were used as keywords searched within the abstract of articles. Limiters were placed by age such that only results involving adults were returned. It was specified that scholarly journal articles should be returned, written in English. This resulted in 15 hits.

Within the Science Direct search the same words as above were used for search within the abstract of articles, topic requests were highlighted such that results only returned those concerning 'patients' or 'nurse'. Content was again limited to academic journals. This resulted in 362 results

Duplicates were removed and then titles and abstracts of articles were viewed and inappropriate articles discarded. Articles were discarded at this stage if they included assessment of spirituality in child patients, if they did not consider the role of nurses or student nurses in a patient's spirituality. The remaining articles were then viewed in full. Articles met the inclusion criteria if they included within their methodology measures which related to nursing professionals' spiritual care and assessment of patients.

Results

The search identified 14 measures related to spiritual care and assessment and upon examination it appeared they could be largely categorised into the following five domains as detailed below. Further details of the specific scales can be found in Table 1.

Table 1. List of Measures identified in the review and their description and properties

	Measure name	Mode of rating	N items	Dimensions / domains	Psychometrics
1	Spirituality and Spiritual Care Rating Scale (SCCRS) (Mcsherry et al., 2002)	Respondents indicated their agreement to a series of statements via a 5 point likert scale from strongly disagree to strongly agree.	17-item scale	Assesses the beliefs and values of nurses in four areas: Beliefs about spirituality; Beliefs about the way nurses can provide Spiritual care; Beliefs about Religiosity and the expression of religiosity and Beliefs and values around Personalised Care. e.g. items I believe nurses can provide spiritual care by arranging a visit by the hospital Chaplain or the patient's own religious leader if requested" I believe nurses can provide spiritual care by showing kindness, concern and cheerfulness when giving care".	Cronbach's alpha coefficient of 0.64.
2	Student Survey of Spiritual Care (SSSC) (Meyer, 2003)		9 item scale	Assesses students' perceived ability to provide spiritual care, their religious commitment and how much emphasis spirituality was given during their nursing training.	Reliability coefficient of 0.84.
3	The Spiritual Care in Practice (SCIP) (Burkhart & Schmidt, 2012)	5 point Likert scale ranging from "1" never to "5" always	12 items	Assesses how often respondents engage in methods to recognise the cues patients give of spiritual needs and the extent to which they provide spiritual interventions. E.g. When I believe a patient needs spiritual care, I take the time to be present with them	Cronbach's alpha for the tool was .91.
4	The Spiritual Care Inventory (SCI) (Buckhart, Schmidt & Hogan, 2011)	Likert-type ranging from 1 strongly disagree to 5 strongly agree	17 item scale	Measures the nurses' perceived belief of the extent they give spiritual care. Three subscales: spiritual care interventions, meaning making and faith rituals.	Subscale 1: internal consistency reliability of 0•82.
				The first assesses the extent to which respondents' feel that they provide interventions to promote the patients spirituality. E.g. I listen to patients when they are searching for meaning in situations' ' I give patients an opportunity to express spiritual aspects of themselves. Incorporates four items	The second subscale internal consistency reliability of 0•92
				The second subscale Meaning Making considered the reflective practices and meaning making that nurses used following spiritual encounters with patients Reflection helps me find meaning after providing spiritual care ten items	Subscale 3 internal consistency reliability of 0•86
				Subscale 3 Faith Rituals the extent to which the respondents used faith rituals in response to spiritual encounters with patients, 'After providing spiritual care, I find support through prayer'. three items	

(continued)

Table 1 ***(continued).*** List of Measures identified in the review and their description and properties

	Measure name	Mode of rating	N items	Dimensions / domains	Psychometrics
5	Spiritual Care Needs Inventory (SCNI) revised version (Wu, Tseng & Liao, 2016).	Participants responded as to their willingness to provide spiritual care from "willing" "don't know how to provide" and "unwilling."	21 item scale	Measures nurses willingness to provide care of spiritual dimensions. Assessed Willingness to Provide Spiritual Care in two spiritual care domains "Caring and Respecting" and "Meaning and Hope." 7 items formed "caring and respecting" e.g. Listening, accompanying, and providing reassurance," "Providing interaction," and "Respect for privacy and dignity. 14 items formed "Meaning and Hope." E.g. Guidance to find inner peace .	The item-level content validity index (CVI) ranged from 0.82 to 1.00 with an instrument-level CVI of 0.87 and a Cronbach's alpha of 0.96.
6	Spiritual Care Perspectives Scale (SCPS) Highfield, Taylor & Amenta, 2000	Likert scale responses 1-5 e.g. rarely or never to everyday weak or limited to strong, comprehensive ; or 1-4 Check boxes	6 items	The SCPS was developed to examine nurse attitudes, beliefs, practices, perspectives, and preparation regarding spiritual care. Assesses the frequency of providing spiritual care; Ability to provide spiritual care; Comfort level while providing spiritual care; Training/education in spiritual care; Adequacy of training; Influence of cancer/ terminal illness on spirituality.	
7	Spirituality Questionnaire Evaluation Tool (Hoffert, Henshaw, & Mvududu, 2007).	Participants responded to the extent that they agreed with the statement on a 5 point likert scale where 5 indicated a strong level of disagreement.	10 items	Evaluating the Perceived Comfort and Ability of Nursing Students to Perform a Spiritual Assessment: Spirituality Questionnaire Evaluation Tool, Included demographic information and assessing students perceived level of comfort with conducting a spiritual assessment, their perceived ability to perform spiritual assessment, their ability to differentiate between religion and spirituality, and the role of the nurse in spiritual care provision. e.g. " "I feel uncomfortable asking questions related to spirituality".	A value of .74 was found for this tool
8	The Spiritual Care Perspective Scale-Revised (Taylor et al., 1999)	5 point likert scale responses	Ten item scale	Attitude toward spiritual caregiving was quantified	The internal reliability was 0•75.
9	Modification of the Response Empathy Scale (RES; Elliott et al., 1982)	Respondents explained "would be the most spiritually healing response' that they would 'speak in immediate response' to each vignette		Used to assess the extent to which respondents were able to respond in an empathic way to patients' spiritual pain. It involved respondents evaluating written responses to vignette illustrating various patient expressions of spiritual pain	Interrater reliability of 0•86 and 0•82
10	Communicating for Spiritual Care Test (CSCT) (Johnston Taylor et al., 2009).		Scale of 24 items	Assesses the amount of knowledge that respondents have about communication for spiritual care. 24 item reflecting content taught in the intervention programme.	

(continued)

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	Measure name	Mode of rating	N items	Dimensions / domains	Psychometrics
11	The measure: The Spiritual Importance scale (SI)			Assesses students understanding of spiritual issues and how important they perceive them to be based on the content delivered to them on a Spirituality and Clinical Care course	Cronbach coefficients for the SI were .72 at pretest and .74 at posttest.
12	The Nurse Spiritual Assessment Questionnaire (NSAQ) (Johnston Taylor, 2013)	5 response options. Response options were available 'extremely uncomfortable', 'somewhat uncomfortable', 'somewhat comfortable', 'quite comfortable', and 'I don't understand this question'. Likert scale questions Open ended questions	21 items	Ascertained the level of comfort nurses had with asking patients various questions around spirituality as part of their nursing assessment. Comfort around spiritual care delivery Demographic information, Person spirituality and religiosity, perceived importance of spiritual care assessment by nurses and preparedness to conduct spiritual assessment types of spiritual assessment questions nurses use in their current work, what ways they employ with patients to gain spiritually relevant information	
13	Spirituality Scale (Nardi & Rooda, 2011).			The Spirituality Scale is used to identify respondents' level of awareness of spirituality and their use of strategies to address patients' spiritual needs. The questionnaire was formed of three sections. First part was formed of 10 demographic questions. The second part considered personal spirituality and life satisfaction. The final section considered 30 questions on beliefs and values, 15 questions on therapeutic strategies and behaviours	Cronbach's alpha (r = .949)
14	Adaption of Taylor's Nurse Spiritual Care Therapeutics Scale (DeKoninck, Hawkins, & Fyke, 2016).	Short answer and multiple choice questions. 4 point likert scale from strongly disagree, to strongly agree).	41 items	The measure adapted from the Taylor's Nurse Spiritual Care Therapeutics Scale. Demographic information and perceived barriers to the provision of spiritual care in nursing practice were addressed in 15 short answer and multiple choice questions. 26 questions ascertained the spiritual care practices of the respondents	

Beliefs and values and attitudes around spiritual care

1. Spirituality and Spiritual Care Rating Scale (SCCRS) (24), is an instrument developed to assess nurse's individual nurses' beliefs and values about spirituality and spiritual care. The original scale was of 23 items. After a pilot testing on seventy nurses working in surgical wards, the structure was changed to a final of 17 items with answers on a five-point Likert scale. The validation was conducted on a sample of 1029 ward-based nurses and the factor analysis identified four subscales: Spirituality, Spiritual Care, Religiosity and Personalised Care.

Frequency of provision or extent to which they provide spiritual care or willingness

1. The Spiritual Care in Practice (SCIP) (25), is an instrument used to measure the frequency of use of different methods to recognize a patient cue and providing spiritual interventions. It is a survey made of 12 items with answers on a five-point Likert scale. Its psychometric properties were tested on a sample of 78 nurses.
2. The Spiritual Care Inventory (SCI) (26) is an instrument developed to assess spiritual care provision. It was developed starting from a grounded theory study on the provision of spiritual care by nurses that labelled seven categories: recognition of patient cue, decision to engage/not engage in spiritual care, spiritual care intervention, immediate emotional response, searching for meaning, formation of meaningful memory and spiritual well-being. The first version was designed with 48 items with answers on a five-point Likert scale, tested on 298 adults (patients, nurses, general population). After an exploratory factor analysis, a final version of the scale with 17 items was released and tested on 78 adults (nurses and nursing students). It includes three subscales. Spiritual nursing intervention, meaning making, and faith rituals.
3. Spiritual Care Needs Inventory (SCNI) nurses version (27), is an instrument developed to assess nurses' willingness to provide specific aspects of spiritual care. It is based on the 21 items SCNI for patients (28) which identifies two subscales: Caring and Respecting and Meaning and Hope. In this nurses' version, the response categories were changed from "needs" (need, neutral, do not need) to "willingness" (willing, don't know how to provide, unwilling).

Respondents' level of knowledge around spirituality and spiritual care

1. Communicating for Spiritual Care Test (CSCT) (29), is an instrument developed to evaluate the knowledge about how to communicate to provide spiritual care. It is formed of 24 items with true/false answer options on: using personal 'woundedness' for healing purposes; listening to spiritual pain; making sense of what is heard; creating verbal responses to patients' expressions of spiritual pain.

Ability to respond to spiritual pain

1. Modification of the Response Empathy Scale (RES; 30), is an instrument assessing the ability to respond empathically to patient spiritual pain. It is made of three vignettes illustrating different patient expressions of spiritual pain. Respondents are asked to write down verbatim what 'would be the most spiritually healing response' that they would 'speak in immediate response' to each vignette. Each response is rated according to criteria including four items with five point Likert scales: topic centrality, staying 'here and now', choice of words, and exploratory manner. Scores range from 12 (low) – 60 (high empathy).

Multiple domains: beliefs and attitudes around spirituality and spiritual care, amount of preparation, training and knowledge, spiritual care practices, perceived ability and comfort with provision and perceived barriers to provision

1. Spiritual Care Perspectives Scale (SCPS) (31), is an instrument assessing nurse attitudes, be-

liefs, practices, perspectives, and preparation regarding spiritual care. It is made of six items, three of them with a five points Likert scale answer, one with a check list and two with a four points Likert scale answer. It was used to assess spiritual care education in 181 oncology and 645 hospice nurses.

2. Student Survey of Spiritual Care (SSSC) (32), is an instrument developed to assess student's perceived ability to provide spiritual care. It is made of 9 items with a six-point Likert scale answer.
3. Adaption of Taylor's Nurse Spiritual Care Therapeutics Scale (33), is an instrument developed to assess spiritual care barriers and practices. It is made of 15 short-answer and multiple-choice questions about demographics and perceived barriers to spiritual care and 26 questions about spiritual care practices on a 4-point Likert scale answer.
4. Spirituality Questionnaire Evaluation Tool (34), is an instrument developed to assess students' perceived comfort level with and ability to perform a spiritual assessment. It is made of 10 items with answers on a Likert scale. It was validated on a sample of thirty-nine students and assesses three domains: level of comfort related to performing spiritual care, ability to differentiate between religion and spirituality, and the role of nurses in providing spiritual care.
5. The Spiritual Importance scale (SI; 35), is an instrument developed to assess students' understanding of the importance of spiritual issues related to the Spirituality and Clinical Care. It is made of 8 items.
6. The Nurse Spiritual Assessment Questionnaire (NSAQ) (36) is an instrument developed to assess nurses' comfort with asking patients' spiritual assessment questions. It includes 21 items reproduced from North American and British health-care literature advocating spiritual assessment. Response options were ranged from 'extremely uncomfortable' to quite comfortable', including 'I don't understand this question'.
7. Spirituality Scale (37), is an instrument developed to assess the awareness of spirituality and use of nursing strategies to address the patient's spiritual needs. It consists of three sections. The first section contains 10 questions on demographic variables. One open-ended question in the second part eliciting self-exploration about personal spirituality and life satisfaction. The responses to this question are intended to be analysed using qualitative methods. The third section consists of 45 items on a Likert scale relating to the dimensions of spirituality: beliefs, values, therapeutic strategies, and behaviours. These therapeutic strategies and behaviours included the spirituality-focused nursing diagnoses (North American Nursing Diagnosis Association [NANDA]), Nursing Interventions Classifications (NIC), and Nursing Outcomes Classifications (NOC). The first part of this section contains 30 questions on beliefs and values, the second part contains 15 questions on therapeutic strategies and behaviours.
8. The Spiritual Care Perspective Scale-Revised (38) is an instrument developed to assess nurses' attitude towards spiritual caregiving. It includes ten items with five-point Likert response options. It was validated on 638 nurses and factor analysis suggested a uni-dimensional scale. A high score indicates positive attitude toward spiritual care.

Discussion

Reviewing the studies employing the measures outlined above, evidence around willingness to provide spiritual care initially appears to suggest that nurses are generally willing to provide spiritual care. For example, (27) examined nurses' education, knowledge of spiritual care and willingness to provide spiritual care using the Spiritual Care Needs Inventory (SCNI) revised version (27). The domains of spiritual care that were evaluated covered two facets of spiritual care: 'Caring and respecting' and 'Meaning and hope', outlining a total of 21 different spiritual care activities. Nurses were generally willing to provide spiritual care to their patients, in particular in the areas of 'Listening', 'accompanying', and 'providing reassurance'; 'Providing

interaction' and 'Respect for religious and cultural beliefs'.

However, (37) observed that whilst students had a good knowledge of the importance of spiritual beliefs and values in nursing care, a smaller number of students regularly provided spiritual based care. Similarly, (33) in their study of advanced nurse practitioners suggested that whilst around 93% acknowledged that patients do have spiritual needs a much smaller number (around 2 thirds) attempted to engage with spiritual care with patients. It would appear then that whilst nurses and nursing students acknowledge and have an awareness of the spiritual needs of patients and the importance of spiritual care as part of their nursing role, they do not always provide this care to their patients.

Studies examining the willingness to provide spiritual care found that there exist some differences in willingness to provide spiritual care, however the findings appear variable. Whilst (33) found some suggestion that younger nurses were more willing to perform spiritual assessment, others, such as (27) found that age and other nurse characteristics including clinical experience, gender level of education, and personal religiosity did not influence willingness to deliver spiritual care. It was however noted that those who perceived that they had received sufficient training in the delivery of spiritual care felt more willing to provide such care to their patients (27). When considering specific aspects of spiritual care provision, the source of the education appeared important. If respondents had attended spiritual care classes as part of their nurse training they were more willing to perform spiritual care such as "allow spiritual communication" with their patients than those who had not attended such courses at nursing school. Further, those who had undertaken spiritual care training as part of continued professional development were more willing to provide spiritual care such as "guide their patients to find confidence" than those who had not attended such training (27).

(33) found that those who had been trained in spiritual care were more confident to address spiritual needs without specialist support e.g. clergy; and had lower levels of discomfort around provision of spiritual care. (36) reported that respondents' level of comfort in providing spiritual care was not seen to relate to age, years in nursing, religiosity, or spirituality. However interestingly it was also reported that students who perceived spirituality as important were also more likely to be comfortable delivering spiritual care to patients, a finding echoed by (33). (31) in their examination of oncology and hospice nurses found that those that feel patients have a positive impact on their own spirituality were more likely to be comfortable with delivering spiritual care and also more likely to report more frequent delivery of spiritual care. Meanwhile (33) found no association between one's own spiritual beliefs and carrying out of spiritual assessment. It appears that there may be subtle nuances at work, with nurses' level of personal spirituality not contributing, but their perceptions of the importance of spirituality having a role in their comfort in delivering spiritual care.

Level of comfort with delivering spiritual assessment has also been considered. A study of hospice nurses (36) investigated factors associated with the level of comfort hospice nurses have in conducting spiritual assessment. Findings suggested that the nurses were generally comfortable with the types of questions involved in spiritual assessment and they also perceived spiritual assessment to be important. (36) also reported that those who had received training in spiritual assessment were more likely to be comfortable with such assessments as were those who felt that they had been adequately prepared for this aspect of their role.

What does seem apparent is that a number of factors are relevant to spiritual care delivery by nurses. Research has identified several barriers to the provision of spiritual care including time constraints, concern about spiritual care being inappropriate within their practice setting as well as a lack of knowledge (33). This is consistent with the literature which suggest many nurses report feeling inadequately prepared to deliver spiritual care to patients. Staff commonly report that they feel they receive inadequate preparation for this aspect of their role (27) and often report a lack of spiritual care training in nursing school (33). (32) reports similar findings observing that whilst students did perceive spiritual care to be an essential part of nursing care and of vital importance within health promotion, many felt that they had not received sufficient preparation to undertake spiritual assessment and to meet patients' spiritual needs.

Training therefore is an important consideration, with numerous studies considering the influence that this holds. Students within (37) study reported an awareness of spirituality and revealed beliefs and values around spirituality such as agreeing "that spiritual well-being is a major determining factor in response to illness" and that "spiritual care is a basic component of nursing care", or that "caring for the spirit of the patient is just as important as meeting other needs". Outcomes from factor analysis and the themes from qualitative analysis were said to suggest that student nurses are aware of the importance of spiritual health and of incorporating it into their nursing practice.

(37) in their study of student nurses found variations in spirituality score (defined as level of awareness of spirituality and respondents use of strategies to address patients' spiritual needs) were influenced by some factors not others. Demographics including age, years working in healthcare, highest level of education, religion, ethnicity, participation in a healing group, life satisfaction or degree of emphasis on spirituality in the nursing curriculum did not correlate with spirituality scale score. Spiritual connectedness (defined as a strong faith in a higher being or power and strong connection with the spiritual side of the self) did however correlate positively with spirituality scale score. It appears that spiritual connectedness may be a construct which is distinct from religiosity. This serves to emphasise the importance in terminology and the importance of clearly distinguishing religiosity and aspects of spirituality.

The literature has also considered students perceived level of spiritual care ability. For example, (32) used the Student Survey of Spiritual Care (SSSC) (32) as part of an examination of spiritual care attitudes and spiritual care practices in students with findings around student characteristics and environmental factors. Hierarchical regression suggested that student characteristics (spirituality, age and religious commitment) predicted perceived ability to provide spiritual care as did environmental factors but to a lesser extent. The strongest contribution was students' level of spirituality and their level of religious commitment, whilst the amount of emphasis on spirituality within the nursing course according to staff and faculty were the greatest environmental predictors. (32) notes that within and between private and public nursing school programmes there can be variations in spiritual care training, with an impact upon the spiritual awareness of students. It was suggested that those who attended religious colleges were more likely to regard spirituality as important, and that those attending courses with a greater emphasis or integration of spirituality into the curriculum were more likely to have increased spirituality awareness.

However, (37) reported that degree of emphasis on spirituality in the nursing curriculum did not relate to level of awareness of spirituality and their use of strategies to address patients' spiritual needs and (36) reported that level of comfort in providing spiritual care was not seen to relate to spirituality. (37) in their comparison of faith based and public school nursing programmes, observed that students' scores on the Spirituality Scale (which assessed level of awareness of spirituality and their use of strategies to address patients spiritual needs) did not differ significantly between the two types of students. This again emphasises the many aspects of spirituality which are considered within the literature and the array of ways variables can influence different facets of spiritual care.

Though assessing the degree to which student nurses are willing and able to provide spiritual care is important, possibly of more relevance is an understanding of what affects spiritual care provision in qualified nurses, as not only are they the ones in the trenches but will provide role models and mentors to student nurses as they enter practice. In their study of hospice and oncology nurses (31) examined the nurses' levels of spirituality training. It appeared there may have been differences in the education the nurses received before qualifying: Differences were apparent in their basic education: 35% of oncology nurses reported that spirituality was integrated throughout their basic education whilst 4% of hospice nurses did, however neither group were likely to report completing a course as part of their basic education (6% oncology, 10% hospice). This may of course reflect differences in education which impacted the choice of specialism that the nurses chose to work in (e.g. hospice versus oncology). However, considering education after qualifying, data on the two groups of nurses also produced interesting findings. 57% of hospice nurses said they had received

training through continued education compared to 27% of oncology nurses, whilst 73% of hospice nurses stated they carried out reading compared to 45% of oncology nurses. It seems then that nurses working within the hospices surveyed received more training than oncology nurses; it was also reported that hospice nurses perceived their preparation as more adequate than oncology nurses, although the discrepancies in sample size are observed. The majority of the nurses overall (hospice and oncology) felt that they had been inadequately prepared for spiritual care provision, particularly those working in oncology.

Inadequate preparation appears to be another key theme in spiritual care provision, with this review observing that interventions have been considered as a way of improving nurses' ability and willingness to provide spiritual care. For example, (34) suggested that educational interventions can increase levels of knowledge and comfort with conducting spiritual assessment, whilst (25) used The Spiritual Care in Practice (SCIP) (25) and found that interventions help increase respondents' perceived ability to provide spiritual care, especially in complex clinical situations. Intervention programmes have also been seen to improve attitudes towards spiritual care giving (SCPS-R), the ability to provide an empathic response, and levels of knowledge about communicating with patients about spirituality (29). (29) report that a number of factors were seen to predict improvements in attitude towards spiritual care giving: Age, frequency at attendance at religious services and initial spirituality score (DSES) although explaining only a small amount of variance. This is contrasted with (34) who found that improvements in level of knowledge and comfort with conducting spiritual assessment were not influenced by religiosity amongst other factors. (29) also suggested that the amount of spiritual care education received predicted learning about responding emphatically. However, these improvements did not appear to be impacted by the type of institution the participants were currently attending: religious or non-religious institution. This may suggest that it is not the religiosity of the institution that needs to be considered but the content of the programmes therein.

It appears that training and or interventions can have an important role in spiritual care delivery by nursing health care professionals. Research (27) suggests that the source of spiritual care training can be influential in terms of willingness to provide specific aspects of spiritual care: Those who had attended continued professional development were the most likely to state they were "willing to guide patients to find inner peace" (a specific facet of spiritual care) than those who had received training in other ways e.g. school and self-learning education. This may suggest that training from different sources can lead to competence in different areas. Therefore, it may be the case that just ensuring nurses have spiritual care provision education is not enough. The research considered above fragmented spiritual care knowledge into different facets and has suggested that knowledge varies in different types of spiritual care. It was reported that nurses were often less knowledgeable around spiritual care under the Meaning and Hope factor of spiritual care than the Caring and Respecting factor (considered above), and this went on to impact their comfort with the delivery of spiritual care in specific domains (27).

As well as considering the source of spiritual care education and the type of education which is covered, the individual participants in this training also warrant consideration. There is suggestion in the literature that interventions influence qualified nurses and student nurses differently. (29) found that whilst attitudes towards spiritual caregiving improved amongst both qualified staff and students following intervention training there were differences observed. Students' Scores on SCPS-R began at a lower level than qualified nurses and ended with a higher score than the qualified nurses. As such educational interventions may need to consider the stage of the career of the participants, with more experienced staff potentially responding in a different manner to those less experienced. Similarly, levels of spiritual importance can reportedly change differently over time between different types of students: (35) report how over time nursing students increase in general spiritual importance more than medical students; this variation should therefore be considered when contemplating ways of increasing spiritual care delivery.

This review has identified several measures that relate to spiritual care and assessment by nursing health professionals. Reviewing the articles which

reported the use of these measures has revealed the multitude of ways of conceptualising facets relevant to spiritual care and assessment by health professionals. This reflects the complexity and lack of agreed definition over spirituality commonly reported in the literature (e.g. 39). Because of the variety of ways in which aspects relating to spiritual care and assessment are conceptualised, operationalised and defined it becomes difficult to ascertain which factors are the most important when considering how to increase spiritual care delivery. However, a consistent theme seems to be a perception of lack of preparedness, and there is some evidence to suggest that intervention programmes may hold numerous benefits including increasing the perceived ability and comfort with conducting spiritual care and assessment, increases in the ability to respond emphatically, improvements in levels of knowledge and in attitudes towards spiritual caregiving.

It is vital to improve the provision of spiritual care delivery; indeed the importance of assisting patients to meet their spiritual needs is recognised internationally (13). Where spiritual needs are met reduced levels of spiritual distress are observed (40), additionally there are reports that adequate meeting of spiritual needs can act to facilitate a more rapid recovery (41). There are also known to be adverse psychological outcomes for patients who do not meet their spiritual needs (12). Despite the urgency of this situation, there still remains a necessity to conceptualise, define and operationalise spirituality to therefore enable training to increase ability to assess spiritual needs and to provide support for spiritual needs.

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References

1. O'Brien MR, Kinloch K, Groves KE, Jack BA. Meeting patients' spiritual needs during end-of-life care: A qualitative study of nurses' and healthcare professionals' perceptions of spiritual care training. J Clin Nurs 2019 Jan; 28(1-2): 182-9.
2. McSherry W, Jamieson S. An online survey of nurses' perceptions of spirituality and spiritual care. J Clin Nurs 2011 Jun 1; 20(11-12): 1757-67.
3. Burkhardt MA. Spirituality: An analysis of the concept. Holist Nurs Pract 1989 May; 3(3): 69-77.
4. Dossey L. Prayer is good medicine: How to reap the healing benefits of prayer. Harper Collins; 1996.
5. Tanyi RA. Towards clarification of the meaning of spirituality. J Adv Nurs 2002 Sep; 39(5): 500-9.
6. Büssing A, Balzat HJ, Heusser P. Spiritual needs of patients with chronic pain diseases and cancer-validation of the spiritual needs questionnaire. Eur J of Med Res 2010 Dec; 15(6): 266.
7. Balducci L. Geriatric Oncology, Spirituality, and Palliative Care. J Pain Symptom Manage 2019 Jan 1; 57(1): 171-5.
8. Blaber M, Jone J, Willis D. Spiritual care: which is the best assessment tool for palliative settings?. Int J of Palliat Nurs 2015 Sep 2; 21(9): 430-8.
9. Williams JA, Meltzer D, Arora V, Chung G, Curlin FA. Attention to inpatients' religious and spiritual concerns: predictors and association with patient satisfaction. J Gen Intern Med 2011 Nov 1; 26(11): 1265-71.
10. Yardley SJ, Walshe CE, Parr A. Improving training in spiritual care: a qualitative study exploring patient perceptions of professional educational requirements. Palliat Med 2009 Oct; 23(7): 601-7.
11. Selman LE, Brighton LJ, Sinclair S, Karvinen I, Egan R, Speck P, Powell RA, Deskur-Smielecka E, Glajchen M, Adler S, Puchalski C. Patients' and caregivers' needs, experiences, preferences and research priorities in spiritual care: A focus group study across nine countries. Palliat Med 2018 Jan; 32(1): 216-30.
12. Pearce MJ, Coan AD, Herndon JE, Koenig HG, Abernethy AP. Unmet spiritual care needs impact emotional and spiritual well-being in advanced cancer patients. Support Care Cancer 2012 Oct 1; 20(10): 2269-76.
13. Paal P, Leget C, Goodhead A. Spiritual care education: results from an EAPC survey. Eur J Palliat Care 2015 Jan 1; 22: 91-5.
14. Caldeira S, Carvalho EC, Vieira M. Spiritual distress—Proposing a new definition and defining characteristics. Int J of Nurs Knowl 2013 Jun; 24(2): 77-84.
15. Chan MF, Chung LY, Lee AS, Wong WK, Lee GS, Lau CY, Lau WZ, Hung TT, Liu ML, Ng JW. Investigating spiritual care perceptions and practice patterns in Hong Kong nurses: results of a cluster analysis. Nurse Educ Today 2006 Feb 1; 26(2): 139-50.
16. Giske T, Cone PH. Discerning the healing path–how nurses assist patient spirituality in diverse health care settings. J Clin Nurs 2015 Oct; 24(19-20): 2926-35.
17. Willemse S, Smeets W, van Leeuwen E, Janssen L, Foudraine N. Spiritual Care in the ICU: Perspectives of Dutch Intensivists, ICU Nurses, and Spiritual Caregivers. J Relig Health 2018 Apr 1; 57(2): 583-95.
18. Stranahan S. Spiritual perception, attitudes about spiritual care, and spiritual care practices among nurse practitioners. West J Nurs Res 2001 Feb; 23(1): 90-104.
19. Rushton L. What are the barriers to spiritual care in a hospital setting?. Br J Nurs 2014 Apr 10; 23(7): 370-4.
20. Keall R, Clayton JM, Butow P. How do Australian palliative care nurses address existential and spiritual concerns?

Facilitators, barriers and strategies. J Clin Nurs 2014 Nov; 23(21-22): 3197-205.

21. Hu Y, Li F, Chiou JF. Psychometric properties of the Chinese mainland version of the Palliative Care Spiritual Care Competency Scale (PCSCCS-M) in nursing: a cross-sectional study. BMC Palliat Care 2019 Dec; 18(1): 27.
22. Best M, Butow P, Olver I. Do patients want doctors to talk about spirituality? A systematic literature review. Patient Educ Couns 2015 Nov 1; 98(11): 1320-8.
23. Balboni MJ, Sullivan A, Amobi A, Phelps AC, Gorman DP, Zollfrank A, Peteet JR, Prigerson HG, VanderWeele TJ, Balboni TA. Why is spiritual care infrequent at the end of life? Spiritual care perceptions among patients, nurses, and physicians and the role of training. Journal of Clin Oncol 2013 Feb 1; 31(4): 461.
24. McSherry W, Draper P, Kendrick D. The construct validity of a rating scale designed to assess spirituality and spiritual care. Int J Nurs Stud 2002 Sep 1; 39(7): 723-34.
25. Burkhart L, Schmidt W. Measuring effectiveness of a spiritual care pedagogy in nursing education. J Prof Nurs 2012 Sep 1; 28(5): 315-21.
26. Burkhart L, Schmidt L, Hogan N. Development and psychometric testing of the Spiritual Care Inventory instrument. J Adv Nurs 2011 Nov; 67(11): 2463-72.
27. Wu LF, Tseng HC, Liao YC. Nurse education and willingness to provide spiritual care. Nurse Educ Today 2016 Mar 1; 38: 36-41.
28. Wu LF, Koo M, Liao YC, Chen YM, Yeh DC. Development and validation of the spiritual care needs inventory for acute care hospital patients in Taiwan. Clin Nurs Res 2016 Dec; 25(6): 590-606.
29. Johnston Taylor EJ, Mamier I, Bahjri K, Anton T, Petersen F. Efficacy of a self-study programme to teach spiritual care. J Clin Nurs 2009 Apr 1; 18(8): 1131-40.
30. Elliott R, Filipovich H, Harrigan L, Gaynor J, Reimschuessel C, Zapadka JK. Measuring response empathy: The development of a multicomponent rating scale. J Couns Psychol 1982 Jul; 29(4): 379.
31. Highfield ME, Taylor EJ, Amenta MO. Preparation to care: the spiritual care education of oncology and hospice nurses. J Hosp Palliat Nurs 2000 Apr 1; 2(2): 53-63.
32. Meyer CL. How effectively are nurse educators preparing students to provide spiritual care? Nurse Educ 2003 Jul 1; 28(4): 185-90.
33. DeKoninck B, Hawkins LA, Fyke JP, Neal T, Currier K. Spiritual care practices of advanced practice nurses: a multinational study. J Nurse Pract 2016 Sep 1; 12(8): 536-44.
34. Hoffert D, Henshaw C, Mvududu N. Enhancing the ability of nursing students to perform a spiritual assessment. Nurse Educ 2007 Mar 1; 32(2): 66-72.
35. Sandor MK, Sierpina VS, Vanderpool HV, Owen SV. Spirituality and clinical care: exploring developmental changes in nursing and medical students. Explore (NY) 2006 Jan 1; 2(1): 37-42.
36. Johnston Taylor EJ. New Zealand hospice nurses' self-rated comfort in conducting spiritual assessment. Int J Palliat Nurs 2013 Apr; 19(4): 178-85.
37. Nardi D, Rooda L. Spirituality-based nursing practice by nursing students: an exploratory study. J Prof Nurs 2011 Jul 1; 27(4): 255-63.
38. Taylor EJ, Highfield MF, Amenta M. Predictors of oncology and hospice nurses' spiritual care perspectives and practices. Appl Nurs Res 1999 Feb 1; 12(1): 30-7.
(39. Pike J. Spirituality in nursing: a systematic review of the literature from 2006–10. Br J Nurs 2011 Jun 23; 20(12): 743-9.
40. Deal B, Grassley JS. The lived experience of giving spiritual care: A phenomenological study of nephrology nurses working in acute and chronic hemodialysis settings. Nephrol Nurs J 2012 Nov 1; 39(6): 471-83.
41. Lundberg PC, Kerdonfag P. Spiritual care provided by Thai nurses in intensive care units. J Clin Nurs 2010 Apr; 19(7-8): 1121-8.

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