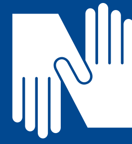

RCN spirituality survey 2010

A report by the Royal College of Nursing on members' views on spirituality and spiritual care in nursing practice

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Acknowledgments

The author would like to thank all the RCN members who participated in the *RCN spirituality survey 2010*. Their contributions provided valuable insights into this important aspect of nursing care and made this work possible.

Additional thanks are extended to Steve Jamieson, Stephanie Wilson, Neil Gadhok and Michael Wakeman, along with RCN nurse advisers and members of the RCN Spirituality Interest Group, all of whom provided assistance and support in the development of the survey.

Finally, special thanks are due to Professor John Swinton, Dr Linda Ross, Dr Aru Narayanasamy and Mr Paul Dearey for their advice and guidance in the development of the survey questionnaire.

Results of this survey are also published in: McSherry W and Jamieson S (2011) An online survey of nurses' perceptions of spirituality and spiritual care, Journal of Clinical Nursing, 20: no. doi: 10.1111/j.1365-2702.2010.03547.

About the report author

Wilfred McSherry PhD, MPhil, BSc (Hons), PGCE (FE), PGCRM, RGN, NT, FHA

Centre for Practice and Service Improvement, Faculty of Health, Staffordshire University and Shrewsbury and Telford Hospital NHS Trust, Stafford and Shrewsbury, UK

In August 2008 Wilf McSherry was appointed Professor in Dignity of Care for Older People – a joint appointment between Staffordshire University and the Shrewsbury and Telford Hospital NHS Trust. His interest in the spiritual dimension developed alongside a realisation that this aspect of care was often neglected or forgotten by some health care professionals.

Having completed his doctoral studies at Leeds Metropolitan University in 2005, researching *The meaning of spirituality and spiritual care: an investigation of health care professionals, patients and public perceptions*, Wilf has gone on to publish numerous books and articles addressing different aspects of the spiritual dimension.

In his previous role as a Senior Lecturer in Nursing at the University of Hull, Wilf, alongside colleagues, was instrumental in creating the Centre for Spirituality Studies, of which he became a Director. Currently he is a Vice President of the British Association for the Study of Spirituality, **www.basspirituality.org.uk**.

Executive summary

The last two decades have seen a groundswell of interest in the concepts of spirituality and spiritual care in health care and nursing. This is evident in the vast numbers of research studies conducted and publications written on the subject. Despite this, there is still a great deal of uncertainty and hesitancy by some nurses to engage with the spiritual dimension of their profession, even though there is a professional requirement for nurses to provide holistic care that involves assessing and meeting the spiritual needs of their patients (Nursing Midwifery Council, 2010). This hesitancy may stem from recent media coverage in which the area of spirituality and the relationship between personal belief and professional practice have come under criticism, bringing into question the role of the nurse regarding the provision of religious and spiritual care.

In March 2010 the Royal College of Nursing (RCN) commissioned an online survey to establish the understanding and attitudes of its members in relation to the concept of spirituality and the provision of spiritual care.

The survey consisted of a five-part questionnaire, incorporating the Spirituality and Spiritual Care Rating Scale (SSCRS), to explore perceptions of spirituality and the delivery of spiritual care. An overwhelming 4,054 members responded to the survey – the second largest response to a survey undertaken by the RCN – making it possibly the largest UK exploration of spirituality in nursing undertaken to date.

Descriptive statistical tests were applied to survey responses and the results were presented as frequencies, percentages and bar charts. The use of descriptive statistics provided a preliminary overview of nurses' opinions, assisting with the identification of key findings. The final section of the survey provided a free text facility, enabling respondents to provide qualitative comments. Content and thematic analyses were used to identify recurrent themes and categories.

Both the quantitative and qualitative analyses confirm that nurses across the full health economy in the UK consider spirituality to be a fundamental aspect of nursing and central to the delivery of high quality nursing care.

Furthermore, the survey findings reveal nurses recognise that supporting patients with their spiritual needs has the potential to enhance the overall quality of nursing care. Yet, despite a growing focus on the spiritual dimension of care, many of the respondents feel more guidance and support from professional and governing bodies is necessary to enable them to engage more meaningfully and confidently with spiritual aspects of care.

1

Introduction

1.1 Historical overview

Several commentators note that nursing and health care have held long associations with religious and spiritual traditions (Bradshaw 1994, Narayanasamy 1999). For example, Koenig, McCullough and Larson (2001) describe how, in the past, religious communities have offered a sanctuary for the socially outcast and the sick and dying. These communities, through their vocation and charity, provided for the earthly and spiritual needs of those in their care. Consequently many of these religious communities unknowingly practiced holistic and integrated care. With the advent of the National Health Service (NHS) the state took control of its citizens' health and welfare, resulting in a decline in these religious connections. It could be argued that the importance of people's religious and spiritual beliefs was overlooked and neglected as health care became publically funded and more scientific and secular.

1.2 Changing culture

The Patient's Charter (DH 1991, 2001) signalled a cultural shift from caring for the physical needs of individuals by drawing attention to other equally important dimensions of people's lives; the psychological, social and spiritual. Health care professionals were asked to respect the holistic needs of those requiring care. In addition, there has been an increasing emphasis on the spiritual dimension within governing and professional bodies (WHO 1998; International Council for Nurses 2006; Nursing Midwifery Council 2007, 2010; DH 1991, 2001, 2003).

1.3 The personal and professional

There have been a number of recent cases in the media where nurses have provided inappropriate religious and spiritual care (Cobb 2001, Castledine 2005). A review of these cases reveals the nursing profession needs to explore and debate the boundaries that exist between personal belief and professional practice. However, excellent progress has been made by some UK Government health departments to formally integrate the religious and spiritual elements of care within service design and delivery, raising awareness of the importance of spirituality and spiritual care, and provide resources to achieve this goal (Scottish Government 2009, NHS Education for Scotland 2009). Despite this, some nurses are still reluctant to be involved in the delivery of 'spiritual and religious care' because of the fears, misconceptions and myths that prevail around the concept.

This apprehension to engage with religious and spiritual aspects of care underlines the critical role education may play in preparing nurses to deal with religious and spiritual aspects of care (McSherry et al 2008). Education can provide a safe environment in which to explore the relationships between personal belief and professional practice, and the boundaries that exist between patients and practitioners.

2

The RCN spirituality survey

2.1 Context

The *RCN spirituality survey*, while a discrete piece of work, dovetails with and builds on other work streams undertaken by the college – such as the Dignity in care campaign (RCN 2008). One cannot treat a person with dignity and respect unless attention is given to personal beliefs and values. The notion that spirituality is central to the dignity and therefore the identity of each person is echoed in the following definition of dignity:

> "Dignity is a state of physical, emotional and spiritual comfort, with each individual valued for his or her uniqueness and his or her individuality celebrated. Dignity is promoted when individuals are enabled to do the best within their capabilities, exercise control, make choices and feel involved in the decision-making that underpins their care."
>
> Fenton and Mitchell (2002, p.21)

This definition affirms that dignified care cannot be provided unless nursing adopts a holistic and individualised approach that takes into account the uniqueness of each individual. By acknowledging and supporting the uniqueness of each person the model of care must accommodate and be prepared to support the personal, religious and spiritual beliefs and needs of each individual, however these may be defined, articulated and expressed.

In the summer of 2009 the RCN established the Spirituality Interest Group (SIG), comprised of leaders within the College, RCN Fellows and invited members. At its inaugural meeting this group explored and discussed the meaning of spirituality, its place within nursing and what the College may need to do to become more informed and aware of the key issues in order to support members with this aspect of nursing practice. One of its first actions was to commission a survey to ascertain members' perceptions and experiences on this sensitive and sometimes contentious subject which Burnard (1998) refers to as one of the last remaining taboos within nursing.

2.2 Research questions

The RCN spirituality survey was designed to explore three broad questions:

1. What do RCN members understand by the terms spirituality and spiritual care?
2. Do RCN members consider spirituality to be a legitimate area of nursing practice?
3. Do RCN members feel that they receive sufficient support and guidance in these matters?

In an attempt to make these broad questions more meaningful and manageable within the context of the survey, four discrete categories – each with a specific aim – were developed (see Table 2.1).

Table 2.1 RCN spirituality survey: categories and aims

Exploration and analysis
Discover and explore RCN members' understanding of, and attitudes toward, the concepts of spirituality and spiritual care.
Prevalence and practice
Identify whether the spiritual needs of patients are recognised by RCN members in the delivery of nursing care.
Education and training
Establish whether RCN members feel that they receive sufficient education and training to enable them to effectively meet patients'/clients' spiritual needs.
Religious belief and spirituality
Explore the associations that may exist between religious belief and RCN members' understandings of spirituality and the provision of spiritual care.

2.3 Method

The survey was developed by the principal author, in conjunction with the RCN head of nursing and representatives from the communications and information technology departments within the RCN. This collaboration ensured the survey met RCN expectations and conformed to its standards for final validation and approval. An electronic survey design was chosen because the RCN has considerable experience in the design and utilisation of electronic surveys and previous surveys posted on the home page of the RCN website had yielded excellent response rates. While this method of administration meant that RCN members without access to the internet were unable to participate, it was envisaged that this would be only a small proportion since most members have access to the internet at home, work, university/college or public places such as libraries. The administration method was also judged against other more costly forms of administration, such as a postal survey. The online survey was developed and run using a Questback platform that automatically collated responses, saving valuable resources in terms of coding and data input into statistical programmes for analysis.

The Spirituality and Spiritual Care Rating Scale (SSCRS) (McSherry 1997, 1998, 2006; McSherry et al 2002) was used as the primary data collection instrument. The SSCRS scale has demonstrated consistent reliability and validity in establishing nurses' perceptions of spirituality and spiritual care. The final questionnaire comprised of five parts (see Appendix 1):

Part 1: Spirituality and Spiritual Care Rating Scale

Part 2: Questions about nursing practice

Part 3: What action do you feel is required?

Part 4: Demographic information (standard demographics provided by RCN)

Part 5: Free text box for respondent comments

The reason for using a pre-validated instrument (SSCRS) was to increase the reliability and validity of the survey. The SSCRS has been used in over 42 studies in eleven different countries. Results from international studies using the SSCRS have been published in Master and Doctoral dissertations as well as academic journals (See Table 2.2).

2.4 Piloting

The questionnaire was sent electronically to four experts in the area of spirituality to verify the content validity. Divisional leads and nurse advisors across the RCN were asked to complete the online survey and forward comments for improvement directly to the principal author. The feedback was reviewed and minor amendments made prior to the online survey going live.

Table 2.2 Selection of studies using the SSCRS

Meredith W and O'Shea E (2007) Perceptions of spirituality and spiritual care among older nursing home residents at the end of life, *Holistic Nursing Practice*, 21 (6), pp.285-289.
Lovanio K and Wallace M. (2007) Promoting spiritual knowledge and attitudes: a student nurse education project, *Holistic Nursing Practice*, 21 (1), pp.42-47.
Nucero M (2005) Nurses' perceptions of spiritual care and nurses' spiritual activity, presentation in the *Complementary/Alternative Health Practice* stream, at the *Sigma Theta Tau International 38th Biennial Convention – Scientific Sessions*, delivered 14 November, Indianapolis, United States of America.
Oswald K (2004) *Nurses' perceptions of spiritual care*, Doctoral dissertation (research), Drake University, United States of America.

2.5 Ethics

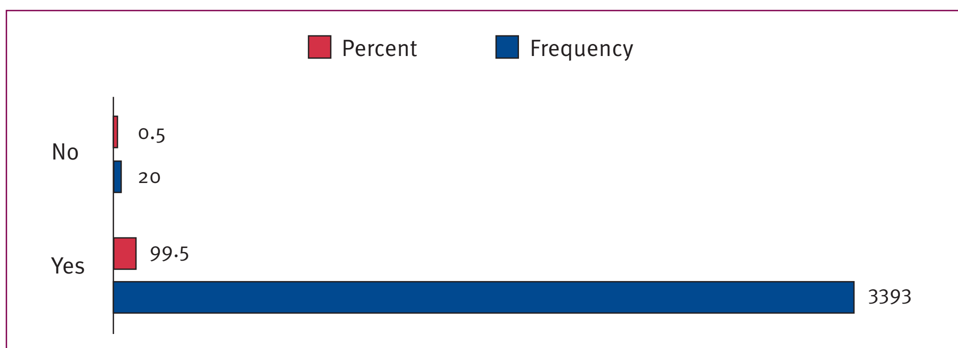
Ethical approval to undertake the survey was obtained from the Faculty of Health Ethics Committee. Permissions and access to survey RCN members was gained from the head of nursing and other appropriate leads within the RCN. By participating in this survey it was assumed that individual respondents were giving their full consent. All responses were treated anonymously and in the strictest confidence. There were no real ethical issues or risks arising from participation in this survey other than participants being asked to reflect upon a dimension of their lives that previously they might never have considered. Completion of the survey might have meant that their understanding of spirituality was broadened. In the eventuality that a member felt that participation in the survey had triggered some emotional response they were to be referred to the RCN Occupational Health Department for support and advice.

2.6 Sample

All RCN members were eligible to participate in the survey; there were no exclusion criteria. The survey went live on the RCN website on 10 March 2010 for a three-week period, closing on 31 March 2010. More than 85,000 members with active email accounts were sent alerts. In addition a number of adverts were placed in the weekly RCN Bulletin, which is posted out to members. The email and advert contained information on the background and rationale for the survey and provided information on how to access the online survey (via a link). In addition, nursing forum leads were contacted and asked to alert and encourage their members to support and participate in the survey.

On accessing the survey a statement was presented to respondents in relation to gaining authorisation/consent before completing the online survey. In total 3,939 (99.5 per cent) of respondents utilised this facility. Only 20 (0.5 per cent) decided not to continue (see Chart 2.1).

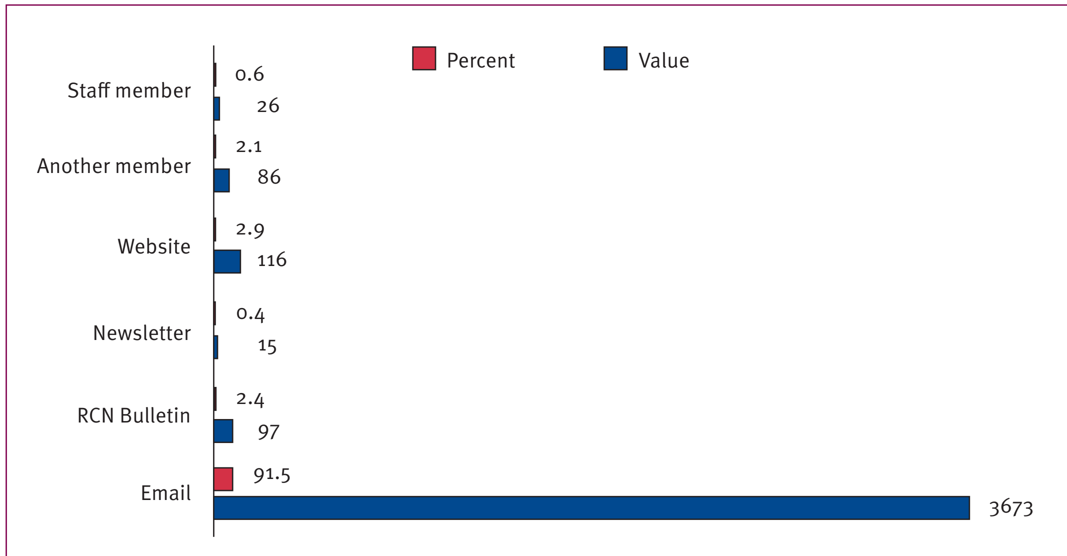
Chart 2.1 Authorisation



A second email alert was sent to members to increase the final response rate. All responses were treated anonymously and respondents had the option of hiding their identities when accessing the survey. These mechanisms ensured that the membership was fully informed about the nature of the survey and what participation entailed.

As part of the survey process, participants were asked how they had found out about the survey (see Chart 2.2) and 3,673 (91.5 per cent) confirmed they had learned about the survey by email. Given the short window of opportunity to complete the survey more strategies could have been utilised to increase the overall response rate.

Chart 2.2 How RCN members found out about the survey



2.7 Data analysis

Responses were automatically recorded and collated – using the Questback platform – as respondents answered each question. The full data set was saved as a Microsoft Word 7 file and SPSS data file (Statistical Package for the Social Sciences) using SPSS version 16.0. Because of the tight deadlines only descriptive statistics were used to analyse and interpret the results. Therefore frequencies, percentages and bar charts were used to identify and describe the significant findings. The data set will be subjected to further in-depth statistical analysis, using inferential statistics to measure underlying relationships between the different variables (for example age, education, religious belief and practice) and items in the SSCRS. The findings from this more in-depth analysis will be submitted for publication in academic journals.

At the end of the survey respondents were given the opportunity to:

- convey their understanding of spirituality and spiritual care
- provide additional or further comments relating to the subject of spirituality/ spiritual care.

The qualitative analysis was undertaken retrospectively, and content and thematic analysis was undertaken on the qualitative data. The content analysis identified emergent themes and the relative importance of these themes through repetition of coding (Priest et al 2002; Woods et al 2002). The content and thematic analysis was undertaken manually using the 'find and highlight' facilities within Microsoft Word.

3

Findings and discussion

A total of 4,054 members completed the survey, equating to approximately one per cent of the total 400,000 RCN membership (RCN 2010). Since the results represent a small percentage of the RCN membership, caution is required when reaching conclusions and making comparisons with nursing generally; the Nursing and Midwifery Council (2008) indicates that there are 676,547 nurses and midwives on the professional register, and therefore the RCN survey results may not be representative or reflective of the general nursing population. Furthermore, respondents who participated may have had a particular interest in the concept of spirituality and may have been motivated by specific personal beliefs or values. While all these factors must be borne in mind when considering the results, the findings do shed important light on nurses' perceptions of spirituality and the practice of spiritual care.

Quantitative and qualitative findings

Of the 4,054 members who completed the survey more than 2,000 respondents used the free text facility to provide additional information and clarification around the concepts of spirituality and spiritual care. Responses ranged from a few words, such as "no further comments", to extensive descriptions of what constitutes spirituality and spiritual care. Analysis of these qualitative responses provided added richness and depth that complemented and illuminated some of the quantitative findings.

The descriptive statistics, in conjunction with the thematic analysis, revealed that the overall findings can be addressed under the following broad categories (see Table 3.1). These categories are presented and discussed sequentially in this section of the report:

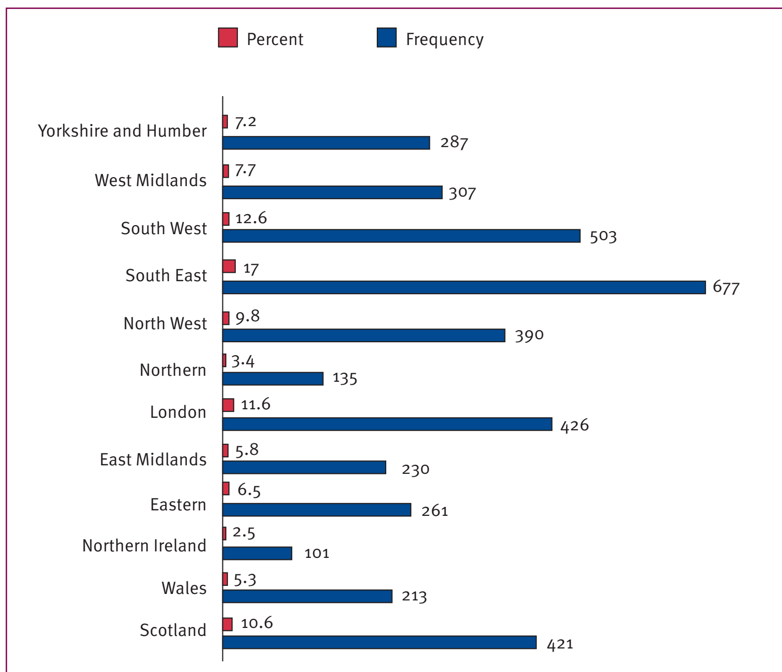
Table 3.1 Survey categories

Survey categories
Demographic profile of respondents
Spirituality and quality nursing care
Perceptions of spirituality
Provision of spiritual care
Personal and professional boundaries
Educational challenges and opportunities
Role of government and regulatory bodies

3.1 Demographic profile of respondents

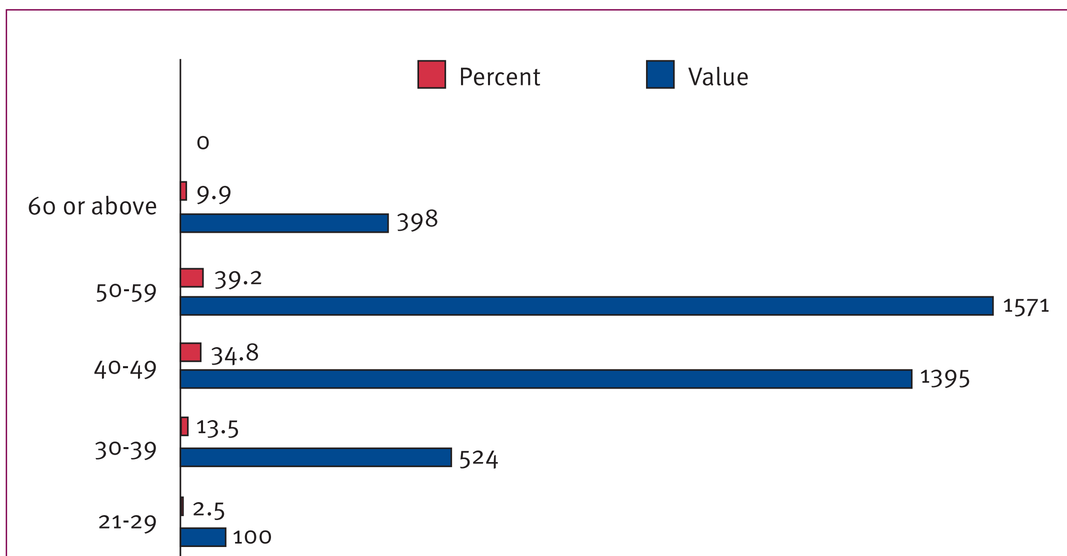
RCN members from nine English regions, Scotland, Northern Ireland, and Wales took part in the survey (see Chart 3.1). The majority of respondents – 677 or 17 per cent – were based in the South East region.

Chart 3.1 Response by country and region



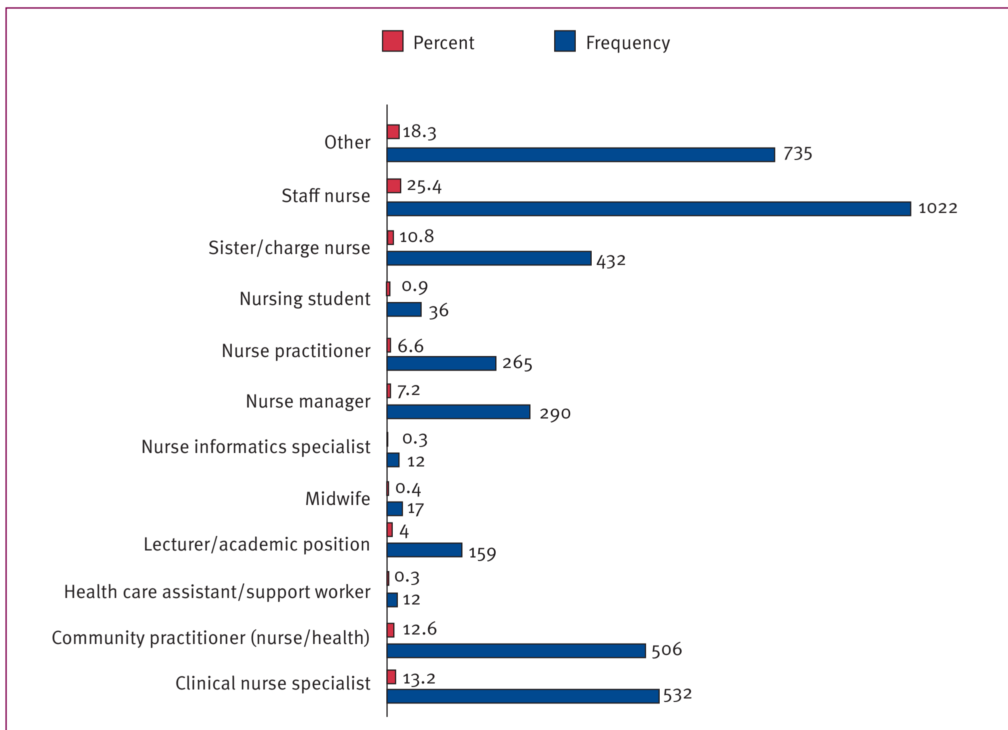
While the majority of respondents worked in the NHS (1,642 – 41 per cent), other sectors were also represented (see Chart 3.2). The 'Other' category elicited a wide range of responses, such as 'hospice', 'palliative care', 'independent consultant' and 'civil service'.

Chart 3.2 Employer



Staff nurses were the largest group represented (see Chart 3.3). Interestingly, only 36 (0.9 per cent) students and 12 (0.3 per cent) health care assistants/support workers participated in the survey. This finding is a little worrying as there is a growing evidence base to suggest that HCAs and HCSWs are providing most of the direct care to patients (Clover 2010).

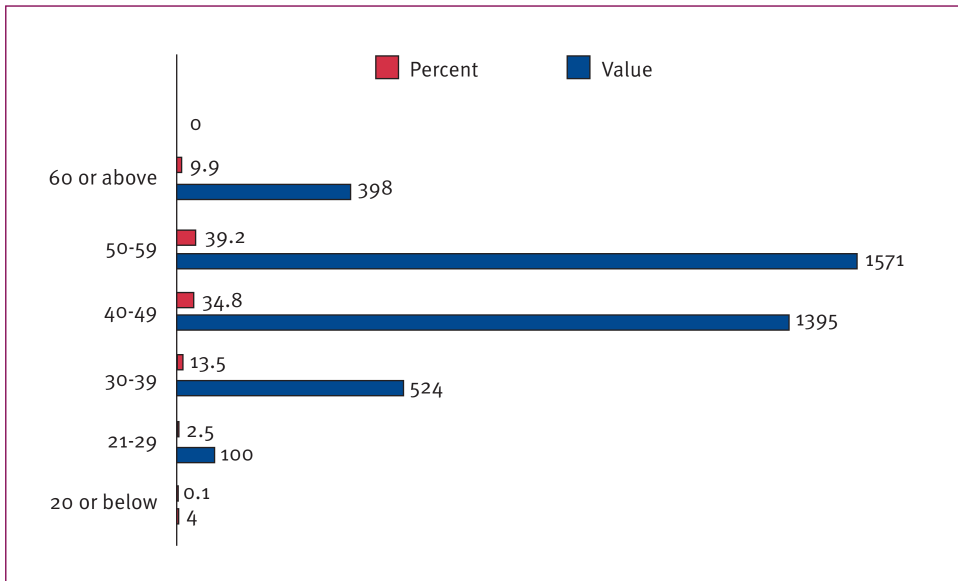
Chart 3.3 Groups



Representatives from all the main nursing specialities participated in the survey. Members working in adult care accounted for 1,285 (32 per cent) of respondents, with the second largest field of practice being primary care/community/public health service, which accounted for 979 (24.4 per cent) of respondents. Mental health and learning disabilities totalled 378 (9.4 per cent) of respondents while children and young people services accounted for 315 (7.8 per cent per cent) of overall responses, raising questions about the general application of the findings to these underrepresented areas of nursing. It also suggests a need for additional exploration of these concepts within these nursing practice specialities, as the survey's major findings may reflect an adult understanding of spirituality that may not be suitable for some of the underrepresented areas.

The age of respondents ranged from 20 years and under to over 60 years; some respondents, when answering the question on role, stated that they were now retired from the nursing profession. Those aged below 20 was the smallest group, with only four respondents (0.1 per cent), followed by the over 60 age group with 398 (9.9 per cent) respondents. Collectively the largest age groups were aged between 40 and 59 (see Chart 3.4); the distribution of age is very similar to the statistical analysis of the NMC Register (NMC 2008). This wide variation in age means the survey captured the views of nurses from across the different decades of nursing and at different chronological stages on the life span continuum.

Chart 3.4 Age



Age is mirrored in the question enquiring about year of qualification or of obtaining a vocational qualification in health and social care (see Table 3.2); the majority of respondents qualified in the 1970s or 1980s. However, a small proportion qualified in the 1950s or 1960s. This means that some respondents will have experienced many and significant changes in the education and the delivery of nursing care over several decades.

Table 3.2 Year of qualification

Decade	Percent	Value
2000s	13.3	527
1990s	21.7	874
1980s	34.0	1367
1970s	25.9	1041
1960s	4.9	196
1950s	0.3	14

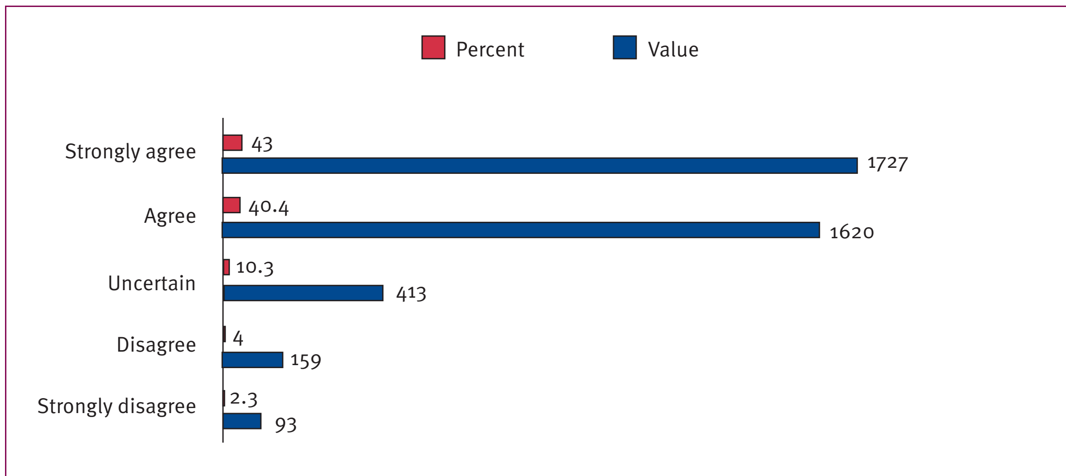
In terms of gender, 477 (12 per cent) of respondents were male while 3,512, (88 per cent) were female. This finding seems to reflect the general composition of males to females within the nursing workforce as recorded by the NMC (2008). The majority of respondents – 3,725 (92.1 per cent) identified themselves as 'White'; other ethnic groups based on the National Census categories were represented, totalling 196 (4.3 per cent), while 125 (3.1 per cent) of respondents did not state their ethnicity.

3.2 Spirituality and quality nursing care

There has been an ongoing debate within the nursing literature about the nature of spirituality (Bash 2004) and whether nurses should concern themselves with spiritual and religious aspects of people's lives (Paley 2008, 2009; Ross 2008). The findings from two questions offered to nurses as part of the survey suggest that respondents consider spiritual aspects of care to be fundamental to nursing and to add to the overall quality of nursing care.

Chart 3.5 reveals that the overwhelming majority of respondents consider spirituality and spiritual care to be fundamental aspects of nursing. Fundamental, in this context, means essential to the provision and delivery of nursing care. A further question asked respondents whether they felt providing spiritual care enhances the overall quality of nursing care. Again the response was unanimous with 90 per cent of respondents either agreeing or strongly agreeing with the statement. These findings imply that nurses working within a range of specialist areas and roles consider spirituality integral to the provision of quality nursing care.

Chart 3.5 Spirituality and spiritual care are a fundamental aspect of nursing



The following transcripts highlight that spirituality is an essential component of holistic care and is a dimension that requires equal attention and integration within nursing practice; Table 3.3 provides information on the groups and numbers who provided qualitative comments together with the coding range for each group.

Table 3.3 Groupings in the qualitative analysis

Group	Number	Coding	Coding
Staff nurses	572	1	572
Health care assistant/health care support worker	8	573	581
Sister/charge nurse	225	582	807
Clinical nurse specialist	308	808	1116
Community practitioner	289	1117	1406
Academic/lecturer	97	1407	1504
Midwife	8	1505	1513
Nurse informatics specialist	2	1514	1515
Nurse manager	139	1516	1655
Nurse practitioner	151	1656	1807
Nursing student	19	1808	1827
Other	499	1828	2327

> "...I believe spirituality is fundamental to good nursing practice both within the nurse and how they behave towards patients and carers. Compassion, dignity, respect for other human beings are the essence of nursing in my opinion and essential to good care."
>
> **Respondent 1882**

> "I believe that we cannot say that we offer or deliver holistic care unless spiritual care is an essential and equal part of that care. It is essential that it is integrated into all our practice, taught and supported with expert advisors."
>
> **Respondent 1907**

It should be emphasised that not all respondents felt that spirituality was a fundamental aspect of nursing. For example, one respondent stated:

> "I don't believe that spirituality is a fundamental nursing role; nursing is to help people get back to their physical health."
>
> **Respondent 33**

Overall the findings imply that the majority of nurses recognise this as a legitimate aspect of nursing care, and believe that failure to engage with spiritual aspects of care may be detrimental to the provision of high quality nursing care.

3.3 Nurse perceptions of spirituality

This survey sought to establish nurses' attitudes and understandings of spirituality in addition to exploring their experiences in the provision of spiritual care. No definition of spirituality was offered in the introductory material, briefing notes, or alerts issued prior to the survey. This was deliberate in order to capture the 'raw views' and experiences of members. Offering a definition could have raised awareness and understanding of the concepts prior to completing the online survey.

Several authors have constructed a definition of spirituality (Stoll 1989, Murray and Zentner 1989, Males and Boswell 1990, Reed 1992, Swinton 2001, Tanyi 2002). The definition most frequently quoted in nursing literature is the one provided by Murray and Zentner (1989, p.259):

> "A quality that goes beyond religious affiliation, that strives for inspirations, reverence, awe, meaning and purpose, even in those who do not believe in any good. The spiritual dimension tries to be in harmony with the universe, and strives for answers about the infinite, and comes into focus when the person faces emotional stress, physical illness or death."

This definition implies that spirituality is individual and universal, in that all people possess a spiritual dimension, and, importantly, seems to be a legitimisation of health care professionals' involvement with this aspect of the person. This point is noteworthy for nurses because they are often supporting individuals encountering emotional stress, physical/mental illness and ultimately death. If one looks at other definitions of spirituality there appear to be attributes of spirituality that are recurrent and common across all definitions. Greenstreet (2006) is right to point out that while there is no universal definition of spirituality, there seems to be a consensus as to the defining attributes of spirituality that contributes to understanding the concept.

Part 1 of the survey explored members' perceptions of spirituality and spiritual care using the Spirituality and Spiritual Care Rating Scale (SSCRS) (McSherry 1997; McSherry et al 2002). The SSCRS addresses several of the broad attributes of spirituality and spiritual care (see Table 3.4).

Table 3.4 Fundamental aspects of spirituality explored in the SSCRS

Aspect of spirituality explored in SSCRS	Item in SSCRS
Hope	i, l
Existentialism that is meaning, purpose and fulfilment	f, h
Forgiveness	C
Beliefs and values	P
Spiritual care	a, b, g, h, k, n
Relationships	O
Belief in a God or deity	d, e,
Morality and conduct	j, q
Creativity and self expression	M

These attributes imply that spirituality is a broad, generic and subjective concept, concerned with both tangible and hidden aspects of life, and encompasses connection with – and awareness of – transcendent relationships and connections with people, the environment and the wider universe. For some people spirituality will be inextricably linked to a religious faith and a belief in a deity or deities.

The quantitative and qualitative findings reveal that the majority of nurses held a broad, generic view of spirituality. There was an acknowledgement that spirituality was something universal applying to all people, including those with and those without religious beliefs. The mainstream of respondents did not see spirituality as only pertaining to people with and practising religious beliefs (see Table 3.5). The majority of respondents considered spirituality to be an important aspect of daily life and routine. For some members spirituality was described as the essence of their being and at the core of their lives; an inner force giving harmony and peace.

The idea that spirituality is at the centre of one's being is captured in the following response:

> "Spirituality is the 'essence' or 'inner realm' of a person and creates individual inner beliefs, thoughts, and feelings that combine the whole unique person. Ironically, it is intangible, individual, and yet unifying as part of the human condition."
>
> **Respondent 363**

Table 3.5 Members' perceptions of spirituality

Item and statement in SSCRS	Strongly disagree		Disagree		Uncertain		Agree		Strongly agree	
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
I believe spirituality is concerned with a need to forgive and a need to be forgiven	**447**	**12.0**	**806**	**20.3**	**1032**	**25.9**	**976**	**24.5**	**687**	**17.3**
I believe spirituality involves only going to church/place of Worship	**2721**	**68.2**	**1009**	**25.3**	98	2.5	63	1.6	98	2.5
I believe spirituality is not concerned with a belief and faith in a God or Supreme Being	**954**	**24.0**	**1027**	**25.9**	731	18.4	778	19.6	478	12.0
I believe spirituality is about finding meaning in the good and bad events of life	176	4.4	401	10.1	647	16.3	**1841**	**46.3**	**914**	**23.0**
I believe spirituality is about having a sense of hope in life	107	4.4	401	10.1	647	16.3	**1841**	**46.3**	**914**	**23.0**
I believe spirituality is to do with the way one conducts one's life here and now	147	3.7	353	8.9	572	14.4	**1728**	**43.6**	**1167**	**29.4**
I believe spirituality is a unifying force which enables one to be at peace with oneself and the world	203	5.1	281	7.1	663	16.8	**1544**	**39.1**	**1254**	**31.8**
I believe spirituality does not include areas such as art, creativity and self expression	**1459**	**36.9**	**1548**	**39.1**	556	14.1	255	6.4	138	3.5
I believe spirituality involves personal friendships, relationships	97	2.4	323	8.2	684	17.3	**1763**	**44.5**	**1093**	**27.6**
I believe spirituality does not apply to atheists or agnostics	**2021**	**51.0**	**1165**	**29.4**	415	10.5	182	4.6	183	4.6
I believe spirituality includes peoples' morals	206	5.2	416	10.5	817	20.6	1719	43.3	813	20.5

Respondent answers to the questions presented in the SSCRS suggest that many hold a definition of spirituality similar to the one developed by Murray and Zentner (1989). A common theme in members' qualitative responses was the need for sensitivity. Members were acutely aware of the need to be sensitive to other people's understandings of spirituality and that these might be very different to their own. This sensitivity was also reflected in the responses from atheists and humanists; while not necessarily accepting spirituality as a fundamental aspect of nursing these respondents were acutely aware of the need to support other people with their personal beliefs and practices. The following response emphasises the need for sensitivity, indicating that personal attitudes and caring qualities are crucial to supporting patients:

"I think while some kind of spiritual support is helpful for some patients, it is not necessarily fundamental to nursing, although an awareness of a patient's spiritual needs may help the nurse give the patient more personalised care. As in all areas of nursing, if a nurse feels unable to deal with the spiritual needs of a patient, they should refer the patient to someone who can. As an atheist I almost always find that a caring, respectful and interested attitude towards patients counts for far more than any specific religious beliefs."

Respondent 807

Many of the definitions of spirituality provided by respondents were eclectic and diverse in nature. Some of the definitions were complex, possessing many of the commonly perceived attributes of spirituality such as individuality, beliefs, values, meaning and purpose and religious belief and practice.

> "I believe spirituality is something special and individual to each person where they may find meaning and peace in their life. It may be from a religious belief or from something that is important to them i.e. family or nature."
>
> **Respondent 186**

Closer analysis of respondent definitions reveals that these may be explained by the pioneering work of Ruth Stoll (1979, pp.7-8) who developed a two dimensional model of spirituality. She suggests that spirituality consists of a vertical and horizontal dimension. The vertical relates to the transcendent aspects of life that may be uplifting, inspiring and inspirational, suggesting something outside or beyond the individual. Some of the attributes used by respondents were words such as awe, wonder, transcendence. For some members the vertical dimension was expressed through a faith and belief in a deity or deities. The notion of transcendence is reflected in the following:

> "... It is about a sense of personal value and meaning, a sense of being valued for who we are, be that by ourselves, by others or by our God. Spirituality transcends all that each of us does or does not do – it is what is left when we strip away all material things and all matters worldly – that underlying sense of who we are, how we relate to ourselves, to others and to the universe as a whole."
>
> **Respondent 1242**

Meanwhile the horizontal aspect is concerned with the values and experiences that the individual considers important – such as relationship with God or a deity, other people, lifestyle, quality of life, or interactions with oneself, others, nature and the environment. This two-dimensional model demonstrates that spirituality is concerned with connections and interrelatedness between the individual, a higher authority (for some), other people, and the world at large.

Stoll (1989, p.7) suggests that this model can be equally applied to those with and those without religious beliefs or belief in God. She writes:

> "Within a humanistic framework, however, the God concept does not constitute a transcendent being or a religious beliefs framework. Instead, the person has consciously or unconsciously chosen values that become the supreme focus of life and/or around which life is organized. These supreme values motivate people's life-style toward fulfilment of their goals, needs and aspirations. This self-actualization focus encourages a person towards a spiritual quest for being on a human plane only."

In summary, members who replied to the survey had a broad, generic view of spirituality. The findings suggest that nurses consider spirituality to be individual, unique and something relevant to all people – including those with and those without religious beliefs. Many described spirituality as being the essence of the person – something inner or at the core of the individual – bringing meaning, purpose and fulfilment.

3.4 The provision of spiritual care

The survey provided a valuable insight into nurses' perceptions of spiritual care, and responses to items in the SSCRS that specifically enquired about spiritual aspects of care are shown in Table 3.6.

The findings suggest that spiritual care is integral and perhaps indistinguishable from other aspects of care, such as the psychosocial. Spiritual care is also very much dependent upon

the personal attributes and qualities displayed by the nurse in their interaction and dealings with patients. The following words were used frequently by nurses when describing spiritual care; compassion, kindness, comfort, dignity and respect. The use of such words suggests that many nurses feel good quality fundamental nursing is essential to the delivery of any type of nursing care – be this physical, psychosocial, or spiritual. The use of words such 'individualised' and 'integrated' suggest that spiritual care is not just an add-on or an optional extra. This is evident in the following response:

> "Spiritual care should not be added as an 'add on' to patient care but should be embedded in an integrated holistic healthcare approach."
>
> **Respondent 1999**

This is not to say that there is no need for spiritual care. Swinton (2001) offers a thoughtful and insightful explanation as to why spirituality may not be translated easily into the language of psychology:

> "However, on deeper reflection it becomes clear that such words as 'hope', 'faith' and 'purpose', and ideas such as 'the search for meaning' and 'the need for forgiveness', are not adequately captured in language that assumes they are *nothing* but thought processes or survival needs. Although it may not fit neatly into the current scientific paradigm, as one encounters such language one experiences a deep, intuitive sense of affirmation that these desires refer to dimensions that include, yet at the same time transcend, psychological explanations."
>
> **Swinton (2001 p.25)**

This quotation affirms that psychological care alone may not be sufficient to support and offer explanations to patients in their search for meaning and purpose in life. Furthermore, the quotation alerts nursing to the dangers of compartmentalising and reducing individuals to a set of discrete dimensions. Omitting the spiritual, as some authors (Paley 2009) suggest, is not holistic but reductionist care. Nursing cannot make assumptions with regards to the provision of spiritual care; not all patients will require support in this area (McSherry 2007). However, to remove the spiritual dimension from holistic care would be to seriously compromise those patients who express a spiritual or religious need and require support to meet this expressed need. The idea of spirituality being integral to the delivery of nursing care is a recurrent theme in the qualitative analysis.

The following response indicates that this nurse considers spiritual care to be integral to practice and that an inclusive approach is required. The findings from this survey indicate that – in contrast to the exclusively secular model that seemingly dominates society and health care today – there is a range of views and opinions surrounding spiritual care, and that the overriding principle of spiritual care is giving individuals choice, power and control in the decisions that need to be made about their nursing and health care:

> "I firmly believe that spiritual care is an integral element of health care. Once acknowledged as such patients/clients/staff should be offered choices as to where and from whom they receive such care. If such spiritual care is available from a patient's own faith group then access to that care should be offered. The over-riding principle in spiritual care should be based on an inclusive model, not a lowest common denominator model, or exclusive secular model as appears to exist now."

Table 3.6 Members' perceptions of spiritual care

Item and statement in SSCRS	Strongly disagree		Disagree		Uncertain		Agree		Strongly agree	
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
I believe nurses can provide spiritual care by arranging a visit by the hospital chaplain or the patient's own religious leader if requested	99	2.5	142	3.6	325	8.1	**1726**	**43.2**	**1701**	**42.6**
I believe nurses can provide spiritual care by spending time with a patient giving support and reassurance especially in time of need	88	2.2	126	3.2	195	4.9	**1607**	**40.4**	**1963**	**49.3**
I believe nurses can provide spiritual care by enabling a patient to find meaning and purpose in their illness	**224**	**6.1**	**495**	**12.4**	**936**	**23.5**	**1399**	**35.1**	**910**	**22.8**
I believe nurses can provide spiritual care by listening to and allowing patients time to discuss and explore their fears, anxieties and troubles	87	1.9	100	2.5	187	4.7	**1577**	**39.5**	**2043**	**51.2**
I believe nurses can provide spiritual care by having respect for privacy, dignity and the religious and cultural beliefs of a patient	76	1.9	69	1.7	116	2.9	**1272**	**31.9**	**2456**	**61.6**

Interestingly 92.6 per cent of the nurses surveyed indicated that all health care professionals – in conjunction with the patient, family and friends – are responsible for providing spiritual care. This finding suggests that nurses feel they do not have a monopoly with regard to the provision of spiritual care. Importantly it highlights that a team, inter- and intradisciplinary approach is required to support patients with their spiritual needs. This finding is bolstered by the qualitative responses in which nurses indicated that they would never impose this aspect of care upon patients and that they would always be guided by the individual, stressing the importance of expressed need.

Spiritual needs

The survey asked nurses a number of questions around the concept of spiritual needs. Respondents were asked to identify from a list of eight spiritual needs developed by Narayanasamy (2001, 2010). The results are presented in Table 3.7; the four most frequently rated spiritual needs are highlighted in bold. These findings seem to signal a shift away from an earlier classification of spiritual needs provided by Shelly and Fish (1988):

- the need for meaning and purpose
- the need for love and relatedness
- the need for forgiveness.

This shift may reflect a broader understanding of spirituality that focuses more on meeting and supporting the individual and less on the existential and religious aspects of care, although these were still considered spiritual needs by the nurses surveyed.

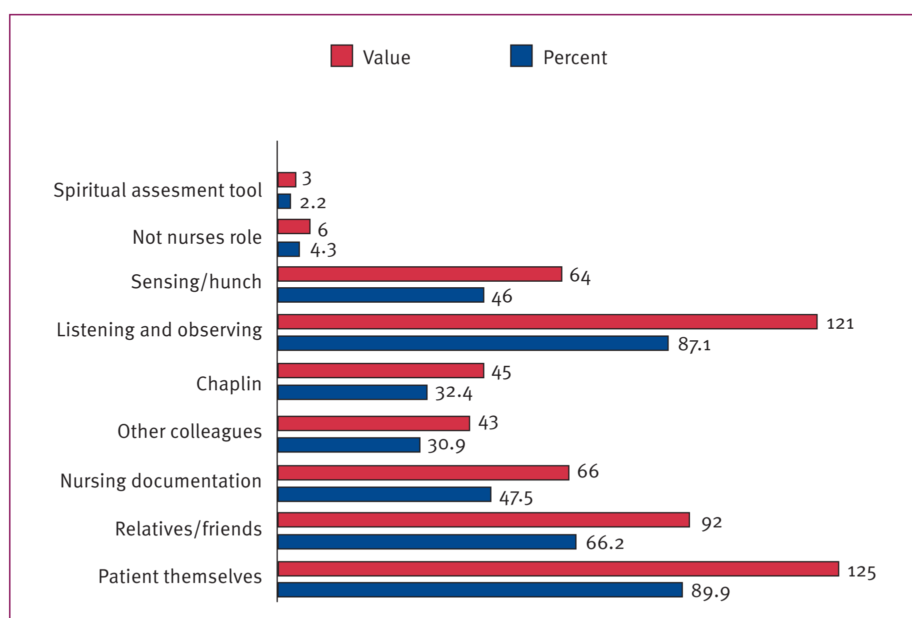
Table 3.5 Members' perceptions of spiritual care

	Freq	%
1 – The need for meaning and purpose	**3276**	**81.9**
2 – The need for love and harmonious relationships	2820	70.3
3 – The need for forgiveness	2604	65.1
4 – The need for a source of hope and strength	**3661**	**95.1**
5 – The need for trust	2885	72.1
6 – The need for expression of personal beliefs/values	**3558**	**88.9**
7 – The need for spiritual practices, expressions of concept of God or a deity	**3277**	**81.9**
8 – The need for creativity	1983	49.6

Identification of spiritual needs

One question enquired how respondents indentified patients' spiritual needs (Chart 3.6).

Chart 3.7 Identification of spiritual needs



Of the 139 respondents who answered this question, 89.9 per cent confirmed the most frequent way of identifying a patient's spiritual needs was from the patients themselves, while listening and observing was ranked second (87.1 per cent). These findings underline the importance of communication and interpersonal skills in identifying spiritual needs, and emphasise the importance of nurses spending sufficient and quality time with patients.
Of the nurses who completed the survey, 95.5 per cent indicated that they had encountered patient(s) with spiritual needs. Clarification was sought as to the frequency with which members were encountering patients with spiritual needs. The findings revealed that 41.4 per cent of nurses encountered patient(s) with spiritual needs on a daily basis; only 3.5 per cent of nurses said they had not encountered a patient with a spiritual need.

A major concern is that while 95.5 per cent of respondents indicated they had encountered a patient with a spiritual need, 92.2 per cent

of respondents indicated that they are only 'sometimes' able to meet their patients' spiritual needs. In hindsight the question about encountering a patient with spiritual needs could have been better constructed, giving respondents a 'not applicable' option (especially for those who were in non clinical roles or had retired). This might have reduced the inclination to select 'sometimes'. However, the fact that many nurses only feel able to sometimes meet their patients' spiritual needs is worrying. This may mean patients are not receiving adequate support to meet their spiritual needs. A review of the qualitative responses explains why nurses only 'sometimes' feel able to meet their patients' spiritual needs:

> "It would concern me if spiritual care were forced upon staff who were not comfortable with it – but I do feel that there is not enough support, guidance and time given to those who may have the skills and abilities to provide spiritual care."
>
> **Respondent 1391**

> "Nurses will always say they need more education, but in the crowded curriculum there will never be enough time for spirituality. It should be embedded in all our teaching, not stowed away in separate sessions."
>
> **Respondent 1436**

These comments reveal potential reasons why nurses are not meeting patients' spiritual needs. They also highlight that the situation is more complex than it might first appear. There are a number of organisational, personal, professional and educational factors that may be impacting on the ability of nurses to support patients with their spiritual needs.

Interestingly, only 4.3 per cent of respondents felt that it was not the role of the nurse to identify a patient's spiritual needs. This suggests that nurses consider the identification and supporting of patients with their spiritual needs to be very much part of the nurse's role and duty of care.

3.5 Personal and professional boundaries

This section explores briefly the relationships that exist between nurses' personal beliefs and values, and their professional duty of care. The survey raises some important questions about the personal and professional boundaries associated with the provision of religious and spiritual care, and the findings reveal that many nurses would like guidance and direction in dealing with spiritual aspects of care, especially around the issues of praying with or for a patient. It must be stressed that most of the respondents who expressed a personal belief were acutely aware of the need to be objective, not to be imposing or pressurising, and the importance of not using their role as a nurse to proselytise or convert patients to a religious belief or practice.

Religious belief and nursing practice

The survey enquired about the religious beliefs and practices of members, and one question asked *What is your religion?* While Table 3.8 reveals that all the major world religions were represented in the survey, of the members who responded to this question 631 (15.8 per cent) stated they did not have a religion.

Table 3.8 World religions represented

	Freq	%
1 – None	631	15.8
2 – Christian	2969	74.3
3 – Buddhist	38	1.0
4 – Hindu	14	0.4
5 – Jewish	10	0.3
6 – Sikh	2	0.1
7 – Muslim	14	0.4
Other, please specify	804	20.0

Christianity was the most frequently cited religion; these results are similar to the findings of the 2001 census in terms of representation and distribution (Office for National Statistics, 2004). Of the nurses who indicated they had a religious belief, 67.2 per cent (2,487) stated they were practising their religions with 32.8 per cent (1,231) stating they did not practice their religions. This finding must be borne in mind when generalising the findings of this survey to a wider nursing audience since the sample may not be representative. A further limitation of the question addressing religious practice was how the term 'practice' was interpreted by respondents. In hindsight an additional question enquiring about the extent and type of religious practice would have been useful. Interestingly 8 per cent (319) respondents selected the 'other' category, providing a wide range of responses that included 'atheist', 'agnostic', 'humanist', and 'Wicca'; 'Jedi Knight' was also listed as a religious belief which again reflects the findings of the 2001 census.

The statistical findings are supported by the qualitative feedback provided by some respondents in statements outlining their religious beliefs and practices:

> "I am a practising Christian without rigid beliefs and do not try to persuade or look down upon those who do not go to church or believe."
>
> **Respondent 484**

> "Having concerns for the spiritual welfare of a patient and families reflects the fundamental ethic of nursing care, which has to be truly holistic. Although I am a practising Christian, spirituality does not require religious dogma, but an ability to empathise, listen and support in any way that the patient finds to be helpful. It must be tailored to the individual, and part of the relationship established between the health professional and the patient. I have never encountered a problem with this in over 40 years of nursing, having worked in acute, chronic and primary care nursing."
>
> **Respondent 1794**

One noticeable observation was the apologetic nature of some respondents who expressed a religious belief, indicating that because of the high profile public and media cases in recent months they were embarrassed about and wary of expressing their beliefs. The word 'marginalised' featured in several responses, highlighting the strength of feeling associated with the subject. Some respondents indicated that the reason for this marginalisation was the drive for political correctness. These sentiments and opinions are articulated in the following selection of statements:

> "Christians must not be marginalised by political correctness."
>
> **Respondent 2108**

> "People, including staff, are entitled to their beliefs and everyone has their own spirituality, whether they believe in a God or not. There are so many moves to not offend ethnic minorities that Christians feel almost embarrassed to express their beliefs."
>
> **Respondent 380**

> "I would never see it as my job to convert someone to my religion but because of highly publicised cases in the press I am incredibly wary of ever expressing my own religious beliefs. I work in children's oncology which is an incredibly emotive area and sometimes it would be nice to know there was more spiritual support available to people within their own chosen faith."
>
> **Respondent 2**

The findings from the survey imply that nurses with or without a religious belief consider spirituality to be an integral part of their role. There seems to be an acceptance that, irrespective of one's own personal belief and values, there is a fundamental need to support patients with their spiritual and religious needs.

3.6 Educational challenges and opportunities

There already exists a professional expectation that nurses will attend to and support the holistic needs of their patients (NMC 2007, 2010). The survey asked respondents to comment on whether they felt sufficiently prepared to deal with patients' spiritual needs. Of the nurses surveyed 79.3 per cent agreed that they do not receive sufficient education and training in matters concerning spirituality and spiritual care. The majority of nurses (79.8 per cent) also felt that spirituality and spiritual care should be addressed within programmes of education. The following illustrates this call for integration:

> "I think that many nurses need support to understand their own spirituality and spiritual needs before they can truly help others. It is something that develops over time and with life's experiences and does not always have to relate to a specific religion. I would like to see educational institutions and professional bodies support this."
>
> **Respondent 1523**

The findings from this survey are a little worrying since they are almost identical to the findings of a similar survey conducted by McSherry (1997), which found that 394 (71.8 per cent) of nurses felt that they did not receive sufficient training in spiritual aspects of care. This raises a fundamental question – why has very little changed in the intervening period despite the interest and research that has been conducted in this arena over the last two decades?

Nurses still feel inadequately prepared to deal with the spiritual concerns of patients and are asking for educational preparation and guidance. The qualitative analysis reveals a number of challenges that may be impacting upon the ability of nurses to feel prepared to deal with spiritual aspects of care. For example, the lack of exposure to spiritual issues within programmes of nurse education and the extent and depth to which these concepts are integrated into the curriculum. In addition, the subject of good role models within practice was raised:

> "I believe spirituality and religion are different – however, I also believe they are linked. As far as spirituality and nursing is concerned, I am not sure it can be rigorously taught. More often than not it is seeing another nurse being compassionate, taking time with a patient or family etc., that often sparks the understanding of spirituality. A lot of nursing education now is not role modelled in the same way as previous training."
>
> **Respondent 2156**

The issues associated with education are far more multifaceted and complex than simply introducing the concept of spirituality to the curriculum. The qualitative comments indicate that some nurses are indeed receiving education and training as part of their pre-registration programmes. In addition, several respondents explained how they had undertaken post registration training into spiritual aspects of care. Some described how they had completed post graduate modules on the subject, undertaking masters and doctoral level studies into diverse aspects of spiritual care. This level of activity suggests that some nurses are acutely aware of the importance of this aspect of nursing care and have a willingness, desire and motivation to develop their knowledge and understanding of the concepts.

Some respondents seemed anxious that the teaching of spirituality should be from a broad belief and values base to ensure that the full spectrum of approaches to spirituality and the provision of spiritual care are included. For example:

> "I strongly feel there should be respect for the beliefs of atheists/agnostics/ humanists. These groups are often presumed not to be spiritual or to have morals, which is untrue and promotes discriminatory behaviour towards them. This seems to be ignored in spiritual education."
>
> **Respondent 1617**

Not all respondents felt that spirituality should be taught formally within programmes of nurse education, or indeed that nurses should be concerning themselves with this aspect of care:

"Whatever my understanding of spirituality is, it should not be your job to teach/inform or confirm. Your job is to support the 'job' of being or becoming a nurse – a kind, educated and able nurse. Precious educational funding should not be wasted on such subjects when there are other disciplines out there, the church, family, friends, only too willing to help in such areas. You are in danger of trying to be all things to all people, try just doing one thing well."

Respondent 10

It should be stressed, however, that the majority of respondents were in favour of the formal integration of spirituality within programmes of nursing education. Nonetheless careful thought, consideration and planning will be required to ensure such integration enhances knowledge and understanding in a meaningful way, enabling nurses to feel competent and proficient with regards to the provision of spiritual care.

3.7 Role of government and regulatory bodies

There has been a raft of documents, policies and guidelines produced by UK government and health departments on this topic (Scottish Government 2009; NHS Education for Scotland 2009; DH 2003, 2009; Welsh Assembly Government 2010). To date, the Scottish government and Scottish health department have provided the greatest leadership and strategic direction in these areas – developing guidance and resources for nursing and indeed the entire health care workforce.

Nurse perceptions in regard to the quality of guidance produced are reflected in the following quantitative responses. Of the nurses surveyed 61.8 per cent felt UK government health departments should provide clear guidance and support for nurses to deal with spiritual issues. In relation to the provision of support by the NMC and the RCN, 78.8 per cent of nurses felt the provision of guidance and support should come from the NMC while 78.1 per cent felt that the RCN also has a responsibility in this area and that the College should also provide spiritual support for its members and staff.

Closer inspection of these quantitative responses suggests that there was a greater degree of uncertainty among respondents

concerning the development of guidance than some of the other questions. Not all respondents felt it was the responsibility of either the NMC or RCN to provide guidance. One argument for not developing guidance was the potential to fragment or separate spirituality out from 'proper holistic care':

> "Spirituality should not be considered separate from other aspects of care. It is an integral part of a person's holistic care and should not be considered as 'religion'. Hence my belief that NMC/ RCN etc SHOULD NOT be providing guidance/standards. If nurses are unable to integrate spirituality in everything they do as nurses they should not be nursing. To try and regulate for spiritual care would be counterproductive as it would segregate it out from proper holistic care."
>
> **Respondent 22**

A further concern relating to the development of guidance and support was that this could be overly prescriptive and dogmatic, might not be able to accommodate the full spectrum of beliefs, and could potentially hinder the individual's expression of spiritual beliefs and values.

> "Although I agree that there should be some guidance on dealing with spirituality and spiritual care I would not like it to be in the form of a set of rules and regulations, as everyone has a different concept of spirituality."
>
> **Respondent 115**

One area where nurses seek guidance and clarity was on the issue of personal beliefs and professional boundaries. Several of the respondents asked for clarity around these controversial subjects, especially in light of recent high profile media cases:

> "Very controversial subject – nurses have been suspended for airing their religious views – either in what they say or wear (cross and chain). I feel guidance should be given as spirituality is paramount to some patients particularly in times of sickness."
>
> **Respondent 463**

These findings highlight important themes in relation to how best to proceed in preparing nurses to feel competent and proficient in supporting patients with spiritual aspects of care. In the past some UK government departments, along with the NMC and RCN, could have been accused of not engaging satisfactorily with issues of spirituality and spiritual care. This is in part reflected in the piecemeal approach to policy and guidance that is most noticeable in England, Wales and Northern Ireland. Scotland, by contrast, has adopted a far more systematic and rigorous approach, making excellent progress with the development of policy, strategy and guidance.

There is now an opportunity for UK government health departments – in conjunction with the NMC and RCN – to work collaboratively to shape future educational provision regarding the spiritual dimensions of care. Consultation and collaboration may help inform those in leadership, governing and regulatory roles, providing greater awareness of the issues associated with the spiritual dimension. This level of engagement may assist the nursing profession to better understand and resolve recent debates surrounding the boundaries that exist between personal belief and professional practice.

4

Conclusion and recommendations

The significant findings from this survey reflect the results of earlier studies published in nursing and health care literature over the last two decades, both within the UK and the international nursing community. The large number of nurses who responded affirms that nurses have a willingness to engage with and understand more about this aspect of nursing practice. A noteworthy finding is that nurses working in all the main nursing specialities, in a diversity of roles, sectors and organisations, recognise and believe spirituality to be a fundamental aspect of nursing care.

The quantitative and qualitative findings indicate that respondents had a broad, eclectic and inclusive understanding of spirituality. This indicates that nurses subscribe to a broad spectrum of spiritual beliefs.

Nurses were able to articulate quite clearly and succinctly their perceptions of spirituality and spiritual care. The historical myths and misconceptions associated with spirituality – viewing it as synonymous with religion – seem no longer to prevail. However, for some respondents their spirituality was very much founded on a religious faith and belief. In effect, these findings may help to dispel some of the apprehensions that have been expressed within nursing and wider society surrounding proselytising. Indeed, many of the qualitative responses indicate nurses are acutely aware of the need not to impose their own personal beliefs and values on patients.

The results suggest that there is an acceptance and endorsement that spirituality is an essential component of nursing practice and the findings reveal many nurses see this aspect of care as an essential and integral part of their role and duty of care. Furthermore, many nurses believe that attending to the spiritual needs of patients enhances the overall quality of nursing care provided.

One concern is that despite a great deal of attention devoted to the spiritual dimension and a vast amount of research conducted over many years, nurses still feel hesitant and lack confidence in dealing with spiritual issues. This is reflected in the large number of respondents calling for further guidance and more educational preparation. A further explanation for this apparent lack of confidence may be that many of the higher education institutions (HEI's) providing pre and post registration programmes do not include or adequately address matters of spirituality; HEI's are left to interpret the guidance from the NMC with regards to achieving competencies, and as a result these concepts may not be addressed in any depth or uniformity across programmes.

The findings also imply that some UK government health departments, in conjunction with the NMC and RCN, could do more to clarify the nursing role with regards to the provision of spiritual care. There is a need to take a more coordinated approach and a collective responsibility in providing clearer guidance for nurses in addressing spiritual issues; the development of such guidance and resources may help nurses to deal more effectively and confidently in this area.

The fact that 92.2 per cent of respondents felt they only 'sometimes' met their patients' spiritual needs is disturbing. The area of spiritual need requires further exploration with nurses and patient groups to identify what the implications are regarding the quality of nursing care provided. A possible explanation for this finding may be the language used by nurses and patients to describe spiritual needs. It might be that nurses are in fact meeting their patients' spiritual needs in an integrated and intuitive way. One recommendation, therefore, is to build upon the findings of this survey by asking patients about their perceptions of spirituality and their expectation in receiving spiritual care. Similarly, further clarity is required around the relationship of spiritual care to other important aspects of care such as the psychosocial and cultural dimensions.

In conclusion, the descriptive quantitative and qualitative findings provide valuable and much needed insights into nurses' perceptions of spirituality and spiritual care. **The findings demonstrate and affirm that nurses consider spirituality and spiritual care to be fundamental aspects of nursing care.**

4.1 Key priorities

For the future, the following key priorities should be addressed:

- the development of a range of educational and practical resources for members
- liaison and collaboration with partner organisations (the NMC and other UK government health departments) to explore ways to build on existing work and advance the area of spirituality within nursing and health care
- engagement with patients and the general public to establish their expectations on the provision of spiritual care
- the development of a briefing sheet for use by RCN Direct, outlining organisations and organisations that provide spiritual guidance and support.

5

Dissemination timeline

The findings from this survey will be shared with RCN members and the wider nursing profession in a number of ways, and Table 5.1 contains details of the actions and strategies that will be used to disseminate and encourage the utilisation of the findings within nursing practice. Actions already completed have been highlighted in bold.

Table 5.1 Dissemination strategy

Month	Action
April 2010	Presentation of findings at RCN Congress fringe event
May 2010	Submission of article to Journal of Clinical Nursing outlining preliminary findings of online survey
August 2010	Undertake content and thematic analysis of qualitative responses
October 2010	Establishment of the RCN Task and Finish Group on Spirituality
November 2010	Presentation of findings at the Health Care Assistant Conference, RCN London
	Submission of a further quantitative article addressing the use of the SSCRS in the RCN survey in a leading international nursing journal
December 2010	Completion of final report for publication and dissemination by the RCN
	Submission of a publication presenting the findings from the in-depth quantitative analysis Submission of article outlining the main findings from the qualitative analysis
February 2011	Finalisation and production of resources developed by the RCN Task and Finish Group
April 2011	Launch of Pocket Guide Launch of spirituality resources at RCN Congress
June 2011	Launch of Report

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Appendix 1 – questionnaire

PART 1: We are interested in capturing your thoughts and understanding of the words spirituality and spiritual care. Please complete the following Spirituality and Spiritual Care Rating Scale

PLEASE SELECT **ONE ANSWER** WHICH BEST REFLECTS THE EXTENT TO WHICH YOU AGREE OR DISAGREE WITH EACH STATEMENT

a) **I believe nurses can provide spiritual care by arranging a visit by the hospital Chaplain or the patient's own religious leader if requested**

Strongly disagree	*Disagree*	*Uncertain*	*Agree*	*Strongly agree*
*	*	*	*	*

b) **I believe nurses can provide spiritual care by showing kindness, concern and cheerfulness when giving care**

Strongly disagree	*Disagree*	*Uncertain*	*Agree*	*Strongly agree*
*	*	*	*	*

c) **I believe spirituality is concerned with a need to forgive and a need to be forgiven**

Strongly disagree	*Disagree*	*Uncertain*	*Agree*	*Strongly agree*
*	*	*	*	*

d) **I believe spirituality involves only going to Church/Place of Worship**

Strongly disagree	*Disagree*	*Uncertain*	*Agree*	*Strongly agree*
*	*	*	*	*

e) **I believe spirituality is not concerned with a belief and faith in a God or Supreme being**

Strongly disagree	*Disagree*	*Uncertain*	*Agree*	*Strongly agree*
*	*	*	*	*

f) **I believe spirituality is about finding meaning in the good and bad events of life**

Strongly disagree	*Disagree*	*Uncertain*	*Agree*	*Strongly agree*
*	*	*	*	*

g) **I believe nurses can provide spiritual care by spending time with a patient giving support and reassurance especially in time of need**

Strongly disagree	*Disagree*	*Uncertain*	*Agree*	*Strongly agree*
*	*	*	*	*

h) **I believe nurses can provide spiritual care by enabling a patient to find meaning and purpose in their illness**

Strongly disagree	*Disagree*	*Uncertain*	*Agree*	*Strongly agree*
*	*	*	*	*

i) **I believe spirituality is about having a sense of hope in life**

Strongly disagree	*Disagree*	*Uncertain*	*Agree*	*Strongly agree*
*	*	*	*	*

j) **I believe spirituality is to do with the way one conducts one's life here and now**

Strongly disagree	*Disagree*	*Uncertain*	*Agree*	*Strongly agree*
*	*	*	*	*

k) **I believe nurses can provide spiritual care by listening to and allowing patients time to discuss and explore their fears, anxieties and troubles**

Strongly disagree	*Disagree*	*Uncertain*	*Agree*	*Strongly agree*
*	*	*	*	*

l) **I believe spirituality is a unifying force which enables one to be at peace with oneself and the world**

Strongly disagree	*Disagree*	*Uncertain*	*Agree*	*Strongly agree*
*	*	*	*	*

m) **I believe spirituality does not include areas such as art, creativity and self expression**

Strongly disagree	*Disagree*	*Uncertain*	*Agree*	*Strongly agree*
*	*	*	*	*

n) **I believe nurses can provide spiritual care by having respect for privacy, dignity and religious and cultural beliefs of a patient**

Strongly disagree	*Disagree*	*Uncertain*	*Agree*	*Strongly agree*
*	*	*	*	*

o) **I believe spirituality involves personal friendships, relationships**

Strongly disagree	*Disagree*	*Uncertain*	*Agree*	*Strongly agree*
*	*	*	*	*

p) **I believe spirituality does not apply to Atheists or Agnostics**

Strongly disagree	*Disagree*	*Uncertain*	*Agree*	*Strongly agree*
*	*	*	*	*

q) **I believe spirituality includes peoples' morals**

Strongly disagree	*Disagree*	*Uncertain*	*Agree*	*Strongly agree*
*	*	*	*	*

PART 2: Can you tell us about your nursing practice?

Q1 Whilst practising, have you ever encountered a patient(s) with spiritual needs? (If no please go to Q5)

- ❑ Yes
- ❑ No

Q2 How do you identify patients' spiritual need(s)? You may tick more than one box

- ❑ Patient themselves
- ❑ Relatives/friends
- ❑ Nursing documentation
- ❑ Spiritual assessment tool (if you have ticked this box can you please identify what is used……………………)
- ❑ Other colleagues
- ❑ Chaplain
- ❑ Listening and observing
- ❑ Sensing/hunch
- ❑ It is not the nurses role to identify patients' spiritual needs

Q4 How frequently do you encounter patients with spiritual needs?

- ❑ Daily
- ❑ Weekly
- ❑ Monthly
- ❑ Yearly
- ❑ Not encountered patients with spiritual needs

Q5 Which of the following are spiritual needs? You may tick more than one box

- ❑ The need for meaning and purpose
- ❑ The need for love and harmonious relationships
- ❑ The need for forgiveness
- ❑ The need for a source of hope and strength
- ❑ The need for trust
- ❑ The need for expression of personal beliefs/values
- ❑ The need for spiritual practices, expressions of concept of God or deity
- ❑ The need for creativity
- ❑ Other – please state

Q6 Who do you think is responsible for providing spiritual care?

- ❑ Nurses
- ❑ Chaplains
- ❑ Patients themselves
- ❑ Family and friends
- ❑ All health care professionals
- ❑ Combination of all above

Q7 Do you feel that you are able to meet your patients' spiritual needs?

- ❑ Always
- ❑ Sometimes
- ❑ Never

PART 3: What action do you feel is required?

Q1 **I believe that spirituality and spiritual care are fundamental aspects of nursing**

Strongly disagree	*Disagree*	*Uncertain*	*Agree*	*Strongly agree*
*	*	*	*	*

Q2 **I believe that nurses do not receive sufficient education and training in spiritual and religious beliefs**

Strongly disagree	*Disagree*	*Uncertain*	*Agree*	*Strongly agree*
*	*	*	*	*

Q3 **I believe that spirituality and spiritual care should not be addressed within programmes of nurse education**

Strongly disagree	*Disagree*	*Uncertain*	*Agree*	*Strongly agree*
*	*	*	*	*

Q4 **I believe that the UK Government Health Departments should provide clear guidance and support for nurses to deal with spiritual and religious issues**

Strongly disagree	*Disagree*	*Uncertain*	*Agree*	*Strongly agree*
*	*	*	*	*

Q5 **I believe that the NMC should provide clear guidance and support for nurses to deal with spiritual and religious issues**

Strongly disagree	*Disagree*	*Uncertain*	*Agree*	*Strongly agree*
*	*	*	*	*

Q6 **I believe that the RCN should provide clear guidance and support for members to deal with spiritual and religious issues**

Strongly disagree	*Disagree*	*Uncertain*	*Agree*	*Strongly agree*
*	*	*	*	*

Q7 **I believe that the RCN has a clear responsibility to provide educational and practical resources to enable its members to deal with spiritual issues**

Strongly disagree	*Disagree*	*Uncertain*	*Agree*	*Strongly agree*
*	*	*	*	*

PART 4: Please can you tell us about yourself and your role

Q1 Please indicate which country or English region you work in?

- ❑ Scotland
- ❑ Wales
- ❑ Northern Ireland
- ❑ Eastern
- ❑ East Midlands
- ❑ London
- ❑ Northern
- ❑ North West
- ❑ South East
- ❑ South West
- ❑ West Midlands
- ❑ Yorkshire and Humber

Q2 When did you first qualify as a nurse/obtain a VQ in health and social care?

- ❑ 2000s
- ❑ 1990s
- ❑ 1980s
- ❑ 1970s
- ❑ 1960s
- ❑ 1950s

Q3 Which of the following best describes your employer?

- ❑ NHS hospital
- ❑ NHS community
- ❑ GP practice
- ❑ NHS other
- ❑ Independent Sector
- ❑ University/College of FE/HE
- ❑ Other (specify)

Q4 Which of the following best describes your job?

- ❑ Clinical nurse dpecialist
- ❑ Community practitioner (e.g. community nurse/health visitor)
- ❑ Health care assistant/health care support worker
- ❑ Lecturer/academic Position
- ❑ Midwife
- ❑ Nurse informatics specialist
- ❑ Nurse manager
- ❑ Nurse practitioner
- ❑ Nursing student
- ❑ Sister/charge nurse
- ❑ Staff nurse
- ❑ Other (specify)

Q5 What is your main field of practice?

- ❑ Adult care (hospital)
- ❑ Children and young people
- ❑ Primary care, community/public health services
- ❑ Learning disabilities
- ❑ Mental health
- ❑ Midwifery
- ❑ Management, leadership and support services
- ❑ Nurse education
- ❑ Other (specify)

Q6 Ethnicity (based on Census national standard categories)

White

- ❑ British
- ❑ Irish
- ❑ Any other white background

Mixed

- ❑ White and Black Caribbean
- ❑ White and Black African
- ❑ White and Asian
- ❑ Any other mixed background

Asian or Asian British

- ❑ Indian
- ❑ Pakistani
- ❑ Bangladeshi
- ❑ Any other Asian background

Black or black British

- ❑ African
- ❑ Any other black background

Other ethnic categories

- ❑ Chinese
- ❑ Any other ethnic category

Not stated

Q7 What is your religion?

- ❑ None
- ❑ Christian
- ❑ Buddhist
- ❑ Hindu
- ❑ Jewish
- ❑ Sikh
- ❑ Muslim
- ❑ Other –please state

Q7a Are you practising your religion?

- ❑ Yes
- ❑ No

Q8 Are you

- ❑ Male
- ❑ Female

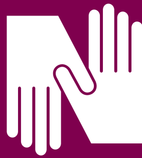
Q9 To which age group do you belong?

- ❑ 20 or below
- ❑ 21 - 29
- ❑ 30 - 39
- ❑ 40 - 49
- ❑ 50 – 59
- ❑ 60 or above

Q10 Please let us know how you found out about this survey

- ❑ I clicked a link on an email that you sent me
- ❑ I read about it in RCN Bulletin
- ❑ I read about it in another RCN Newsletter
- ❑ I just came across it on the RCN website
- ❑ Another RCN member told me about it
- ❑ An RCN staff member told me about it

Please use the box below to convey:
a) your understanding of spirituality and spiritual care
b) any further comments you would like to make concerning the subject of spirituality/spiritual care



The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies

June 2011

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www.rcn.org.uk

RCN Direct
www.rcn.org.uk/direct
0345 772 6100

Published by the Royal College of Nursing
20 Cavendish Square
London
W1G 0RN

020 7409 3333

Publication code: 003 861