



Self-reported frequency of nurse-provided spiritual care



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ABSTRACT

Aim: To describe how frequently RNs provide 17 spiritual care therapeutics (or interventions) during a 72–80 h timeframe.

Background: Plagued by conceptual muddiness as well as weak methods, research quantifying the frequency of spiritual care is not only methodologically limited, but also sparse.

Methods: Secondary analysis of data from four studies that used the Nurse Spiritual Care Therapeutics Scale (NSCTS). Data from US American RNs who responded to online surveys about spiritual care were analyzed. The four studies included intensive care unit nurses in Ohio ($n = 93$), hospice and palliative care nurses across the US ($n = 104$), nurses employed in a Christian health care system ($n = 554$), and nurses responding to an invitation to participate found on a journal website ($n = 279$).

Results: The NSCTS mean of 38 (with a range from 17 to 79 [of 85 possible]) suggested respondents include spiritual care therapeutics infrequently in their nursing care. Particularly concerning is the finding that 17–33% (depending on NSCTS item) never completed a spiritual screening during the timeframe. “Remaining present just to show caring” was the most frequent therapeutic (3.4 on a 5-point scale); those who practiced presence at least 12 times during the timeframe provided other spiritual care therapeutics more frequently than those who offered presence less frequently.

Conclusion: Findings affirm previous research that suggests nurses provide spiritual care infrequently. These findings likely provide the strongest evidence yet for the need to improve spiritual care education and support for nurses.

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Nurses assert that they provide holistic care that addresses the spiritual as well as other dimensions of personhood. Nursing diagnoses recognize that the health-related challenges care recipients experience often create spiritual distress and opportunities for spiritual transformation (Carpenito-Moyet, 2013). Nursing curricula and textbooks include instruction on assessing and addressing patient spiritual needs (Taylor, Testerman, & Hart, 2014; Timmins, Murphy, Begley, Neill, & Sheaf, 2016). This nurse assessment and support of patient spirituality is typically labeled spiritual care.

Spiritual care, or spiritual nursing care, was defined by Pesut and Sawatzky (2006) as essentially an “expression of self.... Spiritual nursing care begins from a perspective of being with the client in love and dialogue but may emerge into therapeutically oriented interventions that take direction from the client’s religious or spiritual reality” (p. 23).

The interventions, or therapeutics, that nurses offer as spiritual care are diverse. Sometimes interventions that are essentially elements of basic caring (e.g., showing respect, non-procedural touch) are considered spiritual care; likewise, care that is psychosocial care (e.g., listening) is also equated with spiritual care. This confusion, along with the concern about what is spirituality versus religion, muddies the research that investigates what spiritual care nurses provide. Plagued by this conceptual muddiness as well as weak methods, research quantifying the frequency of spiritual care is not only methodologically limited, but also sparse (Kalish, 2012; Taylor, 2008). Thus, this paper will present evidence about the frequency of nurse-provided spiritual care that is driven by more conceptual clarity and based on a large sample from multiple sites.

1. Background

Some patients desire a nurse or other health care clinician to inquire about and/or address their spiritual concerns (e.g., Phelps et al., 2012; Williams, Meltzer, Arora, Chung, & Curlin, 2011). Indeed, findings from a study of persons with advanced cancer ($N = 343$) documented

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that when spiritual needs are addressed, medical costs can be reduced, quality of life can be improved, and patients become more receptive to hospice (Balboni et al., 2010; Balboni et al., 2011). When patient spirituality is addressed by a health care provider patients report greater satisfaction with their health care experience (Astrow, Wexler, Teixeira, He, & Sulmasy, 2007; Williams et al., 2011). Using Press Ganey data obtained from Asian Americans ($N = 805$) recently discharged from a hospital, one study found that this relationship between spiritual needs being met and patient satisfaction was best explained by whether nurses provided spiritual care (Hodge, Sun, & Wolosin, 2014).

While this somewhat limited body of evidence suggests spiritual care is often desired and contributes to positive outcomes, there is meager evidence documenting how frequently it is provided. Existing evidence, however, suggests variation in the frequency of nurse-provided spiritual care with nurse self-reports generally being between infrequently and occasionally (Gallison, Xu, Jurgens, & Boyle, 2013; Musa, 2016; Ramondetta et al., 2013; Rodin et al., 2015; Ronaldson, Hayes, Aggar, Green, & Carey, 2012; Taylor, Highfield, & Amenta, 1999). This variation may be explained by how and what type of spiritual care therapeutic is being measured (Epstein-Peterson et al., 2015; Hubbell, Woodard, Barksdale-Brown, & Parker, 2006; Taylor et al.), by subspecialty (e.g., hospice nurses provide spiritual care more frequently than do oncology or acute care nurses [Taylor, et al.; Ronaldson et al.]), by social mores dictated by the country in which the nurse practices (Ramondetta et al.), and by personal spirituality or religiosity that interfaces with perspectives about spiritual care in nursing practice. Indeed, findings from several studies from around the world indicate that nurses' personal spirituality or religiosity is directly correlated with their attitudes about providing spiritual care (e.g., Chew, Tiew, & Creedy, 2016; Musa, 2016; Ross et al., 2016).

The infrequency of spiritual care exists even though nurses simultaneously report believing it is an important part of nursing care (Chew et al., 2016; Epstein-Peterson et al., 2015; Turan & Yavuz Karamanoglu, 2013). This disconnect between perceptions about how spiritual care is important to provide and the infrequency may be explained by the research that describes what nurses identify as barriers preventing spiritual care; these barriers include lack of time, lack of privacy, inadequate training, uncertainty about what are spiritual and religion and the nurse's role in addressing them, and fear about proselytizing religion (Gallison et al., 2013; Kalish, 2012; McSherry & Jamieson, 2011).

Whereas many studies measure nurse beliefs or attitudes about spiritual care, there is a paucity of trustworthy evidence about the frequency of spiritual care. Studies that do examine frequency are plagued by: small, local, and convenient samples; measurement tools with unknown validity; failure to report frequencies of specific spiritual care practices; and vague response options (e.g., what does *occasionally* mean?). Given cultural mores presumably play a significant role in determining frequency of spiritual care, it is important to note that only six published studies with only US American samples were found to date, only two of which was conducted within the past decade (Epstein-Peterson et al., 2015; Rodin et al., 2015; Gallison et al., 2013). Evidence about how frequently nurses provide spiritual care and what spiritual care therapeutics are provided can inform nurses as to what is standard practice. This can guide nurses to reflect on how it ought to be (or ought not to be), and whether more education and managerial support is necessary.

2. Purpose

The purpose of this study was to describe how frequently nurses in the United States of America provide various spiritual care therapeutics using a pooled sample from four different studies. The following research questions were posed: How frequently do nurses report providing each of the 17 interventions included in the Nurse Spiritual Care Therapeutics Scale (NSCTS)? What interventions are most frequent? Least frequent? What are the correlations between providing any

therapeutic and providing spiritual care in general? Does frequency of spiritual care vary among the samples?

3. Methods

This study involved secondary analysis of survey data from four cross-sectional, descriptive studies that used survey methods. Each study received ethical review and approval from an institutional review board. Inclusion criteria for these studies was that the study used the Nurse Spiritual Care Therapeutics Scale (Mamier & Taylor, 2014) and that U. S. American nurses were in the sample. The Mamier (2009) study sought to identify frequency and type of nurse-provided spiritual care practices, as well as potential correlates (i.e., demographic and work-related factors, nurse religiosity). The Taylor and colleagues study (unpublished) investigated how facets of nurse religiosity were associated with provision of spiritual care. Ricci-Allegra (2015) examined whether spiritual perspectives, mindfulness, and provision of spiritual care were related. Foith (2016) assessed not only frequency of spiritual care, but also what were perceived barriers to providing spiritual care.

3.1. Sample

Samples were of convenience although Foith's sampling procedure initially involved randomization. Whereas two studies targeted recruitment of nurse participants from populations highly likely to be Christian (i.e., Mamier et al., and Taylor, et al.), the other two studies recruited participants from professional organizations (i.e., Ricci-Allegra, Foith). Whereas three studies recruited participants via email, one study recruited via websites for the *Journal of Christian Nursing*, *American Journal of Nursing*, and *Home Healthcare Now*. All nurses (except for 6% of Taylor et al.'s sample) were RNs; 51% of Ricci-Allegra's sample were APNs. (Table 1 provides further detail.)

3.2. Data collection

3.2.1. Procedure

All studies utilized online survey methods to obtain nurse responses to the NSCTS. These online surveys began with an anonymous consent procedure that informed potential participants about the study and invited their participation.

3.2.2. Instrument

The Nurse Spiritual Care Therapeutics Scale (NSCTS) measures the frequency of 17 therapeutics determined by an expert panel to represent spiritual care appropriate for a nurse to provide (Taylor, 2008). Except for Item 17 (about being present for a patient) that received partial support, these therapeutics likewise were considered practices that uniquely address patient spirituality rather than the psychosocial dimension; they were also identified as practices that are not uniquely religious. For example, prayer is a common spiritual practice that can be experienced with or without a religious affiliation. The evaluative process provided by this 9-member expert panel generated a content validity index of 0.88 for the NSCTS (Taylor).

Further psychometric evaluation of the NSCTS was completed by Mamier and Taylor (2014). Construct validity was studied with exploratory factor analysis. A one-dimensional solution yielded individual factor loadings between 0.407 and 0.836 and accounted for 49.5% of the variance. Further support for the validity of the NSCTS is provided by studies that document significant associations between nurse religiosity and NSCTS (Mamier, 2009; Taylor, et al., unpublished), and Mamier's finding that those who received spiritual care training reported more frequent spiritual care provision. In this pooled dataset, the NSCTS internal reliability was supported by a Cronbach's alpha of 0.94.

The NSCTS items can be summed to provide a total score. The 17 items are introduced by a stem that reads, "During the past 72 (or 80)

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