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

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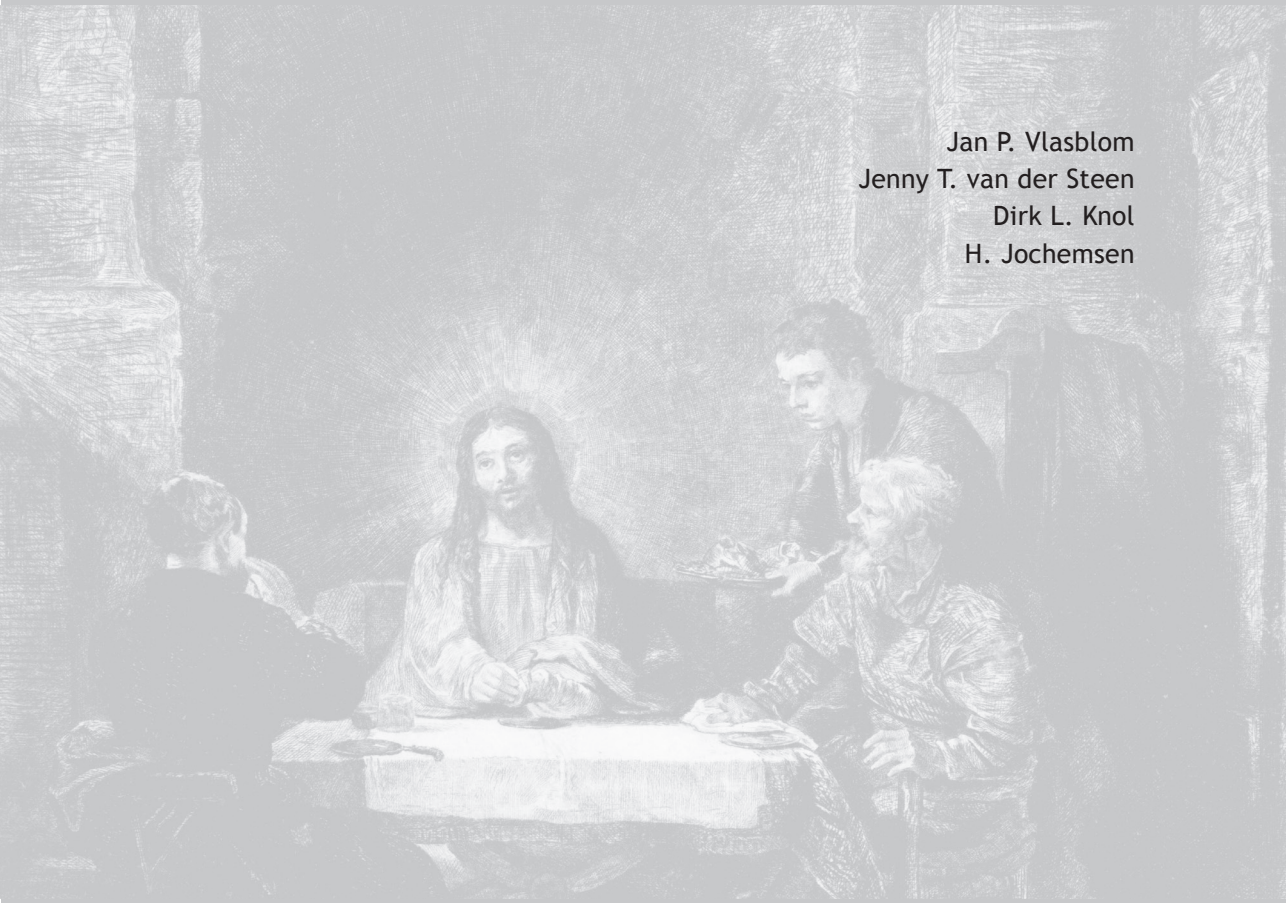
Effects of a spiritual care training for nurses



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Summary

Despite the fact that spiritual care is an essential part of nursing care according to many nursing definitions, it appears to be quite different in practice. A spirituality training for nurses may be necessary to give spiritual care the attention it deserves. In a trial a pre-tested "spirituality and nursing care" training was provided to nurses from four different nursing wards in a non-academic, urban hospital. Prior to the training and six weeks after the training, nurses and all patients were asked to fill up a questionnaire. In addition, the number of referrals from nurses to the chaplaincy was examined. Compared to before (n = 51 patients), after the training (n = 81), the patients from the intervention wards experienced more receptiveness and support when asking questions about illness and meaning. There were also specific changes in nurses' attitudes and knowledge, changes in clinical practice such as documenting spiritual needs and the number of referrals to the chaplains was higher. The results indicate that a training in spiritual care for nurses may have positive effects on health care that patients can experience.

Introduction

Studies conducted in different countries show that spiritual care, though defined in different ways, is an indispensable element of nursing care (Jochemsen, 2005; W McSherry, 2000; Wilfred McSherry, Cash, & Ross, 2004; Narayanasamy & Owens, 2001; Shih, Gau, Mao, Chen, & Lo, 2001). Most of these studies provide a sound basis for the necessity of spiritual care in nursing, especially from the patients' point of view. A review of the literature has shown that there is a relationship between health and spirituality (R. R. Leeuwen van, 2004). Other studies primarily point out a relationship between spiritual care and quality of life (Koenig, 2007; van Leeuwen, 2008).

The integration of spiritual care into nursing is not only necessary from the patients' point of view, it should also enable nurses to provide care in which spiritual questions can be raised. Nurses often experience this as essential to their profession, as it provides depth and greater satisfaction in practicing their profession. There is probably a strong link between the personal approach to spiritual care and the rewarding experience felt by nurses (Narayanasamy & Owens, 2001).

Although spiritual care is commonly regarded a nursing task, it is often inadequately provided in practice(Louis & Alpert, 2000; Ross, 2006). As a consequence of the enlightenment and modernisation, physical life has become separated from the psyche and spirituality from modern medical science (Muldoon & King, 1995). Other obstacles are the increasing protocolling of nursing care in which so far little attention is given to spiritual care, and the use of ever more nursing techniques that claim much attention. Finally, it is apparent that, despite the fact that formally spiritual care has been included in many curricula and nursing codes, nursing schools devote little attention to this form of care. This results in unfamiliarity with spiritual care in the nursing profession, and nurses not being well-prepared for providing spiritual care (Cavendish et al., 2004; Grosvenor, 2000; McSherry, 2006; Ross, 2006).

(Louis & Alpert, 2000), however, found a positive correlation between the ability of nurses who have received spiritual care education and their ability to provide spiritual care. Van Leeuwen (2008) found that spiritual care training positively affects the competencies of nursing students. This supports the notion that spiritual care training in which nurses are familiarised with spiritual care and acquire skills in this field, could be effective. The effects on nursing of various trainings in the field of spirituality have been researched (Hoover, 2002; Leeuwen van, 2008; Lovanio & Wallace, 2007; Meyer, 2003; Milligan, 2004; Pesut, 2002; Sandor, Sierpina, Vanderpool, & Owen, 2006; Wasner, Longaker, Fegg, & Borasio, 2005). The studies indicate that spiritual care training can contribute to the competencies of

the nurses or nurses in training. However, so far, the effects of such training on patient care as reported by the patients have not been studied.

Training in spiritual care is expected to increase the nurses' competencies as well as the spiritual support that patients will experience in their illness (Jochemsen, Klaase-Carpentier, Cusveller, Scheur van de, & Bouwer, 2008; van Leeuwen, 2008; Narayanasamy & Owens, 2001; Ross, 2006). Additionally, spiritual care training would increase the recognition of spiritual questions of patients, which will allow the nurse to refer them to the chaplaincy when appropriate (van Leeuwen & Cusveller, 2004). Moreover, one of the factors that aggravates health care work is the feeling of not being able to come up to the mark (Baldacchino, 2006). Training in providing spiritual care may affect this feeling positively(Baldacchino, 2006, 2008; McNeese-Smith, 1999; Mendes, Trevizan, Ferraz, & Fávero, 2002) and may therefore also be associated with nurses' job satisfaction. Therefore, it was assumed that attention to the patient's spirituality is not only beneficial to the patient, but also to the nurse.

The research described in this article gives an account of the effects of training in spiritual care for nurses in a Christian Dutch hospital, with a relatively large number of Christians among the nurses. The aim was to determine the effects both patients and nursing staff experienced of a nurses' training in providing spiritual care. It concerned the effects of the patients' experience of the care, the nurses' competencies in providing spiritual care, and the number of referrals to the chaplaincy.

Methods

Data were collected between10 January and 10 June 2007 and the design was a trial with questionnaires. Permission was granted for the entire research project by the local Medical Ethical Review Committee. The training and the research took place at the Ikazia Hospital, a medium-sized hospital (330 beds) in Rotterdam with a Christian identity. Many nurses are sympathetic towards religion. A significant part of the patients in the hospital originate from the secularised, urbanised vicinity. Another part is from the surrounding countryside, a region with a significant minority of orthodox reformed Christians.

The nurses' study

The intervention group consisted of all the nurses from four nursing wards of the Ikazia Hospital. These were the internal medicine ward, the neurology ward, the cardiology ward and the **c**oronary **c**are **u**nit. This selection ensured that both nurses who deal mainly with critical patients and nurses who care for mainly chronic

patients participated in the research in about equal numbers. In total, 51 nurses started the training. Two nurses stopped halfway through: one due to a change of ward and one due to stress, so that 49 nurses received the entire training.
The nurses of the four participating wards were proportionally divided into four training groups so that all four training groups held about as many nurses from all four wards (see figure 1). All four groups followed the same training programme.
In addition to the intervention group, there was a control ward. This was the mixed pulmonary disease/urology ward. In this mixed ward, both chronic and more critical patients were cared for and in that respect it matched the composition of the intervention wards. The purpose of the controlled design was to check for possible developments in the area of spiritual care independent of the training programme.
All participants of the intervention and control wards were asked on two occasions to complete a questionnaire. The first occasion was immediately before the training began (T0) and the second one, six weeks after the training (T1) (figure 1). There were insufficient nurses employed to the control ward (only 14) and therefore, we only present data of the ward's patients. All questionnaires were handed in without names because this was requested by the participating nurses.

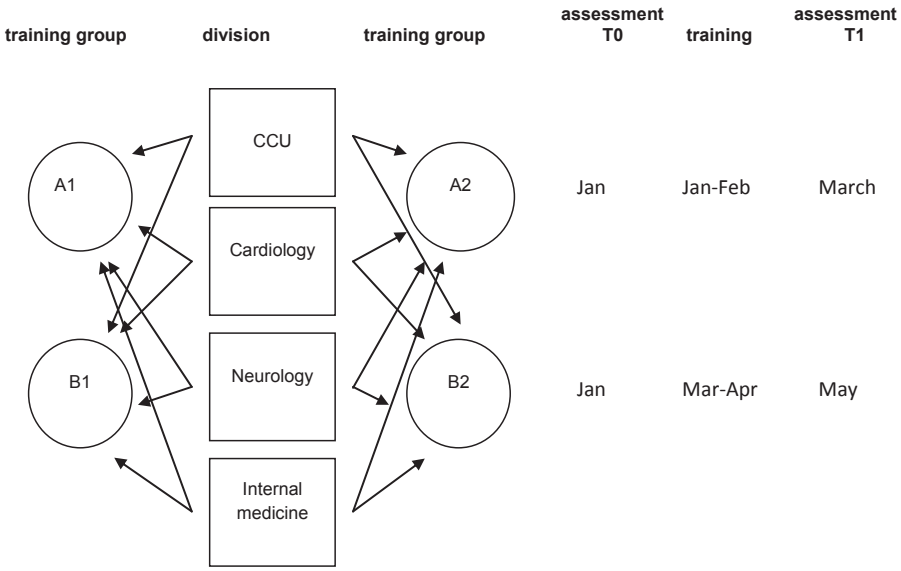

Figure 1 Diagram division training groups

We could, however, retrospectively determine pairs of questionnaires filled out by the same nurse at both moments by linking year of birth, gender, years of experience, and religion. We thus identified 11 paired, 38 single assessments, and 15 assessments that probably included 6 pairs.

The patient study

Patients were blinded to status as experimental and control groups. All (eligible) patients of the intervention wards completed a short questionnaire shortly prior to T0 and about six weeks after T1; both times within a few weeks' time frame. The questionnaire was completed by all patients of the control ward, in addition to patients of the intervention wards. Due to the short-term nature of hospitalisation, the patient population is dynamic and consisted of different people at the various measuring moments. However, the patient populations at T0 and T1 were similar with regard to health and quality of life (see measurement instruments: patients).

Training

The training was based on a thorough analysis of the research projects available to the authors in 2007 (Callister, Bond, Matsumura, & Mangum, 2004; Greenstreet, 1999; Groër, O'Connor, & Droppleman, 1996; Hoover, 2002; van Leeuwen & Cusveller, 2004; van Leeuwen, 2008; Meyer, 2003; Narayanasamy, 1999; Shih et al., 2001). The aims of the training are shown in Box 1. The training is similar to the training as described by van Leeuwen (2008).

In the training (and in the study) we have used the following definition: "Spirituality means the religious or existential mode of human functioning, including experiences and questions of meaning and purpose" (Jochemsen et al., 2008). This functional definition is universally applicable and transcends culture and religion. This enabled both (orthodox) Christian nurses, and those of other faiths or none, to accept and follow the training.

The training consisted of four sessions of four hours that were offered biweekly. In addition to these 16 hours of training, the participants were asked to do homework assignments. The extra hours spent on the homework were paid as overtime. This homework consisted of preparing for the training session, writing reflection reports after every session, and a literature study.

Referral and measurement instruments

The number of patients referred to the chaplaincy by nurses was measured in May 2006 and May 2007. The data was obtained from the registration data of the chaplaincy.

Box 1 Training programme and its aims

Definition of spirituality employed in the training:

Spirituality means the religious or existential mode of human functioning, including experiences and questions of meaning and purpose' (Jochemsen et al., 2008). So it is universally applicable and transcends culture and religion

Aims of the spiritual care training for nurses:

The participants will learn:

- what spirituality is understood to mean;
- which form spiritual questions can assume with patients (related to their illness), which philosophical framework plays a part, which rituals could be of importance;
- what, as seen from their profession, is and is not a part of nursing competency with respect to questions about spiritual matters;
- to put their own spirituality into words and to talk about it with colleagues, especially as far as they deal with the practice of their profession;
- to recognise, acknowledge and map spiritual questions;
- to enter into conversation with patients without any preconceptions and with respect for his culture and for his religious biography;
- to plan, execute, guard and evaluate the spiritual care of the patient in association with other nurses and other disciplines;
- methods of supporting patients in their spiritual perception;
- which material provisions are required in the hospital for an adequate perception of the patient's spirituality;
- to inform the patient about the provisions the hospital offers for spiritual support;

Schedule of the training programme:

4-hour block 1: The place of spiritual care in the nurse's competency profile
4-hour block 2: Communicating about spirituality in the nursing practice
4-hour block 3: Dealing with various religions and working together with the chaplaincy service
4-hour block 4: Spirituality in the nursing plan and in multidisciplinary consultation

Before the inquiry, questionnaires for both nurses and patients were developed and assessed by a few experts in the fields of quantitative research and spirituality and a dozen nurses, and patients pilot-tested the questionnaire with respect to comprehensiveness and practicability. This resulted in a few small linguistic adjustments.

Measuring instruments: Nurses

The questionnaire for nurses examined (based on the nurses' self-report inventory):

— the demographic characteristics;
— their own spirituality;
— the competencies with regard to spiritual care operationalised as spiritual attitude and behaviour concerning spiritual care (clinical practice) and knowledge of the provision of spiritual care;
— job satisfaction.

For this questionnaire, when available, previously employed Dutch-language measuring instruments were used. A part of the Flemish Lucas questionnaire on spiritual care giving (Cornette, 1996), relevant to the research project, was used with some minor adaptations to the Dutch language.
Attitude was assessed with statements on attention to, and recording of spiritual needs. These statements had 4 or 5 answering categories ranging from 'not important' to 'very important'. (box 2)

Box 2 Examples of items of the nurse questionnaire

With an eye to good health care, attention for spiritual questions and/or needs is:	0 not important	0 less important	0 important	0 very important	0 essential
You consider a clear registration of spiritual questions and/or needs compared with the registration of other questions and/or needs as:	0 not important	0 less important	0 important	0 very important	0 essential
If you were asked to record spiritual questions and/or needs would you think this is:	0 pointless (a waste of time)	0 pointless (not my job)	0 worthwhile (helps me to understand the patient)	0 worthwhile (helps the whole team)	0 necessary
For how many patients (attended by your team) is the attention for spiritual questions and/or needs sufficient?	0 none	0 few	0 about half	0 many	0 all

Behaviour (clinical practice) was measured in various ways. For example, questions were asked about recording of spiritual needs, because this is an essential element

of spiritual care (Jochemsen et al., 2008). Furthermore, nurses were asked about their use of faith talk and the performance of religious acts such as praying and Bible reading as elements of spiritual care in practice.
Knowing about the spiritual care services that the hospital offers is part of the clinical practice of spiritual care. According to Van Leeuwen (2008), bearing responsibility for the quality of the spiritual care by the institution belongs to the nurses' spiritual care competencies. Therefore, we have researched what the nurses know of the services provided by the hospital.
Job satisfaction was measured with a series of 5 items that could be affected by the course, such as "The circumstances in which you work". Answering categories ranged from 1 (very dissatisfied) to 5 (very satisfied). Summing up these 5 items, we constructed a scale ranging from 5 to 25.
The questionnaire also included two questions about the difficulty the nurses experienced supporting people with a different view of life and the enrichment they experienced in doing so. Both questions had three answer categories (very difficult, difficult, not difficult, resp. very enriching, enriching, not enriching).

Measuring instruments: Patients
The questionnaire for the patients examined demographic characteristics as well as the patient's characteristics concerning health, view and quality of life and experiences at 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). From this instrument we specifically used the questions which did not directly apply to the end of life. Based on conceptual work in defining spirituality at the end of life (Gijsberts et al., 2011), we assumed that the concepts which are relevant at the end of life are also relevant for spirituality at other times. Quality of life was assessed with the EuroQol (EQ-5d) (Euroqol Group, 1990). Questions about the identity of the hospital and their experience of the admission interview, were phrased for the purpose of the study.

Statistics

Descriptive statistics comprise percentages, averages and standard deviations (SD). Because of the dependency in the dataset (part of the nurses completed two questionnaires), nurse data were analysed using the method of generalised estimating equations (GEE), allowing both for paired and unpaired data in combined analyses (Fitzmaurice, Laird, & Ware, 2004). An exchangeable working correlation was used allowing for correlation between T0 and T1.
For the patient data, Chi-square tests were used for proportions when comparing the T0 and T1 measurements, and independent sample t-tests for means.

We adhered to a significance level of $p < 0.05$; but were also interested in trends ($p < 0.10$).
The GEE analyses were carried out in Stata 10.0 (StataCorp, College Station, TX, USA). All other analyses were performed with PASW 17 (from SPSS Inc., Chicago, IL, USA).

Results

Nurses

Forty-four out of 51 nurses (86%) from the intervention ward completed the questionnaire for the T0 and 31 out of 51 (61%; or 63% of the 49 nurses who followed the training) at T1.
The nurses were mostly women (91%) and half of them (52%) were Protestant (Table 1). More than half (55%) had 16 years or more of experience. The groups on T0 and T1 did not differ in this respect.

After the training, considerably more patients evaluated the attention for spiritual questions and/or needs as adequate (14% on T0, 42% on T1; $p = 0.006$).

Table 1 Characteristics of the nurses of the intervention group

Characteristic, % (n = 44 on T0)	
Female sex	91
Age in years	
20-29	21
30-39	33
40-49	33
50 and above	14
Experience as a nurse in years	
1-5	7
6-10	25
11-15	14
16 or more	55
Religion/religious community	
Protestant	52
Roman Catholic	2
evangelical	5
“religious” (not specified)	23
liberal	2
agnostic	5
“not religious”	11

At the same time, fewer nurses had the impression that this number could be increased (T0: 93%, T1 67%; p=0.003.

The importance attributed to attention to spiritual questions and/or needs and a clear registration of these did not change from T0 to T1. After the training, perceived influence of the nurses' personal view of life had changed. Prior to the training, 67% of the nurses indicated that their personal view of life resulted in easier discussion of spiritual questions and needs. After training, this percentage had risen to 90% (p=0.05).

After training, the nurses indicated to be doing more to identify spiritual questions (Table 2). They searched the patients' files more often for any spiritual needs. They asked patients more often if they desired to go to the chapel, the 'silence centre' or the consultation centre. Except for these points, there was no change in direct communication with the patient about his or her spiritual questions. Nurses still did not systematically address spiritual questions and the degree to which they paid attention to patient behaviour indicating spiritual questions did not increase. According to the nurses under study, more reports were filed about spiritual questions and needs of the patient after training. In the T0 measurement, 18% of the nurses indicated that this was not reported. After the training, this non-reporting no longer occurred (p=0.01) (Table 3). The increase was mostly due to planned documentation during shifts rather than due to unplanned reporting. There was no difference between the number of nurses who prayed together with patients (57% on T0, 65% on T1; p=0.40).

Table 2 Manner of discovering spiritual questions by nurses

Number of times possibility was checked, %	T0 (n=44)	T1 (n=31)	P
By asking if the patient desires to go to the consultation centre, silence centre or the chapel	27	52	0.02
During the admission interview	32	55	0.01
By checking the file	39	68	0.02
By asking systematically for it	7	13	0.67
By asking open questions about what the patient is worried about	89	90	0.85
By watching for certain behaviour or veiled words that point to this fact	80	81	0.92
By waiting for the patient to bring it up himself	57	52	0.62

T0 = measurement before the training; T1 = measurement 6 weeks after the training.

Table 3 Report about the patient's spiritual questions and/or needs

Who makes notes about the patient's spiritual questions and/or needs in %	*T0 (n=44)*	*T1 (n=31)*	*P*
Until now, no reports are written anywhere yet	18	0	<0.001
Report is written by: the nurse	77	97	0.05
This report is written:			
In between times, not planned	57	65	0.50
During the daily transfer	32	55	0.02

Table 4 Knowledge of provision of spiritual care in the hospital

Number of times that possibility was checked in %	T0 (n=44)	T1 (n=31)	P
A Bible for personal use	98	97	0.75
The chapel	79	94	0.10
Anointing of the sick	36	61	0.02
Personal prayer for the illness	71	77	0.48
Sunday church service	96	100	0.98

As regards knowledge of what the hospital offers its patients in the field of spirituality (Table 4), there was little change in issues that were already known by the majority (71% and up) of nurses. However, at the T1 measurement, a higher number of nurses indicated that they realised that patients could ask for the administration of the anointing of the sick, a Roman Catholic sacrament (at T0: 36%, at T1: 61%; p=0.02).

The greater part of the nurses experienced supporting people with another view of life as difficult and enriching. This had not changed after the training (difficult at T0: 58%, at T1: 69%; p=0.36; and enriching at T0: 68% and T1: 62%; p=0.42). The average score for job satisfaction did not differ between T0 and T1 (T0: on average: 18.4, SD 3.1; T1: on average: 19.0, SD 2.9; p=0.44; observed range 13-25 in both assessments).

Finally, results from paired multi-level analyses were similar to results from analyses not taking into account dependency in the data (independent tests comparing T0 and T1).

Patients

Of the 235 patients, 42 (17.8%) were neither able to complete the questionnaire at the time the survey was conducted nor to be interviewed, and 6 patients (2.6%)

refused. Therefore, the response of the patients was 79.5% on average (187/235) and varied between 75% (T1 intervention group) and 89% (T0 control group). More than half (57%) of the patients was male. Nearly half of the patients (47%) was 70 years of age or older; 35% ranged from 50 to 70 years of age, and 17% was younger than 50. There was no difference between the control and intervention groups.

At the intervention wards the satisfaction with regard to information provision of spiritual care did not vary from T0 to T1 (Table 5). At the control ward, however, there was a significant change in this respect: 25% on T0 and 55% on T1 (p = 0.03) of the patients had been informed about the chaplaincy of the hospital.

Table 5 Patients' opinions about nursing care before (T0) and after (T1) the training

	Intervention group			Control group		
Satisfaction, %	T0 (n = 51)	T1 (n = 81)	p	T0 (n = 24)	T1 (n = 31)	P
Information provision with regard to religion and view of life						
about the possibility of attending the church services within the hospital and/or to listen to it on the home channel	45	47	0.84	54	68	0.30
about the hospital's pastor/spiritual worker	31	32	0.93	25	55	0.03
With regard to space and support in general						
I have experienced sufficient support from the nurses in dealing with my illness	69	85	0.02	75	77	0.83
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	47	72	0.005	67	77	0.38
I have experienced receptiveness and support for faith/view of life	43	46	0.78	42	52	0.46

Note: differences between the intervention and control group were not significant at T0 (p = 0.11 for experiencing of space and support, and p = 0.46 to 0.90 for other comparisons).

With respect to the content of spiritual care no change was noted at the control ward. In contrast, at the intervention ward, the patients experienced significantly more often sufficient receptiveness and support for spiritual matters ("I experienced sufficient space and support from the nurses for my questions about the purpose and the meaning of my life and my illness", T0: 47%, T1: 72%; p = 0.005). The intervention group seemed to achieve about the same level

as the control group, who initially, at T0 already tended to somewhat higher endorsement of this item compared with the intervention group (67%; the difference was not significant, however: $p = 0.11$). The scores at T0 and T1 for "experiencing space and support for faith/ view of life" did not differ, and the intervention and control group also did not differ at T0 regarding the other items ($p \gg 0.10$).
The number of patient referrals by nurses from the intervention group increased. Both in and after office hours, an appeal was made on both the hospital's chaplains. In May 2006, 4 referrals were made, in May 2007, there were 13 referrals by nurses to the chaplaincy.

Discussion

We have investigated if, due to spiritual care training, changes occurred in care as experienced by patients, nurses' competencies in spiritual care, the nurses' job satisfaction and the number of patient referrals to the chaplaincy.
Six weeks after the conclusion of the spiritual care training to nurses, positive effects were measured in three of the four fields: with patients, in patient referrals and regarding the nurses' competencies, especially in the field of clinical practice. An important finding is that the patients have experienced more receptiveness and support with regard to their questions about the purpose and the meaning of their lives and their illness. After the training, an increase in the number of patient referrals to the chaplaincy was noticed. Nurses altered their behaviour in several aspects, such as e.g. better registration and asking about the patients' needs. Nurses also more frequently indicated that their personal view of life helped them discuss spirituality with patients. Possibly the nurses were better equipped to use their own spirituality to discuss patients' spiritual questions and needs. We found little to no change as regards knowledge, attitude and job satisfaction after the training. There was no significant change in providing spiritual care in the sense of praying together, an established spiritual care action in a partly Christian setting like the hospital under study.
We found less change in job satisfaction than Wasner et al. (2005). This may be related to the nature of the wards under study. Wasner et al. studied palliative wards. Moreover, one of the goals of Wasner's training was "coping with the emotional effects of the patients' suffering" which is directed towards dealing with work-related stress. This was not part of our training course.
With regard to knowledge about the range of the hospital's services in the field of spiritual care, only the knowledge of the possible provision of the Roman Catholic sacrament of the anointing of the sick increased. Beforehand, the predominantly

reformed believers were apparently less informed about this Roman Catholic sacrament (36%, versus 71-98% of other services).

A remarkable result of the patient inquiry at the control ward is the difference in T0 and T1 as regards satisfaction about information provision with regard to spiritual care. The differences at the control ward (where no intervention was planned, so no training had taken place) were greater than at the intervention wards, where the nurses had received the training. It is possible that awareness developed among the nurses, as a result of the first questionnaire. However, this change could also be due to the visit members of the identity committee paid to the hospital (unrelated to the study) during the time of the data collection. During this visit, the Christian identity of the hospital and the way the ward deals with this was discussed. To explore this issue, in a conversation the researcher had with the people in this ward, he noticed that the committee's visit had quite an impact on this ward, which had been willing to participate in the training, but had to withdraw from participation due to external circumstances. Hence, we could not validly compare parallel changes between the intervention and control group. However, our findings imply that training nurses to provide information efficiently (as evidenced by patients) may be achieved with a relatively simple intervention. By contrast, training to support patients in their struggles with illness and finding meaning in this, is achieved with a full training programme, even in our sample of relatively experienced nurses.

A limitation of this study lies in the small sample sizes. However, the response of the nurses (86% on T0 and 61% on T1) was moderate to good, compared to other researchers' experiences (Baldacchino, 2006), and the patients' response rate was very good. A second limitation is that the nurses all worked at wards of the same hospital with a specific identity and population of nurses. The hospital's long-term policy plan acknowledges the importance of spiritual care as part of the institute's "identity." The plan justifies this approach by referring to part of the patients selecting the hospital because its identity matches their Christian worldview. Support by the management and the hospital policy facilitated the introduction of the training in a predominantly secular environment. However, receptiveness to the training in this study may be similar to settings in U.S. hospitals. Follow-up research should reveal if the effects discovered can be generalised to other hospitals. Further, although patient groups before and after the training were different, we found no difference in patient characteristics. Moreover our approach allowed for examining effects beyond the days after the training (examining such short-term effects would have been unavoidable when asking the same patients during their stay) and also avoided possible bias in the second assessment by the attention being paid to spirituality because of the first interview. Finally, although

we could not fully pair all nurses' data and this limited the power of our analyses, unpaired analyses provided similar results.

Many have argued to train nurses (better) in providing spiritual care (Baldacchino, 2008; Cavendish et al., 2004; van Leeuwen, 2008; Narayanasamy & Owens, 2001). Given the effects we found in our study, which extend to measurable positive effects on patients, we recommend training nurses in providing spiritual care. In our study, modest effects on nurses' attitudes and knowledge of spiritual care were found, and nurses were still rarely asking for spiritual needs directly. They more frequently documented spiritual issues, and a more systematic implementation and consideration of spiritual care by experienced nurses may have affected the important patient outcomes related to finding meaning in life. Follow-up research should concentrate on the most effective elements of the training programme and assess long-term effects in order to establish if periodical repetition of the training will be necessary to maintain positive results.

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