Spiritual care by nurses and the role of the chaplaincy in a general hospital

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Spiritual Care in a Hospital Setting: Nurses' and Patients' Perspectives

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Abstract

Background: Many patients wish to discuss spiritual issues with nurses. Previous work has shown that nurses do so infrequently.
Design: Mixed-methods research.
Methods: Fifty-one nurses and 75 patients of five hospital departments of a non-academic hospital in the Netherlands were surveyed in 2007. We recorded the nurses' perception of patient wishes, perceived relevance of spiritual care for patients, spiritual care provided in practice, and their evaluation of the spiritual care provided for the patients. With regard to the patients the nurses cared for, we recorded their satisfaction with the information and experiences of spiritual care provided by the nurses. Furthermore, semi-structured qualitative interviews with eight nurses examined the nurses' perceptions of spiritual care including perceived barriers and facilitators of spiritual care giving.
Results: The nurses generally perceived spiritual care as important. The quantitative and qualitative research indicated that time to listen, availability, empathic skills, openness to other opinions, and a good relationship of trust were important facilitators. Forty-one per cent of the nurses said that few patients received sufficient attention to their spiritual needs. Patients also experienced limitations in the support for and registration of their spiritual needs.
Conclusions: Both nurses and patients acknowledged shortcomings in the provision of spiritual care. Even though some issues may be improved relatively easily, such as registering needs, in practice giving spiritual care is complex, as it requires being available and building a relationship with the patient.

Introduction

Previous work has indicated that patients wish to discuss spiritual issues with nurses(Taylor, 2007). However, nurses do so infrequently(Highfield, 1992; Lundmark, 2006). Although spiritual care is commonly regarded as a nursing task, in practice it is often provided inadequately(Cavendish et al., 2006; Louis & Alpert, 2000; L. Ross, 2006). Grant et al (2004). conclude that patients find it important that their professional caregivers provide spiritual support noting that: "All accepted that if spiritual issues or questions were raised these should be responded to, but most had neither the time nor the skill to 'do spiritual care'"(E. Grant et al., 2004, p. 374). In response to these concerns training has been reported as one way of increasing not just skills but also facilitating the required attitude and facility for spiritual care giving(Edwards, Pang, Shiu, & Chan, 2010; Lundmark, 2006; L. A. Ross, 1996; Strang, Strang, & Ternestedt, 2002).

Spirituality is a broad concept, interpreted and defined in different ways by different people. This may impede care giving in practice as well as research in this area. Many studies are limited to end-of-life situations. Furthermore, few studies have assessed nurses' own views on facilitators of, and important attributes for, spiritual care giving. Reinke et al (2010). found that nurses perceived communication skills as extremely important and most underutilized skills in providing end-of-life care, but their study was not specific to spiritual care. Another study, in a hospital setting not specific to the end of life, suggested that nurses feel that a wide variety of spiritual interventions, such as listening and prayer, are helpful to patients (D. Grant, 2004).

Moreover, most previous research surveyed either patients or nurses separately. By contrast we felt it was important to investigate the perceptions of both groups in a common setting, because a discrepancy between patients' and nurses' perceptions may result in unmet patient needs. In this study, we investigated nurses' perceptions of their own spiritual care and perceived facilitators of providing it, as well as the perceptions of their patients in the same setting. We defined spirituality as the religious or existential mode of human functioning, including experiences and questions of meaning and purpose (Jochemsen, Klaase-Carpentier, Cusveller, Scheur van de, & Bouwer, 2008). We employed this functional definition because we acknowledge that human beings express spirituality in different ways and in this study we were not so much interested in specific contents of nurses' spirituality, but rather in the way spirituality functions in their care giving.

Materials and Methods

Setting

The study was conducted at a medium-sized non-academic hospital (330 beds) with a Christian ethos in a metropolitan area of the Netherlands. Religious involvement in this setting is highly variable, which is relevant to the study of mutual perceptions of spiritual care. A considerable number of nurses are sympathetic towards religious faith, and a significant part of them probably selected the hospital as a preferred place of work because of its religious affiliation. Patients are both from the so-called "Bible belt" of the Netherlands, a region with a relatively high proportion of orthodox reformed Christians, but also from the secularised, urbanised surrounding area. Therefore, some of the patients may have selected the hospital because of its Christian affiliation.

Design

We used a mixed-methods design with quantitative data collected from nurses and patients, and qualitative data from nurses for reasons of triangulation, credibility and completeness as well as enhanced opportunities for explanation and illustration (Bryman, 2006). Our aim was not to generalize results, but rather to present a comprehensive report of findings in a single setting, integrating presentation and interpretation of quantitative and qualitative data (Bryman, 2006) mostly by relating codes from qualitative nurses' interviews to findings of the quantitative questionnaires and vice versa. We surveyed nurses and the patients they attended to within the same two-week time frame in 2007. The quantitative and qualitative data were collected in preparation for a study on training of nurses to provide spiritual care and represent data in untrained nurses (pre-test data) (Vlasblom et al., 2011). As we aimed to investigate spirituality in nursing care (Van Leeuwen, Tiesinga, Post, & Jochemsen, 2006), we needed a functional, broadly applicable definition that transcends culture and specific religious contents. Therefore, in this study we used the definition of spirituality given above, i.e.: "Spirituality means the religious or existential mode of human functioning, including experiences and questions of meaning and purpose."(Jochemsen et al., 2008) The definition guided the selection of instruments (Vlasblom et al., 2011). The study protocol was approved by the hospital Ethics Committee.

Measurements

Questionnaires were based mainly on previously used items and instruments, as described below. Before use, the questionnaires for both nurses and patients were pilot-tested with regard to comprehensiveness and practicability by experts and a

dozen nurses and patients. This resulted in a few small, mainly linguistic adjustments.

The nurses' study

All nurses from five departments of the hospital under study were asked to complete a written questionnaire. These were: a department of internal medicine, neurology, cardiology, a coronary care unit, and a mixed pulmonary disease/ urology department. This selection implied that some participating nurses dealt mainly with critically ill patients and others mainly with chronically ill patients. After three weeks a written reminder was sent to the nurses.

Semi-structured interviews were conducted with nurses, purposefully sampled to select at least one from each of the five departments for diversity of experience, but otherwise selected randomly from all the nurses employed at the departments. The interviews continued until saturation was reached after eight interviews. The interviews were carried out by three trained BSc nursing students. The training included creating an open atmosphere because it was important to avoid imposing beliefs on interviewees. An interview guide listed the principal topics, which included providing spiritual care, personal spiritual experience, barriers to and facilitators of spiritual care- giving, professional responsibility, knowledge and ability, and areas for improvement. Interviews were audio taped and transcribed verbatim. All interviews were analysed by two interviewers who independently developed codes for aspects relevant to perceptions of spiritual care giving. The researcher discussed the codes with the interviewers until they agreed upon a common set of codes.

Measurements among nurses

Nurses' questionnaires included demographic characteristics, their own religious and spiritual involvement, their perception of patient wishes/expectations, the perceived relevance of providing spiritual care for patients, the spiritual care they provide in practice, their evaluation of the spiritual care provided and their perception of facilitators of spiritual care giving.

To assess spiritual care we used the Lucas questionnaire (Cornette, 1996) that was originally used for research among Flemish employees in palliative care. The authors tested it for design and content before use, and in our study we used the resulting adjusted instrument. It has also been used by Broeckaert, Gielen, Van Iersel, & Van den Branden (2009). While upholding the essential contents of the form, we adjusted the Flemish idiom to Dutch, and references to the palliative care setting was altered to adhere to a general hospital setting. We present findings specific to spiritual care provided by nurses, and perceived facilitators of and barriers to spiritual care giving.

Table 1 Nurses measurements

Items	Response categories
Nurses' perceptions of patient wishes and expectations	
a. How frequently do patients have questions about God?	-never -rarely -occasionally -about half -frequently -very frequently -always
b. How frequently do patients have questions about life after death?	
c. How many patients ask for prayer	0-20% 20-40% 40-60% 60-80% 80-100%
d. How many patients ask for bible reading	
e. How many patients have you known, or do you know, with obvious spiritual questions and/ or needs?	-none -few -about half -many -all
Perceived importance nurses attach….	
f. For how many patients (attended by your team) is the attention to spiritual questions and/ or needs sufficient?	-none -few -about half -many -all
g. In my own team, attention to spiritual questions and/or needs is	-an indispensable element -a very important element -an important element -a less important element -an unimportant element
h. You consider the clear documenting of spiritual questions and/or needs compared with the recording of other questions and/or needs	-unimportant -less important -equally important -more important
Spiritual care provided in practice	
i. Nurses perception of importance of attributes in facilitating of addressing patients' needs	Response options represented a 5-point numerical rating scale with extremes labelled "unimportant" (score 1) to "essential" (score 5).
j. Nurses' strategies to assess patient's spiritual questions and/ or needs	List of options with boxes checked or not

Nurses' perception of patient wishes/ and expectations was measured in five questions (Table 1a-e). The perceived importance that nurses attach to aspects of spiritual care was assessed through three propositions (Table 1f-h). Spiritual care in actual practice was determined with two instruments. First, a list of potential facilitators and barriers referring to perceived importance of nurses' attributes, which comprised 19 items selected from a list of 35 items that also included other characteristics such as demographics. The 19-item list was sufficiently homogeneous with a Cronbach's alpha of 0.80. The items were measured on a 5-point interval scale ranging from 1 (unimportant) to 5 (essential), with labeling of end points only (Table 1i). The second instrument consisted of a list of 14 strategies to assess spiritual questions and/or needs of the patients; endorsement was indicated when the nurse felt this was compatible with her or his personal strategy (Table 1j).

The patient study

All patients in the five departments were asked to complete a short questionnaire; to minimize patient burden the list was as short as possible. Patients capable of doing so completed the questionnaires themselves; if needed, assistance was provided by a trained BSc student or volunteer.

Measurements among patients

The patients' questionnaire examined demographic characteristics, the patient's health status, world view, and experiences regarding admission to the hospital. For these items we used the instrument "Spiritual care in the last stage of life" from the Prof. Dr. G.A. Lindeboom Institute (Jochemsen et al., 2008). The items "Was religious or spiritual background recorded on admission" and "Should religious or spiritual background be recorded on admission" had three answer categories "yes, thoroughly" (in detail); "yes, to some extent;" "no." Furthermore, patients were asked if they were satisfied with the spiritual care (response options: yes, no, not applicable) with five statements, two relating to provision of services, and three to space and support. Questions about the admission experience were formulated for purpose of the study. We used kappa to test agreement between patients' spiritual needs and the practice of recording religious or spiritual background, calculating 95% confidence intervals. Analyses were performed with PASW Statistics version 18.

Results

Nurses

Fifty-one of the 65 participating nurses (78%) completed the questionnaire. Ninety per cent were female, and their mean age was 39.4 years. The majority of nurses (86%) reported a religious affiliation, most reporting being Protestant (51%), or adhering to other (Christian) religions, and some (6%) reported being agnostic (Table 2).

Nurses' perceptions of patients' spiritual needs

More than half of the nurses reported that most of their patients (50% or more) expressed spiritual questions and/or needs (0% of the nurses reported no patients with questions or needs; 43% reported few patients with questions or needs; 27% of nurses reported about half of their patients expressed questions or needs; and 31% of the nurses reported there were many such patients). However, patients infrequently asked direct questions concerning God (never 2%, rarely 42%, occasionally 50%, in half the cases 4% frequently 2%) or about life after death (never 18%, rarely 41%, occasionally 37%, frequently 4%). In addition, according to the nurses, few of the patients wanted someone to read the Bible or pray with them. Almost all of the nurses (98% and 90% respectively) reported that 0% to 20% of the patients made such a request.

It emerged from the interviews that, according to the nurses, patients asked spiritual questions more readily if they noticed that the nurse provided the opportunity. "If the nurse is open to spiritual questions they come naturally;" … "If there is an opportunity, it just happens" (Nurse 6).

Perceived relevance of providing and documenting spiritual care for patients

In the qualitative research, the nurses consistently considered attending to spiritual questions and/or needs a part of their role. They commented that these questions and needs were a part of nursing. "As a good nurse, you're also involved in the search for meaning. Spiritual care is a part of it, just like washing" (Nurse 2). Similarly, in the quantitative research, only one nurse (2% of the nurses) considered spiritual care unimportant. Most nurses (77%) considered documenting spiritual needs equally important as other needs, 22% considered it less important, and one nurse (2%) thought it more important.

Some interviewed nurses commented on the importance of documenting spiritual needs and requirements. "Our job as nurses is to notice and make sure that it's recorded in their chart if a patient mentions something repeatedly, and you feel that just listening isn't enough" (Nurse 3). And another: "I make very brief reports

about spiritual care. Personal issues don't really belong in the nursing report" (Nurse 7).

Table 2 Characteristics of the nurses and patients

Characteristics	
Nurses, % (n = 51)	
Female	90
Age in years	
20-29	22
30-39	32
40-49	30
50 and above	16
Experience as a nurse in years	
1-5	6
6-10	26
11-15	16
16 or more	53
Religion/religious community	
Protestant	51
Roman Catholic	2
evangelical	4
"religious" (not specified)	22
liberal	2
agnostic	6
"not religious"	14
Patients, % (n = 75)	
Female	45
Age in years	
1-50	18
51-60	17
61-70	22
71-80	22
81-	21

Barriers to and facilitators for providing spiritual care

The nurses reflected on a variety of possible barriers and facilitators. They were motivated by the questions raised by the patients, or by their emotions: "In this case, it is my duty to inquire further" (Nurse 1). The nurse's view on spiritual care giving as compatible with the profession was also a facilitator for providing spiritual care: "As a nurse, your task is not only to attend to the physical needs of the patient, I try to see the patient as a whole" (Nurse 1).

Nurses consider giving spiritual care a personal enrichment. "The good thing about spiritual care is that it helps you not see the patient as someone with health

issues, but to see beyond the illness"(Nurse 3). Subsequently, the patients' positive reactions to their care encouraged them to offer spiritual support more often: "I felt pleased when I saw that the patients found our conversation helpful. I find it rewarding to get positive feedback about this, it encourages me to do it more often" (Nurse 6).

Some of the interviewees noted that their personal convictions motivated them to speak about spiritual matters, because it was important to them. At the same time, they were aware that emphasizing their personal opinion was inappropriate. Speaking about their own beliefs was not seen as their primary task. This was consistent with our finding that adhering to the same religion or having the same opinion was considered barely or not important by many nurses (lowest ratings of all items; Table 3).

Various barriers to spiritual care giving were also noted. Several nurses found it difficult not to be able to provide answers: "I don't know what I should say" (Nurse 3). Others observed that this is not the aim of spiritual care. One interviewee said "…you have to accept that. A patient doesn't expect me to have all the answers" (Nurse 8). It can also be difficult to be confronted with certain emotions of patients. "Emotions such as anger and sadness aren't easy. Then you don't know what to say. But actually, you don't have to give answers, just to listen. But it's difficult, because you want to"(Nurse 3).

A relationship of trust was brought up as an important precondition of spiritual care giving: "Through trust you hope that they'll share their concerns with you. You have to build up trust first. Then you can try to help them" (Nurse 5). In the quantitative research, 26% of the nurses reported appearing trustworthy as vital (Table 3). However, the nurses varied considerably in their opinions concerning the importance of believing in a personal God. Twenty per cent found it vital, whereas, 35% found it unimportant. Having a positive attitude towards providing spiritual care can be compatible with not believing in a personal God, as illustrated by a nurse in the qualitative interview study: "Personally I have a very broad outlook. I'm not tied to one God, faith, church or idea. I'm open to everything and everyone. I think everything's possible" (Nurse 6). Another nurse stated that "Everyone is made to have a relationship with God, and I want to let other people know that" (Nurse 8). This illustrates the findings in the quantitative study that personal convictions, including broad spiritual views and belief in a personal God, can motivate and perhaps facilitate spiritual care giving.

Concerning the benefits of training in spiritual questions and needs, opinions differed less. Only 4% found training vital against 6% considering it unimportant. Ninety per cent of the responses were equally distributed across the middle

categories. In the qualitative research the importance of training was mentioned several times: "I've also had a lot of interview training. That has helped me to develop skills in conversation techniques" (Nurse 6). Some nurses were convinced that spiritual care giving is mostly a matter of listening, for which training may not be necessary. "You don't have to learn how to do that" (Nurse 2). "It's mostly listening at the right moment — not interrupting, that's counterproductive. Just take time to let people talk" (Nurse 5).

Table 3 Nurses' perceptions of importance of attributes in facilitating of addressing patients' needs (n = 51)*

To what extent do you consider the following characteristics important in sensitizing the nurses to the spiritual questions and needs of the patient %	Unimportant 1	2	3	4	Essential 5
Willingness to listen	0	0	4	34	62
Availability (having time)	0	0	10	33	56
Ability to sympathise	0	0	8	41	51
Appearing trustworthy	0	2	4	51	43
Openness and tolerance for other opinions	2	0	20	38	40
Friendly	4	0	20	35	41
Ability to silently listen	4	6	14	34	42
Peaceful environment for the patient	0	9	26	41	24
Having a trust relationship with the patient	4	12	20	39	26
Knowledge of other religions	0	10	35	45	10
Personal life experience	2	6	43	37	12
Personal faith experience	8	4	41	33	14
Daring to discuss spiritual issues in the team	6	22	20	43	10
Recognition of own spiritual questions	12	2	50	26	10
Training in spiritual questions and needs	6	28	30	32	4
Belief in a personal God	35	14	12	20	20
Believe in life after death	45	12	12	20	12
Adhere to the same opinions	33	31	29	4	2
Adhere to the same religion	49	24	18	8	2

SD = standard deviation
* For some items, up to two responses were missing.

Lack of time was consistently brought up as a potentially major barrier to spiritual care giving. However, not everyone agreed that its negative impact in clinical prac-

tice was unavoidable: "You have time enough to talk whilst you're washing,"(Nurse 5) and "Just take the time for it."(Nurse 8). Listening-both the willingness and the ability to listen-and availability also emerged as being important in the quantitative data (Table 3). Listening and availability were the most important factors in the quantitative study, along with items relating to empathy, openness to other opinions, and a trusting relationship.

In the interviews, experience of work and life was mentioned as a relevant facilitator in addition to the importance of insight into the nurse's own spirituality: "How I see my own situation, who I am, and so on. Because to share good spirituality, first you have to look into yourself, how you experience it. If you know that, you will be able to handle giving spiritual care" (Nurse 5). A consistent pattern emerged from the interviews of conversational skills, knowledge of other belief systems/life choices, and an open and respectful attitude as contributing to good spiritual care.

Nurse Support for spiritual care strategies

The nurses recognised spiritual needs by picking up signals from the patient. Information from the chart could be helpful in practice. "You have to have an antenna for this sort of non-verbal behaviour. Sometimes you need to see through a mask. But it's important to keep people's experiences at the back of your mind." (Nurse 6). Some nurses discover spiritual needs by asking open questions: "Mostly I listen through asking open questions. I identify emotions (you're worried now).

Table 4 Nurses' strategies to assess patient's spiritual questions and/or needs (n = 51 nurses)

Possible strategy	% endorsed
Posing open question about issues which the patient has already raised	88
Being attentive to behaviour or veiled language that indicate it	80
Waiting till the patient raises issues	57
Asking if the patient has specific wishes (communion, confession, anointing of the sick)	39
Posing open questions about spiritual issues which the patient has already raised	37
Looking in the dossier (admissions form)	35
Looking in the dossier (other comments)	31
Asking during the admission process	30
Waiting until the family indicates need	29
Asking if the patient would like to use the Oasis, quiet room or chapel.	26
Waiting until another team member raises issues	12
Regularly asking about it	8
Waiting until a pastoral worker/minister raises issues	6
Asking if you can end a conversation with prayer	6

I work fairly directly and openly. Then patients usually talk. When they respond, it is obvious that they want to talk" (Nurse 8). One nurse indicated that she approached the subject cautiously: "I don't just suddenly start talking about spirituality. I do it in a roundabout way, very carefully. You have to get a feel for it. You have to relate to the patient, and then you can try it. Otherwise you can easily hurt them" (Nurse 4). The quantitative survey indicated that posing open questions in response to issues raised by the patient was the most commonly used strategy (88%; Table 4). In addition to this active form of uncovering spiritual needs, more passive forms were also specified, such as "Waiting till the patient raises issues."
The quantitative survey showed that overall, 41% of nurses were of the opinion that only few patients received sufficient attention to their spiritual needs and questions, 45% were of the opinion that about half of the patients, and 14% that many of the patients received sufficient attention.

Patients

Of the 96 patients who were in residence at the hospital at the time of the assessment, 19 were not capable of completing the questionnaire or of giving an interview. Of the 77 remaining patients two refused, resulting in a response of 97% (75/77). More than half (55%) of the patients were male; 43% were aged 70 or over; 39% were between 50 and 70, and 18% were younger than 50 (Table 2). On average the questionnaire was completed by patients 9.3 days after admission (range 1-55; SD 10.9).
Over half (57%; 40/70; 5 missing responses) of the patients felt that their religious or spiritual background should be recorded on admission, at least to some degree (Table 5). In practice, however, patient background had been recorded only in a minority of cases (41%; 29/70); kappa for agreement between patient wishes and practice was 0.50 (95% confidence interval, 0.33-0.67). Patients not interested in being asked about this were usually (90%) not asked in practice. However, only one third (33%) of the patients who felt that this subject should be thoroughly recorded, were actually asked about it. Overall, one quarter (24%, 17/70) were asked less than they would wish, while on the other hand, only 6% (4/70) were asked more than they believed was necessary.
Half or fewer of the patients were content with the information provided on services. Most patients were satisfied with the support for dealing with the illness and questions about meaning (72% and 55%, respectively; Table 6), and a considerable minority (28% and 45%) were not satisfied. Less than half of the patients (44%) experienced sufficient receptiveness and support for faith/philosophy of life.

Table 5 Patients' needs for enquiry (n = 70 patients)*

	Practice: Was religious or spiritual background noted on admission			
	Yes, thoroughly (in detail)	Yes, to some extent	No	Total
Needs: Should religious or spiritual background be recorded on admission, *row %* (n)				
Yes, thoroughly (in detail)	*33%* (4)	*25%* (3)	*42%* (5)	*100%* (12)
Yes, to some extent	*4%* (1)	*64%* (18)	*32%* (9)	*100%* (28)
No	0 (0)	*10%* (3)	*90%* (27)	*100%* (30)
Total	*7%* (5)	*34%* (24)	*59%* (41)	*100%* (70)

*excluding 5 cases with missing data

Table 6 Patients' satisfaction with nurses' spiritual care (n = 75)

	%
Provision of information on services	
about the possibility of attending the church services within the hospital and/or to listen to it on the home channel	50
about the hospital's pastor/spiritual worker	31
With regard to space and support	
I have experienced sufficient support from the nurses in dealing with my illness	72
I have experienced sufficient space and support from the nurses for my questions about the purpose and the meaning of my life and my illness	55
I have experienced sufficient receptiveness and support for faith/philosophy of life	44

Discussion

Using a mixed qualitative and quantitative approach, we investigated the need for and expectations of spiritual care of hospitalised patients, and how the nurses on the wards recognised and met these patients' needs.

The nurses in our study considered spiritual care to be a part of their work, but were often unable to carry it out in practice. Ninety-eight per cent of the nursing staff considered spiritual care important or even necessary. Almost half (41%) of the nurses in our study felt that only a few of their patients received sufficient attention to their spiritual needs. The quantitative and qualitative findings indicated

that time to listen, availability, empathic skills, and being open to other opinions, a good relationship of trust were important facilitators for spiritual care giving. As many as about half of the patients were not satisfied with spiritual care in spite of satisfaction reports generally being skewed to more favourable responses.

Consistent with our findings, the nature of spiritual care has been defined as recognizing and assessing spiritual needs, demonstrating empathy and developing a trusting relationship, seeking help, recognizing when to let the patient go, and fostering the search for meaning (Christensen & Turner, 2008). Building of trust may act as a catalyst to meet patients' spiritual needs (Lundberg & Kerdonfag, 2010).

The nurses appeared to assess the patients' wishes by listening to their recollections.

The issue of spiritual needs was raised less frequently with patients who considered questions concerning faith/philosophy of life unimportant than with patients who valued these questions. Possibly, nurses sensed these needs (using their "antenna" according to one of the interviewees) and to some extent served patients according to perceived needs. However, it is worth noting that even in this Christian hospital, with perhaps more nurses who are religious than many other hospitals, a quarter of the patients would have preferred caregivers to raise the issue of faith/view of life more explicitly than had been done. This percentage probably is a proxy for the need to discuss spiritual issues more broadly. Also notable is the fact that the patients were more satisfied with the help they received in dealing with illness than with the provision of (practical) information concerning spiritual care.

In agreement with our study, Charters (1999) found that 90% of nurses considered providing spiritual care part of their role, but only 62% felt prepared to actually do so in practice. The qualitative interviews were a rich source of possible barriers to and facilitators of spiritual care. An important potential barrier to providing spiritual care was lack of time. This corresponds with the findings of others (Chan, 2010; Ross, 2006). Menzies (2005) explained that, "Altogether, nursing time is so tightly scripted to the expected workload requirements that there's little discretionary time left for nurses to deal with the unexpected, just to be spontaneous or to take extra time with a patient who is lonely or distressed" (p. 129). In their study of focus group interviews van Leeuwen et al.(2006) also found that nurses admitted that they sometimes had little or no time for the patient and, hence, for spiritual aspects. They also realized that, in some cases, it is a matter of setting priorities and choosing the right moment.

Cavendish et al.(2006) found in a patient study that patients perceived that nurses did not have enough time to provide spiritual care. This is in line with Edwards et al. (2010) who in their meta-study of qualitative research found that according to

nurses and patients having time to listen is a facilitator for spiritual care. In our study we found that some nurses dealt with this by integrating spiritual care with other types of caregiving. This may suggest that some nurses manage to cope with the perceived lack of time, and that sharing such experiences, for example in a training context, may be beneficial.

However, in our study, lack of training was not uniformly perceived as a major barrier to spiritual care giving; only 4% indicated that training was essential in addressing patients' needs. We further found that very few nurses (6%) found training unimportant, which is consistent with the findings of others (Edwards et al., 2010; Lundmark, 2006; L. A. Ross, 1996; Strang et al., 2002) that few nurses regarded training in spiritual care giving as unimportant, but who also found that many perceived training as highly important. Possibly the nurses in our study, for whom training was scheduled, anticipated the practicalities such as the need to invest time in training, whereas the other studies referred only to the general importance of training in nursing. In a study that did actually refer to taking a course, 28% of the nurses did not plan to do so (Charters, 1999). Lower acceptance of training in real-time scenarios may further support the observed difficulty to achieve high-quality spiritual care in practice, even though our training was found to have measurable beneficial effects, which extended to the patients in the nurses' care (Vlasblom et al., 2011).

In our study we investigated nurses' perceptions of their own spiritual care, as well as the perceptions of their patients. There are a few other, mostly older studies that focus on patients' and nurses' perspectives in the same population. Emblen & Halstead (1993), in a study that was performed in part in a single setting, found that both nurses and patients regarded relationships (presence, trust, sensitivity to needs) and communication (talking, listening) as important in actual spiritual caregiving as religious activities or referral to chaplains. Charters (1999) further found that nurses underestimated the importance of spirituality for their patients. Highfield (1992) specifically looked at nurse-patient pairs and found that nurses did not adequately assess patient needs. She attributed this to a lack of direct discussion, a possible focus on acute physical and other problems and limited time. Time constraints were also cited by most nurses in another study in which pairs of nurses and patients were interviewed (Sodestrom & Martinson, 1987). In that hospital study, few nurses systematically assessed spiritual needs, but most were interested in learning how to do so.

A limitation of our study was that the research was performed in a single hospital with a specific identity. Our mixed-methods study focused on the perception of nurses' and patients in the same setting. Although it is not unusual for qualita-

tive studies to be limited to a single setting, it implies that our findings may not necessarily generalize to other settings. Nevertheless, the nurses in our study did not view the hospital's identity as a barrier to spiritual caregiving — e.g., a nurse reported not feeling any constraints despite working in a Christian hospital, partly because of the multicultural environment. Furthermore, as explained in the methods section we employed an inclusive definition of spirituality in our study. This functional definition is broadly applicable and transcends cultural characteristics and religious contents, providing room for all beliefs. As such, spiritual care is part of holistic care, in which physical, psychological, social and spiritual care are interwoven (Charters, 1999). We have not studied patients' perspectives extensively, nor have we researched the actual nurse-patient interaction. This could be studied in greater depth in future qualitative studies using, e.g., participant observation (ethnographic study) or paired interviews.

Our study showed that nurses need to be better equipped to give spiritual care and support patients. It adds to the literature in that nurses need to learn how best to integrate spiritual caregiving within the constraints of daily practice, and how to use empathic skills and relate to their patients. Future research may examine the effectiveness of training such strategies in improving spiritual care giving and patients' perception of care giving and their spiritual wellbeing. Even for nurses who are very willing to provide spiritual care, the reality may be complex. Training in spiritual caregiving should therefore take note of important barriers such as the experienced lack of time, and the facilitating effect of listening and conversation techniques and building a relationship with the patient. Furthermore, better provision of information, by nurses or other staff, on which types of spiritual care are available, is a promising and relatively simple strategy towards improving patients' access to and satisfaction with spiritual care giving. Such simple, practical interventions, combined with spiritual care giving training for nurses that focuses on attitude and more complex skills, but also on how to shape spiritual care giving in daily practice may improve the quality of spiritual care giving in hospital settings.

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