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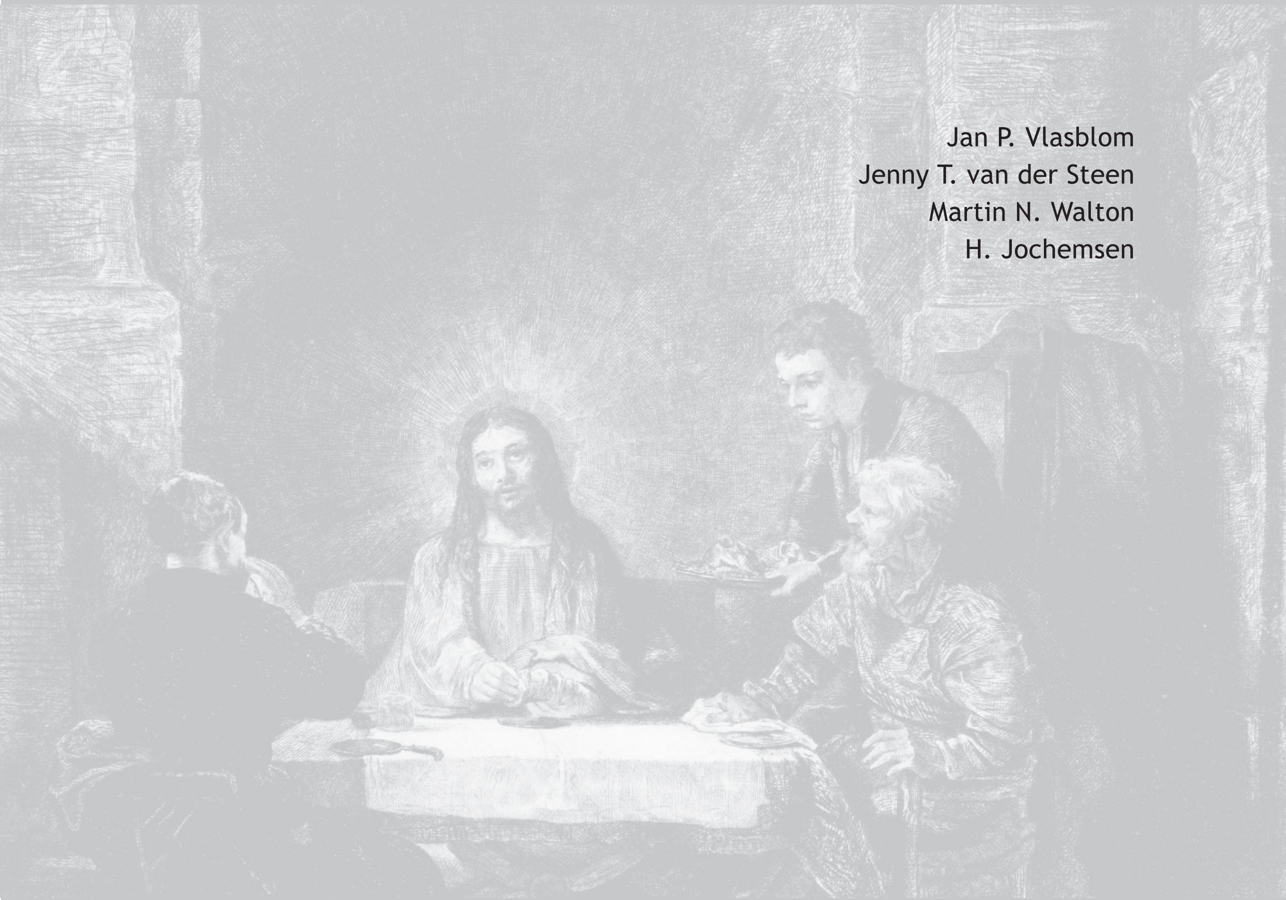
Effects of nurses' screening of spiritual needs of hospitalized patients on consultation and perceived nurses' support and patients' spiritual wellbeing



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Abstract

Background: There is an undeniable relationship between spirituality and health, and taking a spiritual history is a simple way to increase the focus on spiritual care.
Method: Pre/post-test intervention study. Questionnaires were administered before implementation of a spiritual assessment (pre-test, n = 106), and afterwards (post-test, n = 103).
Results: Despite a difficult implementation process the number of consultation requests for the Department of Spiritual and Pastoral Care increased from 2 in the pre-test period to 33 in the post-test period. After adjusting for patient characteristics, we found no differences between pre-test and post-test measurements on the FACIT-Sp-12 total score or nurses' support regarding dealing with illness; we did, however, find a significant decrease on the subscale Faith of the FACIT-Sp-12 and on nurses' support regarding questions about purpose and meaning (97% to 83%).
Relevance to clinical practice: Taking a spiritual history may contribute to the spiritual care of patients in a general hospital in the shape of more frequent referrals to the spiritual caregiver (chaplain), but further research is needed to determine whether this also means that nurses provide less spiritual care.

Introduction

An abundance of research demonstrates a clear relationship between spirituality and health (Handzo & Koenig, 2004; van Leeuwen, 2004; CM Puchalski, 2013). Clinical research on the relationship between spirituality and health finds that, for many patients, spirituality is a critical resource in coping with illness, and is an important component of quality of life (Monod et al., 2011). Other studies indicate a positive relationship between spirituality and quality of life (Brady, Peterman, Fitchett, Mo, & Cella, 1999; Visser, Garssen, & Vingerhoets, 2010). In line with these findings various studies show that attention for their spirituality is important to patients (Lind, Sendelbach, & Steen, 2011; Vlasblom, van der Steen, Knol, & Jochemsen, 2011), so there is a strong relationship between the degree to which staff addressed emotional/spiritual needs and over-all patient satisfaction (Clark, Drain, & Malone, 2003). Also the spiritual care for residents of long term care in the last phase of life was positively associated with family reports of better overall care (Daaleman, Williams, Hamilton, & Zimmerman, 2008). In addition there is evidence that, regardless of their religious or spiritual background, patients consider it important that their practitioner pays attention to their spirituality, (Cavendish et al., 2006; Clark et al., 2003; Edwards, Pang, Shiu, & Chan, 2010; L. A. Ross, 1997; Williams, Meltzer, Arora, Chung, & Curlin, 2011) and that patients prefer that the practitioner takes initiative (Ellis & Campbell, 2004). Taylor justly points out that a respectful approach in this care is of great importance (Taylor, 2007). Despite the conceptual ambiguity, there is increasing evidence for the efficacy of spiritual care, for example correlations between the provision of spiritual care and patients' reported Quality of Life (Kalish, 2012). And so there have been calls from different countries and related cultures to include spiritual care in nursing practice (Biro, 2012; Draper, 2012; Vlasblom et al., 2011). As a result, spiritual care by nurses has been incorporated in many professional nursing codes as part of nursing care (ANA, 2010; ICN, 2012; Leistra, Liefhebber, Geomini, & Hens, 1999).
Despite the evidence-based arguments in favour of spiritual care provision by nurses, spiritual care proves to be a problematic element in nursing practice (Narayanasamy, 2004).
The main barriers to spiritual caregiving reported by nurses are: lack of time (Carr, 2010; Christensen & Turner, 2008; Edwards et al., 2010; Lind et al., 2011; L. Ross, 2006; Vlasblom, van der Steen, & Jochemsen, 2012), the notion that spiritual care is not part of the nurse's tasks (Carr, 2010; Hoffert, Henshaw, & Mvududu, 2007; Meyer, 2003), lack of education/training (Edwards et al., 2010; Meyer, 2003; Narayanasamy & Owens, 2001; L. Ross, 2006), lack of clarity about, or a difficult relationship with one's own spirituality on the part of the nurse (Hoffert et al.,

2007; Meyer, 2003; Vlasblom et al., 2012; Wasner, Longaker, Fegg, & Borasio, 2005), a misperception of the concept of spirituality in which spirituality is seen as a particular type of religion (Baldacchino, 2008b; Narayanasamy & Owens, 2001), medical-scientific ways of thinking and the related technicalization of health care that supposedly leaves no room for spirituality (Carr, 2010; Oldnall, 1996; CM Puchalski, 2013; Vlasblom et al., 2012).

There are many who advocate providing spiritual care training to nurses (Baldacchino, 2008a; Narayanasamy & Owens, 2001; Ruder, 2013; Shih, Gau, Mao, Chen, & Lo, 2001). However, very little research has been conducted into the effects on patients of a spiritual care training of nurses. To the best of our knowledge, there are no studies evaluating the long-term effects of such training, for example after 6 months or longer. Our own research shows that after six months the number of consultation requests for the Department of Spiritual and Pastoral Care following the training as described by Vlasblom et al. (2011) has stabilized at the pre-training level again (unpublished data).

In conclusion, we can state that there is an abundance of evidence that spiritual care is important, but the actual provision of this care is under considerable pressure. The main challenge is to eliminate as much as possible the barriers to providing spiritual care. From the perspective of the above-mentioned barriers this means that spiritual care must not take up too much time, must fit into the nursing activities, must require little training, must be based on a broad definition of spirituality, and must not contradict with medical-scientific thinking.
Based on these requirements taking a (very brief) spiritual history from all patients to assess spiritual needs could well be a good solution. This is not demanding for the nurse. It is easily incorporated in the existing medical history that is completely accepted in care practice.
The idea of the spiritual needs assessment is in line with findings of various researchers who advocate such an assessment (Blanchard, Dunlap, & Fitchett, 2012; Draper, 2012; Monod et al., 2011; Christina Puchalski et al., 2009; Stoll, 1979; van Leeuwen, Schep-Akkerman, & van Laarhoven, 2013; Visser et al., 2010). At the same time various studies indicate patients themselves report that attention for spirituality in their medical history is important (Blanchard et al., 2012; van Leeuwen, 2004; Vlasblom et al., 2012).
In spite of the existing attention for a spiritual needs assessment, no research — that we could find — has been conducted into its effects. We do find reports on the barriers to taking a spiritual history (Ellis & Campbell, 2004; Hoffert et al.,

2007; McSherry & Ross, 2002; Swift, Calcutawalla, & Elliot, 2007), reports that frequently mention the nurses' lack of clarity regarding their own role.

In line with the literature we describe, for illustrative purposes, the process of the implementation of taking a spiritual history, including the obstacles we encountered along the way. The spiritual history was included in the general medical history that is taken on admission of a patient to a general hospital.

Research question 1) concerns whether the question about religious or spiritual background, which was already included in the original history assessment instrument, is asked more frequently by nurses after the implementation of a spiritual assessment.

Hypothesis 1) The question about religious or spiritual background will be asked more frequently as a result of the extra attention for the religious or spiritual background of the patient.

Research question 2) what is the effect of the implementation of spiritual assessment on the number of requests for consultations for the Department of Spiritual and Pastoral Care?

Hypothesis 2) The number of consultations for the Department of Spiritual and Pastoral Care will increase.

Research question 3) what is the effect of a spiritual needs assessment on the care provided by the nurse as experienced by the patient and on the spiritual wellbeing of the patient?

Hypothesis 3) The spiritual assessment results in patients experiencing attention from the nurse and spiritual caregiver for spiritual needs at admission and during their stay, and thereby to experiencing nurses' support and wellbeing.

Method

The pre/post-test intervention study was conducted in a medium-sized hospital (310 beds) with a Christian background in a large city in the Netherlands and it was approved by the review board. On admission of clinical patients the hospital takes an electronic patient history using the software programme Mediscore. The programme's software is used to administer the hospital's own general patient medical history. Using a laptop the nurse administers this assessment to the patients, together with the patient's loved one if applicable. The assessment focuses on, among other topics, the reason for admission, the patient's expectation regarding the admission, experiences during previous admissions, secondary diagnoses, any specific details that need to be taken into account, use of alcohol and/or drugs, risk of delirium and pressure sores and malnutrition. A printed version of the assessment is added to the paper medical records. In addition, various data (e.g.

concerning pressure sores and malnutrition) are used as input for performance indicators. In the digital assessment all questions are addressed automatically. Although it is not the intention, the nurse has the option of skipping questions. In case of particular scores the Mediscore programme has the possibility of automatically sending an e-mail to a department requesting a consultation. Until now these automated e-mails were sent to, for example, the dietetics department in case of (imminent) malnutrition.

Our spiritual assessment was implemented in this existing general assessment. In case of a positive score on the spiritual assessment, the Department of Spiritual and Pastoral Care receives an e-mail containing the patient's personal details and the result of the question about religious or spiritual background.

Prior to the implementation, a pre-test measurement was conducted on the seven hospital wards that use this digital medical assessment instrument. The pre-test measurement took place between September and November 2013. It included three aspects:

1) Based on the data of the electronic medical assessment we investigated how frequently the question about religious or spiritual background actually was asked. (This question had always been part of the general medical history.)
2) The Department of Spiritual and Pastoral Care recorded the number of requested consultations.
3) A questionnaire was administered to patients who were admitted for more than two days.Patients capable of doing so completed the questionnaires themselves; if needed, assistance was provided by a trained BSc student. The patient questionnaire consisted of several instruments. We had used the outcome measures for nurses' support in earlier research (Vlasblom et al., 2011). We selected the items that related specifically to nurses and that were responsive in the earlier study: "Have you experienced sufficient support from the nurses in dealing with your illness?"; "Have you experienced sufficient space and support from the nurses for your questions about the purpose and the meaning of your life and illness?"

There were no ceiling effects and they showed effects of the training course under study. Questions concerned patients' perception of the process of spiritual caregiving:

Was religious or spiritual background noted on admission? There were three response options: "Yes, thoroughly", "Yes, to some extent", "No".

Were you informed about the hospital's pastor/spiritual worker, with the options: "yes" and "no"

About nursing care:
I have experienced sufficient support from the nurses in dealing with my illness (yes, no).
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 (yes, no).
We also included the question whether the patient was asked about his/her spiritual or religious background during admission. For the item spiritual wellbeing we used (with permission from FACIT.org) the Dutch 12-item Scale of the Functional Assessment of Chronic Illness Therapy — Spiritual Wellbeing (FACIT-Sp-12) questionnaire. The FACIT-Sp is frequently used, is not restricted to a particular religion, focuses on experiences and attitudes, and is valid and reliable (Brady et al., 1999; Canada, Murphy, Fitchett, Peterman, & Schover, 2008; Murphy et al., 2010; Peterman & Fitchett, 2002). The Dutch translation comes from www.facit.org. The Dutch translation has also been used by De Jager Meezenbroek et al (Jager Meezenbroek de et al., 2012).
In January 2014, the spiritual needs assessment was implemented. It consists of an introduction, followed by the actual question. With regard to the introduction the nurse was free to improvise; not so with regard to the question.
Introduction: At Ikazia Hospital we feel it is important to not only pay attention to the physical wellbeing of a patient. We also take into account the spiritual wellbeing of this person. Where does an individual find strength, where does he/she find comfort or guidance? When an individual is ill this can be very important.
Question: In your present situation do you sense a need of spiritual support?
Of course you can also let your nurse know at a later stage.
If the patient answers affirmatively to the latter question at admission or perhaps later, an email is automatically sent to the Department of Spiritual and Pastoral Care.
One month after the introduction of the question in the assessement a post-test measurement started, which lasted three months (February-April 2014). In the post-test measurement we examined:
(1) Patient history
Based on the data in the electronic medical assessment we examined how often the question about religious or spiritual background was asked. We used the Z score to test the difference between pre-test and post-test frequency.
We furthermore examined how many times the (new) question “In your present situation do you sense a need of spiritual support?” was asked.
(2) Consultation requests for the Department of Spiritual and Pastoral Care
Apart from the regular consultations requested by nurses, the Department of Spiritual and Pastoral Care also records the number of consultation requests that the

medical assessment programme automatically emails to the spiritual caregivers when the patient answers the spiritual question affirmatively.
(3) Questionnaire: process and patient outcomes
We administered the same questionnaire that was used in the pre-test study to patients who had been admitted for more than two days.

Statistical analysis

We compared patient characteristics of the pre-test and post-test groups using chi square tests in the case of dichotomous variables, and t-tests for age and health condition. Length of stay was compared using the non-parametric Mann Whitney-U test because of the non-normal distribution. For the item 'religious or spiritual background was noted' we conducted a hierarchical Gamma test as well as a chi-square test to check for shifts between the categories. We conducted regression analyses with the intervention (post-test versus pre-test) as the independent variable, and spiritual wellbeing (linear regression) and nurses' support (logistic regression) as the dependent variables. To account for the dynamics of the study population we adjusted for the difference in case mix between pre-test and post-test measurements by including age, gender, religious background and length of stay as independent variables. In a separate regression analysis we also adjusted for health, because of the possible link between subjective health and spiritual wellbeing. We imputed the patient average when fewer than half of the items were missing in the FACIT-Sp-12 total score and subscale scores. A total of 15 total scores were missing, 14 scores on the subscale Meaning and peace, and 24 scores on the subscale of Faith.

Power

Power analysis showed that to be able to demonstrate, in the case of 7 participating wards, a difference of 3 on the FACIT-Sp-12, with an SD of 8.5, required a total of at least 146 patients (73 per group). The 8.5 SD was an estimate based on published articles (Canada et al., 2008; Murphy et al., 2010; Peterman & Fitchett, 2002). We aimed for 100 patients per group.

Results

Genesis of the spiritual history (Box 1)

Early in 2013 the hospital identity committee was contemplating, at the instigation of the spiritual caregivers who are also members of the committee, the implementation of a spiritual needs assessment for all clinical patients.

Box 1 Decision-making process regarding spiritual assessment

The existing general patient medical assessment includes ***A:*** a question on religious/spiritual background: What is your religious/spiritual background: Protestant Roman Catholic Muslim Humanistic Hindu Other No religion	
The identity committee presents proposals for ***B***: spiritual needs assessment	
(a) March 2013, proposal from identity committee	Rejected by management
Can you indicate whether you have had trouble or experienced problems in the past week, including today, with • meaning of life / religious or spiritual beliefs • trust in God / faith *Response options*: yes, no (from the Dutch Distress Thermometer (Werkgroep Richtlijn detecteren behoefte psychosociale zorg, 2010)) Does the patient in the opinion of the nurse have a need for spiritual care *Response options:* yes, perhaps, no	Argument Expanding the general patient history with this spiritual assessment places an unacceptable extra burden on the nursing staff
(b) May 2013, following discussion between management and committee the proposal is presented to team leaders	Proposal also rejected by team leaders
Can you indicate whether in the past week, including today, you have had trouble or experienced problems with • meaning of life / religious or spiritual beliefs *Response options:* yes/no • trust in God / faith *Response options:* yes/no (from the Dutch Distress Thermometer (Werkgroep Richtlijn detecteren behoefte psychosociale zorg, 2010)) Does the patient in the opinion of the nurse have a need for spiritual care *Response options:* yes/ maybe/no	Argument Questions are too confrontational for the patient. Questions are focused too much on oncology patient and too burdensome to present to all patients. Questions demand too much from the nurses In addition there is doubt about the point of these questions
(c) June 2013, in order to accommodate the team leaders the committee decides to relinquish the requirement of a validated instrument	Proposal rejected by team leaders

Do you have trouble finding support in your faith or your religion? yes/no Do you feel a need for spiritual support? *Response options:* yes/no	Argument Questions are too confrontational for the patient. Questions are too much invasion of privacy Too difficult for nurses to handle responses to these questions.
(d) August 2013, to make the question as easy as possible the committee proposes the simple question: do you feel a need for spiritual support? *Response options:* yes/no Because "spiritual support" is a vague term that easily leads to misunderstanding the committee suggests that this question is preceded by an introduction.	Rejected by team leaders
(Introduction) At Ikazia Hospital we feel it is important to not only pay attention to the physical wellbeing of patients. We also take into account the spiritual wellbeing of the person. Where does an individual find strength, where does he/she find comfort or guidance? When an individual is ill these things can be very important. In your present situation do you sense a need of spiritual support? *Response options:* yes/no Naturally you can also let your nurse know at a later stage.	Argument This question is too long for the programme; moreover the team leaders are of the opinion that nurses are capable of formulating the introduction to the question.
(e) September 2013, the team leaders present the proposal	Rejected by identity committee
Do you (presently) feel the need for support from a spiritual caregiver? *Response options:* yes / no	Argument The question is not merely intended to request a consultation from the spiritual caregiver and must not give the impression that the there is no role for the nurse
(f) October 2013, the committee presents proposal (d) again, this time without the introduction. With this question the nurse is expected to provide his/her own introduction	This proposal is accepted
In your present situation do you sense a need of spiritual support? Naturally you can also let your nurse know at a later stage. *Response options:* yes/no. The question can be skipped.	

This assessment had to be implemented in the (digital) medical history that is taken upon admission of the patient to hospital.

As the spiritual assessment had to take as little time as possible, we searched for an instrument consisting of no more than three questions. In addition, the assessment had to be easy to administer and easy to answer for all patients. Because of

these requirements and the digital processing the instrument had to be in the form of multiple-choice questions. Furthermore, we preferred a validated instrument.
The multitude of history-taking instruments did not seem to include any instrument that met our requirements (Draper, 2012; Monod et al., 2011; Pierce, 2004; Piotrowski, 2013; van Leeuwen et al., 2013). Every known spiritual needs assessment instrument was (much) more elaborate than necessary for our purposes. We finally decided to take the two spiritual questions from the Dutch Distress Thermometer as our starting point. The distress thermometer (Bannink, 2012; Werkgroep Richtlijn detecteren behoefte psychosociale zorg, 2010) is a validated instrument (Tuinman, Gazendam-Donofrio, & Hoekstra-Weebers, 2008). The questions for our assessment were formulated as follows: 'Can you indicate whether you have had trouble or experienced problems in the past week (including today) regarding the meaning of life/religious or spiritual beliefs?' 'Can you indicate whether you have had trouble or experienced problems in the past week (including today) regarding trust in God/faith?' Both questions could be answered yes or no. The committee added a question that needs to be answered by the nurse: 'In the opinion of the nurse, is the patient in need of spiritual care?' There are three answer categories: yes — maybe — no.
Box 1 (a) In March 2013 the hospital identity committee advised the management to implement this spiritual assessment. This recommendation was rejected by the hospital management with the argument that these questions demanded too much of the nurses' time. Box 1 (b) After consultation with the management it was decided that the team leaders of the nursing wards were to make the decision about implementation. In a meeting the team leaders rejected the suggested questions. Eventually (f) a compromise was reached to carry out a pilot with only one question that the nurse should introduce as he/she sees fit. "In your present situation do you sense a need of spiritual support?*? Of course you can also let your nurse know at a later stage."* The decision whether or not to continue the pilot, perhaps with other questions, was to be made after an evaluation.
Before the question was implemented all the wards were visited by the hospital's two spiritual caregivers and they briefly presented the spiritual assessment question. The nurses were not informed of the fact that one of the two spiritual caregivers would use the data of the implementation of the spiritual assessment in a study. Two weeks after the implementation all nursing wards received several instruction cards with the proposed introduction text to remind the nurses of the importance of administering this new question carefully.

Spiritual assessment (1)

During the pre-test measurement the religious/spiritual background of the patient was noted for 58.1% (1805/3106) of admissions (see Table 1). During the post-test measurement the answer to the question was recorded for 66.1% (1963/2970) of admissions.

The Z-test results were: difference = −0.0798, Z = −6.407, $p < .0001$. Of the 2970 patients who were admitted during the post-test phase 325 (10.9%) received the question on their sensed need for spiritual support; of these 24 responded yes (7.3%) and 301 responded no (92.6%).

Table 1 Registration of religious affiliation in pre-test and post-test measurements (% of total number of admitted patients)

Religious affiliation	pre-test (n = 3106)	Post-test (n = 2970)
Not recorded	41.9	33.9
No religion	29.5	34.7
Protestant	11.9	15
Roman Catholic	4.6	5.7
Muslim	4.3	4.6
Hindu	0.9	1.1
Humanistic	0.1	-
Other (not specified)	6.6	4.8

Consultation requests Department of Spiritual and Pastoral Care (2)

During the pre-test measurement in the months September to November 2013 there were two requests from the nursing staff for a consultation by the Department of Spiritual and Pastoral Care. During the post-test period 9 requests for consultations were received from the nurses. In addition 24 automatic requests for consultation came in via the digital general history-taking programme.

Patient study (3)

During the pre-test measurement 329 patients were approached with the questionnaire. Of these 329 patients 90 (27%) were not capable of filling in the list. Of the remaining 239 patients 133 patients (56%) refused to participate, and 106 patients (44%) did complete the questionnaire.

During post-test measurement 258 patients were asked to complete the questionnaire. Of these patients 79 (31%) were not capable of filling in the questionnaire. Of the remaining 179 patients 75 patients (42%) refused to complete the questionnaire, and 103 patients did complete the questionnaire.

A little over half of the respondents were female (pre-test 54%, post-test 58%; Table 2). The average age at pre-test was 67.5 years and during post-test 63.7 years. Only the health condition differed significantly (p = 0.018), and received an average score of 62.1 at pre-test and 53.7 at post-test; the other characteristics, including length of stay and spiritual background (Table 2) did not differ.

Table 2 Patient characteristics and patients' perception of the process of spiritual caregiving

		Pre-test (n = 106)	Post-test (n = 103)	p
Patient characteristics				
Female, %		(n = 98) 54	(n = 101) 58	0.54
Age in years (SD)		(n = 96) 67.5 (16.2)	(n = 99) 63.7 (18.2)	0.12
Health condition (1-100) (SD)		(n = 101) 62.1 (27.4)	(n = 102) 53.7 (22.7)	0.018
Length of hospital stay until assessment, mean number of days (SD)		(n = 97) 7.8 (8.3)	(n = 96) 5.2 (4.8)	0.23
Any spiritual background, %		(n = 102) 58	(n = 103) 49	0.18
Perception of the process of spiritual caregiving				
Was religious or spiritual background noted on admission, %	Yes, thoroughly	(n = 15) 15	(n = 4) 4	0.98 (no difference in trend)*
	Yes, to some extent	(n = 26) 25	(n = 40) 40	
	No	(n = 62) 60	(n = 55) 56	
Informed about the hospital's pastor/spiritual caregiver, %		(n = 65) 52	(n = 72) 42	0.21

* Hierarchical gamma test. Chi-square test: p = 0.008 (difference in distribution, no hierarchy assumed).

Process surrounding admission

Before the intervention 15% of respondents indicated that they were asked about their religious background thoroughly, after the intervention this was 4%. Of the pre-intervention patients 25% indicated that they were asked about their religious background to some extent, after the interventions this percentage was 40%. During the pre-test phase 52% of respondents were aware of the presence of the spiritual caregiver, during the post-test phase 42% of respondents were informed.

Outcomes

Table 3 indicates that the outcomes spiritual wellbeing and nurses' support were at a lower level (less positive) at post-test. Table 4 shows that after adjustments for patient characteristics between both patient groups (but also unadjusted) the post-test FACIT-Sp-12 subscale Faith scores were significantly lower than during the pre-test period (unadjusted: 1.6 points lower, fully adjusted: 1.3 points lower and p = 0.036).

The item "support regarding the purpose and meaning of life and illness" showed a significant drop: at pre-test 97% said yes, compared to 83% after the intervention (OR 0.15, CI 0.04-0.61; p = 0.004).

Table 3 Patient outcomes

	Pre-test (n = 106)	**Post-test (n = 103)**
FACIT-Sp-12 total score, mean (SD)	(n = 97) 31.6 (8.8)	(n = 97) 29.2 (6.8)
FACIT-Sp-12 Meaning and peace subscale score, mean (SD)	(n = 97) 23.7 (5.8)	(n = 98) 22.8 (4.3)
FACIT-Sp-12 Faith subscale score, mean (SD)	(n = 92) 7.7 (4.4)	(n = 93) 6.1 (4.3)
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, %	(n = 86) 97	(n = 77) 83
I have experienced sufficient support from the nurses in dealing with my illness, %	(n = 96) 98	(n = 98) 94

FACIT-Sp-12 = Functional Assessment of Chronic Illness Therapy — Spiritual Wellbeing 12 item scale. Range: 0 to 48; higher scores represent higher spiritual wellbeing

Discussion

We investigated the implementation of a spiritual question in the digital general patient medical assessment and the effects of this implementation in a general hospital in the Netherlands.

The entire implementation process proved to be a difficult one. Prior to the implementation numerous arguments were raised not to implement a spiritual history. These counter arguments turned out to be the same as those found by Swift, Calcutawalla and Elliot (Swift et al., 2007) and also mentioned by others (Ellis & Campbell, 2004; Hoffert et al., 2007; McSherry & Ross, 2002). There is a fear that the questions are too confronting for the patient, or that privacy will be violated.

Table 4 Effects of the spiritual assessment on patient outcomes

	Spiritual wellbeing, associations with linear regression, b (95% CI)			Nurses' support, associations with logistic regression, OR (95% CI)	
	FACIT-Sp 12 total score (n = 194)*	FACIT-Sp 12 Meaning/ Peace subscale (n = 195)*	FACIT-Sp-12 Faith subscale (n = 185)*	For my questions about purpose and meaning (n = 163)*	In dealing with my illness (n = 194)*
Unadjusted model					
Intervention (post versus pre-test)	*−2.5 (−4.7; −0.2)*	−0.8 (−2.3; 0.6)	*−1.6 (−2.9; −0.3)*	*0.18 (0.05; 0.65)*	0.33 (0.06; 1.7)
Partly adjusted models					
Intervention, adjusted for age and gender	−2.2 (−4.5: 0.01)	−0.7 (−2.2; 0.7)	*−1.5 (−2.7; −0.2)*	*0.16 (0.04; 0.59)*	0.29 (0.06; 1.5)
Intervention, adjusted for age, gender, religious background, length of stay until assessment	*−2.4 (−4.6; −0.2)*	−0.9 (−2.4; 0.6)	*−1.3 (−2.6; −0.1)*	*0.16 (0.04; 0.62)*	0.24 (0.04; 1.3)
Fully adjusted model (also includes health)					
Intervention	−2.2 (−4.5; 0.1)	−0.7 (−2.2; 0.8)	*−1.3 (−2.6; −0.1)*	*0.15 (0.04; 0.61)*	0.27 (0.05; 1.6)
Covariates in this model:					
– age (per year increment)	0.059 (−0.006; 0.12)	0.019 (−0.023; 0.062)	0.032 (−0.003; 0.068)	0.99 (0.96; 1.02)	0.97 (0.92; 1.02)
– gender, male	1.3 (−0.9; 3.6)	0.71 (−0.77; 2.2)	0.51 (−0.73; 1.7)	0.41 (0.14; 1.2)	*0.17 (0.04; 0.93)*
– having any specific religious background	*2.7 (0.5; 4.9)*	0.4 (−1.0; 1.9)	*2.6 (1.4; 3.8)*	0.71 (0.23; 2.2)	0.43 (0.09; 2.1)
– length of stay until assessment (per day increment)	*−0.18 (−0.34; −0.01)*	−0.10 (−0.21; 0.01)	−0.08 (−0.18; 0.01)	1.04 (0.91; 1.20)	1.04 (0.90; 1.19)
– subjective health (increment 1 point)	0.024 (−0.021; 0.068)	−0.026 (−0.004; 0.055)	0.000 (−0.025; 0.024)	0.997 (0.97; 1.02)	1.01 (0.98; 1.04)

In addition there is a lack of clarity about the nurse's own role and the value of recording spiritual information.
It seems plausible that the barriers that were present at the implementation of the spiritual assessment are partly responsible for its poor execution. After the implementation the spiritual history is taken from only 10.9% of patients. For almost 90% of patients the experience surrounding admission, therefore, does not change. Of the patients who are asked about their spiritual background 7% indicate they feel a need for spiritual support. This means that in less than 1% of the total population the spiritual need assessment has a direct effect, namely a visit from the spiritual caregiver, and possibly additional spiritual care from the nurse.
Despite the poor execution by the nurses and the limited support from management the effects on the number of consultations requested from the Department of Spiritual and Pastoral Care are considerable. During the post-test measurement (February-April 2014), apart from 24 consultations through the digital programme there were 9 requests for consultation via the nurses as compared to 2 requests during the pre-test period (September-November 2013).
The first hypothesis that there will be extra attention for the religious or spiritual background of the patient is affirmed.
Further, the second hypothesis that the intervention will effect an increase in the number of consultations for the Department of Spiritual and Pastoral Care, is also affirmed.
The last hypothesis that by taking patients' spiritual history nurses will develop more attention for spiritual needs and that this will be noticeable for the patient may be plausible in light of the number of consultations not requested as a result of the digital history (from 2 during pre-test to 9 during post-test). In view of the increase in the number of consultations, therefore, taking a spiritual history appears to have added value. However, in contrast to our third hypothesis, there appears to be a negative effect, even after adjusting for patient characteristics, on the spiritual care experienced by the patient from nurses during the hospital stay (Tables 3 and 4). It is remarkable that the item "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" also scores significantly lower after the intervention (pre-test 97%, post-test 83%). There seems to be a ceiling effect here. Although this item was responsive in our previous study (increase from 47% to 72% after training nurses in spiritual caregiving), the post-test scores could barely be higher than the pre-test scores. One possible explanation for this decrease is that the nurses assume they are not required to provide spiritual care after they have requested a consultation from the Department of Spiritual and Pastoral Care. This explanation is supported by our findings that there is a post-test shift in how

adequately patients are asked about their religious or spiritual background from "thoroughly" and "not" towards "to some extent". In view of the difficulty nurses have with providing spiritual care, they might see the possibility of passing this care on to someone else as a welcome solution. Another possible explanation is that there are differences between both patient populations other than, for example, subjective health, for which we could not adjust, which may have resulted in residual confounding. This might also be related to seasonal influences (pre-test period: September — November 2013; post-test period: February — April 2014).

Limitations

According to the power calculations the size of the population was more than adequate. One limitation is that the study was conducted in only one hospital. Our study should therefore be viewed as a case study on the implementation of the spiritual needs assessment which reports on process measures and patient outcomes. Of the 418 patients who were capable of completing the questionnaire, 50% (208/418) refused to do so. A considerable number of them received the questionnaire, but did not return it. One possible reason is, as some non-responders articulated: "it focused a lot on faith and identity". The post-test response was higher (58%) than pre-test (44%) and selective response may have influenced the results.

The intervention was carried out in only a small proportion of general patient histories (10.9%). This obviously limits the direct influence of the intervention on the patient population as a whole; and negative effects could perhaps be explained as having been caused indirectly.

Recommendations

The implementation of a spiritual assessment clearly had a positive effect on the number of consultations for the Department of Spiritual and Pastoral Care, and further research into the implementation of a spiritual assessment is therefore recommended. Further research should focus on determining the best instrument for a general hospital, the barriers to the implementation of a spiritual assessment and the effects of the assessment, including any negative effects on the spiritual care provided by the nurses.

An ethnographic study on how screening affects the interaction between nurses and patients is also highly recommended. Our work also shows that an actively stimulating role of management is essential for a successful implementation of a spiritual assessment.

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