Korean J Hosp Palliat Care 2020 June;23(2):44-54
https://doi.org/10.14475/kjhpc.2020.23.2.44

Original Article

pISSN 1229-1285 • eISSN 2287-6189

Analysis of Spiritual Care Experiences of Acute-Care Hospital Nurses

Ga Eon Lee, R.N., Ph.D. and **KyoungMi Kim**, R.N., Ph.D.*

College of Nursing, Dong-A University, *College of Nursing, Kosin University, Busan, Korea

Purpose: The purpose of this study was to analyze the experiences of acute care hospital nurses' on spiritual care with focus group interviews. **Methods:** Data were collected from 24 nurses recruited from one acute-care hospital in a southern province of Korea. Six focus groups were assembled considering age and religion. All interviews were recorded and transcribed. Data were analyzed using qualitative content analysis. **Results:** Five categories with 14 sub-categories emerged: 1) ambiguous concept: confusing terms, an additional job; 2) assessment of spiritual care needs: looking for spiritual care needs, not recognizing spiritual care needs; 3) spiritual care practices: active spiritual care, passive spiritual care ; 4) outcomes of spiritual care: comfort of the recipient, comfort of the provider; and 5) barriers to spiritual care: fear of criticism from others, lack of education, lack of time, space constraints, and absence of a recording system. **Conclusion:** Participants perceived spiritual care as an uncertain concept. Some participants recognized it as a form of nursing care, and others did not. They practiced spiritual care in acute-care settings according to their personal perceptions of spiritual care. Therefore, in order to perform spiritual nursing in acute-care hospitals, it is a priority for nurses to recognize the concept of spiritual nursing accurately. It is also necessary to prepare a hospital environment suitable for the provision of spiritual care.

Key Words: Spirituality, General hospital, Nurses, Qualitative research

Received November 1, 2019
Revised February 10, 2020
Accepted February 14, 2020

Correspondence to
KyoungMi Kim
ORCID: https://orcid.org/0000-0003-2768-8055
E-mail: kmkim@kosin.ac.kr

This study was supported by the research fund of Dong-A University.

INTRODUCTION

1. Background

Spiritual care refers to the provision of interventions that address patients' spiritual care needs arising from particular circumstances or events to foster their spiritual well-being [1,2]. It is a highly valuable component of overall nursing care [3]. Spiritual care not only has a positive effect on patients' mental health (depression and anxiety) and overall physical health (pain and function) [4], but also improves their spiritual well-being, thereby promoting positive changes in quality of life [2].

Considering that patients can experience needs for spiritual care in acute-care settings (life-threatening illness or surgery), as well as on their deathbed [1], the spiritual care needs of acute-care patients deserve more attention. However, there is a tendency for acute-care nurses to be much less attentive to spiritual nursing care than they are to physical nursing care, such as maintenance of respiration and circulation [5]. In addition, they generally have lower levels of perception and provision of spiritual care than palliative-care nurses due to time constraints [6]. In fact, it has been reported that roughly half

of all acute-care nurses rarely engage in spiritual care [7].

Spiritual care seems to offer considerable therapeutic benefits to both the recipients and the providers: patients experience peace of mind and recovery and caregivers accept the patient's diagnosis, while nurses recognize the provision of spiritual care as a rewarding experience [3]. Therefore, it is necessary to enhance nurses' competence in spiritual care by raising their awareness of the importance of spiritual care for helping patients find the meaning and purpose of life [8]. However, while spiritual care has been considered as an important element of holistic nursing, nurses have low self-confidence in their capability to provide spiritual care [6]. Furthermore, as they often think that competence in spiritual care is dependent on the provider's spirituality and personal feelings, rather than being a knowledge-based domain of expertise [9], they frequently perceive spiritual care as a less specialized field in nursing [10]. These findings may indicate that nurses have not acquired a clear concept of spiritual care and approaches thereto [1]. This can be attributed to their lack of knowledge or their confusion of psychosocial needs with spiritual care needs [11], as well as variations in the conceptualization of spiritual care among nurses caused by the abstract nature of spirituality [1]. Likewise, despite the inevitable need for spiritual care in the clinical setting, many barriers to the implementation of spiritual care may be present.

Spiritual care has been reported to be affected by the providing nurses' circumstances and characteristics [1]. Acute-care nurses show a tendency to consider spiritual care as an additional task due to a lack of time [6], which is a situational factor that can influence the provision of spiritual care. Furthermore, perceptions of the importance and conceptual ambiguity of spiritual care among nurses can be viewed as a conditioning factor [12]. Given the significant influence of nurses' provision of spiritual care on patients [4], it is worthwhile to identify nurses' perceptions of a spiritual care as a major condition affecting the provision of spiritual care.

In most clinical practices, spiritual care, hospice care, palliative care, end-of-life care, and emotional care are considered to be interchangeable terms [1], and spiritual care is often equated with proselytizing [7]. Therefore, research should seek to obtain a thorough understanding of nurses' perceptions of the concept of spiritual care. In this study, we aimed to explore the concept of spiritual care in depth by using qualitative content analysis to investigate the conceptual understanding of spiritual care and its related factors among nurses in acute-care settings.

The purpose of qualitative content analysis is not to formulate a theory or to transcribe vivid experiences of a phenomenon [13], but to interpret the relationship between the explicit meaning and implicit meaning of a text through a systematic analysis of textual data describing the phenomenon of interest [14]. Thus, we conducted a qualitative analysis in this study to describe and understand nurses' experiences in spiritual care from their perspectives, thereby providing evidence regarding the delivery of spiritual care.

A literature review on spiritual care provided by nurses in acute-care settings identified a comparative study of perceptions between patients and nurses [5] and another comparative study of perceptions between acute-care nurses and palliative-care nurses [6]. However, as these previous studies were based on the comparison of the perceptions of acute-care nurses with those of others, they do not facilitate a conceptual understanding of spiritual care or enable a sufficient interpretation of its related factors. In the current study, with reference to a previous concept analysis of spiritual care [1], we conducted focus group interviews and qualitative content analysis to address the three main aspects of spiritual care: prerequisites, practices, and outcomes. The experiences of spiritual care among hospital nurses identified in this study will serve as a basis for expanding the research on spiritual care and for improving education and competence in spiritual care.

2. Purpose

The purpose of this study was to describe the spiritual care experiences of nurses who worked at an acute-care general hospital.

METHODS

1. Study design

This study was a qualitative content analysis of focus group interviews performed among nurses at an acute-care general hospital to identify their spiritual care experiences and to de-

scribe and explain those experiences from their perspectives.

2. Participants

The participants in this study were general nurses and head nurses who worked in the general ward, intensive care unit, emergency room, and artificial kidney unit at a tertiary general hospital located in a metropolitan city. The institution does not have official religious facilities, but Protestant pastors are allowed to provide religious ministry as a form of volunteer work. The participants in the first focus group were nurses who identified as Protestants and were recruited through acquaintances. The participants in the other focus groups were then recruited through snowball sampling (i.e., acquaintances of the participants in the first focus groups).

To ensure effective communication and diverse perspectives with different opinions, homogeneity within groups and heterogeneity between groups were considered in group assignment, as well as clinical experience and religion, which have been reported to affect the practice of spiritual care [15].

A total of 24 nurses participated in this study, and were divided into six focus groups. The first focus group consisted of six Protestants with 14 to 29 years of clinical experience, who worked in the general ward and intensive care unit. The second focus group included four nonreligious nurses with 10 to 15 years of clinical experience, and they worked in the general ward and intensive care unit. The third focus group was composed of one Protestant and two nonreligious nurses with 5 to 9 years of clinical experience, all of whom were men working in the intensive care unit. The fourth focus group contained two Protestant and two nonreligious nurses who worked in the intensive care unit and had 2 to 3 years of clinical experience. In the fifth focus group, there were four Catholics and one Buddhist. They had 10 to 20 years of clinical experience and worked in the general ward, artificial kidney unit, intensive care unit, or emergency room. The sixth focus group contained two Buddhists who worked in the intensive care unit and had 10 to 15 years of clinical experience.

The average number of participants in each focus group was roughly four, a choice based on a previous study that identified four as the most suitable number of participants for people with expertise to share their experiences [16]. However, in the sixth focus group, some participants were not able to participate in the interview for unexpected personal reasons, and the interview thus proceeded with two participants. When no new data emerged from the last group interview, we considered that data saturation had been achieved and therefore concluded the interview.

3. Data collection

In this study, data were collected through focus group interviews to promote the active presentation of participants' opinions. Data collection was performed in six sessions starting from August 7, 2014, when the first focus group interview was conducted, to October 14, 2014, when the sixth focus group interview was conducted. Each group participated in one interview session, which lasted for an average of 1 hour (range, 30 minutes to 1 hour and 10 minutes). The interviews were led by a moderator and an assistant moderator and carried out in a seminar room of the hospital or a university laboratory.

Each interview began with an introduction of the moderator and an explanation of the plan to audio-record the interview, assurance of anonymity, scope of use of the research results, and voluntary consent of participants. Based on the concept analysis of spiritual nursing proposed by Kang [1], the interview primarily focused on the three aspects of spiritual care—prerequisites, practices, and outcomes—and the main question was, "Could you share with us your experiences of spiritual care?", with the following auxiliary questions, if deemed necessary: "What are the prerequisites for spiritual care?", "What are spiritual care activities?", and "What are the results of spiritual care?"

In order to build rapport with the participants, we tried to create a comfortable atmosphere during the group interviews and seated the participants face-to-face so that they could share their experiences easily. All interviews were audio-recorded, and field notes and brief notes were also referred to when analyzing the data.

To ensure that the interviews ran smoothly, we provided an advance explanation of the research topic and questions, the role of the moderator, and the interview procedure. Participants were asked to talk about their experiences, perceptions, and feelings associated with spiritual care, and they were instructed that their statements would be heard non-judgmentally [17]. Prior to the interview, we obtained a consent form

https://doi.org/10.14475/kjhpc.2020.23.2.44

from each participant to participate in the study and collected information on their demographic characteristics using a structured questionnaire.

4. Rigor of study results

To ensure the validity of the study, we considered credibility, dependability, and transferability, as suggested by Graneheim and Lundman [14].

In order to ensure credibility, we considered differences in sex and age among participants and tried to examine the research process from various viewpoints of observers. During data collection, six focus group interviews were conducted, and the interviews were continued until data saturation was judged to have been achieved in the last group interview. During data analysis, identification of meaning units, condensation, and abstraction were jointly performed by the researchers to identify the most appropriate meaning units.

Dependability refers to the degree to which the researchers' decisions or data change over time during the data analysis process. To ensure dependability, both researchers regularly discussed similarities and dissimilarities within the content throughout the analysis process.

Transferability is a measure of whether the research results can be generalized to other research settings. In this study, we tried to ensure that the analysis results reflected the content of the interview by providing a clear and specific description of the data collection process and participants' characteristics, circumstances, and context. Furthermore, we confirmed with some of the participants that the analysis results reflected the content of the interviews.

5. Data analysis

In this study, data were analyzed following the qualitative content analysis procedure proposed by Graneheim and Lundman [14].

In more detail, the data analysis procedure was as follows. First, we read the transcripts of the interviews several times to obtain an overview of the content. Second, we extracted excerpts related to the participants' experiences with spiritual care and separated the data as units of analysis. Third, the separated data were classified as meaning units and condensed. Fourth, the meaning units of the condensed data were abstracted and labelled as codes. Fifth, codes were compared based on similarities and dissimilarities and classified into subcategories and categories. Arbitrary categories were modified through discussion among the researchers. Sixth, the implicit meaning of each category (i.e., the intrinsic content) constituted a theme.

6. Research team

The first author of this study has been lecturing on qualitative research at a graduate school and has been involved in multiple qualitative research activities. The corresponding author has lectured on spiritual care and earned a Ph.D. on qualitative research. The authors are both members of the Academy of Qualitative Research in South Korea and have been steadily striving to enhance their capabilities by participating in academic activities and reading professional books.

7. Ethical considerations

This study was carried out after obtaining approval from the ethics review board of our institution (2-1040709-AB-N-01-201312-SB-05-02). In order to obtain consent for participation in the study, we explained to the participants the necessity and purpose of the research and offered them the choice of voluntary participation. In addition, before signing the consent form, the participants were informed of the interview methods, the assurance of confidentiality and anonymity, the voluntary nature of participation and withdrawal from the study, and the disposal of the interview data after completion of the study. Audio-recording of the interview was conducted with participants' consent. When transcribing the content of the recording, we used numbers instead of names to ensure the anonymity of the participants. To express our gratitude for participation in the interview, we gave the participants small gifts.

RESULTS

A total of 153 condensed meaning units and 20 codes were extracted regarding the participants' experiences with spiritual care, which yielded five categories with 14 subcategories (Table 1).

Table 1. Analysis of Spiritual Care Experiences of Acute-Care Hospital Nurses.

Code	Sub category	Category	
- Religious care	Confusing terms	Ambiguous concept	
- Emotional care			
- Hospice care			
- Others' job, not a nursing care	An additional job		
- Unfamiliar and unknown concept			
- Sensitive to spiritual care needs	Looking for spiritual care needs	Assessment of spiritual care needs	
- Finding a spiritual care request			
- Insensitive to spiritual care needs	Not recognizing spiritual care needs		
- Forming a close relationship with patients	Establishing a channel for spiritual care	Active spiritual care	Spiritual care practices
- Forming a close relationship with nurses			
- Carrying out religious activities	Nurse-led religious behavior		
- Permitting patients' religious behavior	Permitting patients' religious behavior	Passive spiritual care	
- Comfort of the patient	Comfort of the recipient	Outcomes of spiritual care	
- Comfort of the family			
- Nurse's satisfaction	Comfort of the provider		
- Difficulties of revealing religious action	Fear of criticism from others	Barriers to spiritual care	
- Absence of practical training	Lack of education		
- Lack of time	Lack of time		
- Space constraints	Space constraints		
- Absence of a recording system	Absence of a recording system		

1. Ambiguous concept

The subcategories that fell under this theme were 'confusing terms' and 'an additional job'. Some participants perceived spiritual care as a concept that could be used interchangeably with other terms, while recognizing it as a component of nursing. Other participants viewed it as an additional task distinct from nursing.

1) Confusing terms

This subcategory contained three codes: 'religious care', 'emotional care', and 'hospice care'. The participants recognized propagation of their religion as a form of spiritual care. Some participants perceived spiritual care as a concept similar to emotional care in terms of comforting patients. The participants considered hospice care and spiritual care to be similar concepts.

"I think spiritual care is nursing related to religion.... It's like approaching a patient through religion and spreading it. Let's say I were a Christian, then I would talk about God while nursing a patient." (4 FG-N)

"Everything to be psychologically close to a patient, because holding hands and offering warm words can be perceived as spiritual care by people on the receiving end. All behaviors that can be psychologically comforting even if they are not explicit spiritual activities..." (5 FG-R)

"The first thing that comes to my mind is patients facing imminent death. I think spiritual care is psychological support that hospice nurses provide to patients on their deathbed for comfort and reducing pain in their final journey of life." (5 FG-T)

2) An additional job

This subcategory contained two codes: 'others' job, not nursing care' and 'unfamiliar and unknown concept'. The participants considered clergy to be the main providers of spiritual care and stated that patients could meet their spiritual care needs on their own. They reported that the concept of spiritual care was unfamiliar or strange to them.

"Spiritual care cannot be considered as a part of professional nursing practice. We cannot be the main provider; instead, it should be provided by pastors upon request of religious people or caregivers. I think spiritual care is not my responsibility, and

https://doi.org/10.14475/kjhpc.2020.23.2.44

I already have a lot on my plate as a nurse so I can't find time to take on extra responsibilities." (3 FG –L)

"Patients themselves listen to [the Bible, Buddhist scriptures, etc.] or watch Catholic programs, and they do not ask the nurse for help.... I cannot even imagine myself performing spiritual care as a nonreligious person. I cannot even think about bringing myself to provide spiritual care." (2 FG –J)

"We follow protocols for nursing, so we don't know what to do with spiritual care. I've never encountered it in nursing school, and it is a profound concept. That can't be explained easily with words..." (4 FG –P)

2. Assessment of spiritual care needs

There were two subcategories under this theme: 'looking for spiritual care needs' and 'not recognizing spiritual care needs'. Participants 'looking for spiritual care needs' were those who considered spiritual care to be 'confusing terms' and they sought to identify the spiritual care needs of their patients. In contrast, participants who viewed spiritual care as an 'additional job' did not recognize patients' needs for spiritual care.

1) Looking for spiritual care needs

This subcategory contained two codes: 'sensitive to spiritual care needs' and 'finding a spiritual request'. Nurses recognized patients' spiritual care needs by looking for those in need of spiritual care in various situations, such as imminent death, diagnosis of cancer, and long-term hospitalization.

"We pray for the patient when we find out about the patient's spiritual care needs.... For those who are dying, we leave religious music on to the end. I think it's spiritual care that we detect and meet the spiritual care needs of patients by ourselves." (1 FG –A)

"There's a lot of people [caregivers] who pray around a patient. Crying and praying. Especially when I talk with caregivers, I look at their character carefully.... For caregivers who appear to be in need of spiritual care, I provide what I think is appropriate for spiritual care." (3 FG –M)

2) Not recognizing spiritual care needs

This subcategory contained one code, 'insensitive to spiritual care needs'. Because of the busy working environment, nurses thought that their patients did not expect spiritual care from them and resolved spiritual care needs on their own.

"Patients listen to [the Bible, the Buddhist scriptures, etc.] or watch Catholic programs on their own, and they do not ask the nurse for help.... They think the nurse is busy or has a different religion from them, so they don't ask for help in the first place." (2 FG –J)

3. Spiritual care practices

Spiritual care practices were classified as active spiritual care, in which the nurse plays the leading role, and passive spiritual care, in which the nurse recognizes the patient's religious beliefs and permits him or her to engage in religious activities.

1) Active spiritual care

There were two subcategories under this theme: 'establishing a channel for spiritual care' and 'nurse-led religious behavior'.

(1) Establishing a channel for spiritual care

This subcategory contained two codes: 'forming a close relationship with patients' and 'forming a close relationship with nurses'. The participants formed a close relationship with their patients by building rapport with them and established friendly relationships with their colleagues to establish a channel for their spiritual care practices.

"When [one of my patients on dialysis] asks in agony, 'When I die, will I be able to see my husband again?' I say, based on my religious belief, she can meet him again. I also add 'Even if you go to heaven first, if you see me there, please remember me and welcome me with joy.' That's why she calls me the daughter of the hospital." (5 FG –S)

"When I was new to this job, I disclosed to my colleagues that I am Christian and offered them morning prayers on the topic of their choice.... Since then, senior nurses who see me providing spiritual care have never told me, 'Do you really have to do it [spiritual care] even when you are up to your ears in work?' [To perform spiritual care], there should be rapport

among nurses." (3 FG –M)

(2) Nurse-led religious behavior

This subcategory contained one code, 'carrying out religious activities.' The participants encouraged nonreligious patients to become religious, proselytized them, put on religious music or read religious books, and prayed for them.

"Once placed on dialysis and the dialysis diet, they [new dialysis patients] start to feel like they can't eat anything, depressed, lonely, and tired. I encourage such patients to engage more deeply with the religion that is most approachable to them or preferably the religion of their closest family members." (5 FG –S)

"A high-school student had a car accident. His mother felt like she had no one to lean on, so she started going to church and left the Bible by her son's bedside every day. So I said to her, 'Whenever I have time, I'll read your son the Bible whether he listens to it or not. I can also pray for you if you want.' As there was a rapport between us, she asked me to pray." (3 FG –M)

2) Passive spiritual care

This theme had one subcategory, 'permitting patients' religious behavior'.

(1) Permitting patients' religious behavior

The subcategory contained one code, 'permitting patients' religious behavior.' The participants tried to respect patients' religious beliefs and to understand the refusal of medical treatment based on their religious beliefs. They allowed their patients to perform religious rituals and organized specific times and places so that other patients would not feel uncomfortable.

"Even if someone looks at the wall and chants a spell, if it causes harm to others, I would stop him or her, but otherwise I don't think I would give a strange look. I don't see a problem with weak human beings leaning on religion.... Their [Jehovah's Witnesses] condition gets worse because they don't get blood transfusions. But I think it is my responsibility as a nurse to refrain from telling them that they would recover faster if they had a blood transfusion." (5 FG –S)

"I wait while patients perform religious rituals. I give them sufficient time [without proceeding] hastily to the next schedule." (2 FG –J)

4. Outcomes of spiritual care

This theme had two subcategories: 'comfort of the recipient' and 'comfort of the provider'.

1) Comfort of the recipient

This subcategory contained two codes: 'comfort of the patient' and 'comfort of the family'. The provision of spiritual care by nurses comforted the patients and brought them relief of pain and suffering. The caregivers were also grateful and felt comforted.

"Not long ago, one of my patients was unable to sleep at night, so I let the patient listen to hymns. Next day, I was told that the patient had a good night's sleep thanks to the hymns. A few days later, we did the acceptance prayer together.... About three days later, the patient said, 'The hymns grew on me and they were so relaxing that I could sleep well' with an extremely peaceful expression on the face." (1 FG –E)

"Caregivers [of patients in the intensive care unit] ask me to put on hymns or sermons recorded on a cassette tape or USB flash drive. So I leave those on for the requested time...because it helps caregivers feel comfortable." (1 FG –D)

2) Comfort of the provider

This subcategory included one code, 'nurse's satisfaction.' The nurses who provided spiritual care felt comforted after delivering the intervention. They also felt proud and rewarded when their patients and caregivers looked comforted.

"I feel proud after doing what I can [spiritual care] for patients, I found it rewarding that I provided the patient with the best thing I had and that the patient at least realized jt [the presence of God]." (4 FG –N)

https://doi.org/10.14475/kjhpc.2020.23.2.44

5. Barriers to spiritual care

Five subcategories were derived for this theme, as follows: 'fear of criticism from others', 'lack of education', 'lack of time', 'space constraints', and 'absence of a recording system'.

1) Fear of criticism from others

This subcategory contained one code, 'difficulties of revealing religious action.' Due to their worries about what patients or colleagues would think, the participants found it difficult to reveal their religion while providing spiritual care.

"I talk to myself very quietly so that only the patient can hear the story of God I believe in. I do [spiritual care] when there are no other colleagues around me. It's because I'm talking about my personal belief. Because I feel uncomfortable talking about it when I am with other people." (4 FG -N)

"It was quite a shock when a devoted Buddhist nurse told me [a Protestant] that I should not overtly display my [religious] beliefs. Since then, every time I happen to talk about my religion, I look around to check whether the nurse is within earshot." (1 FG -B)

2) Lack of education

This subcategory contained one code, 'absence of practical training'. The participants indicated that they had no experience of receiving education on spiritual care and that they did not consider themselves capable of practicing spiritual care. They recognized the need for practical education and training for providing spiritual care.

"When I was a newbie, I was responsible for explaining the discharge procedure and death certificate application procedure and preparing for admission of new patients. Since they do not teach us how to practice spiritual care or end-of-life care from the beginning, [we find ourselves wondering] what we should do if a patient dies. We need to receive education to be fully prepared for that situation. We never receive on-the-job training on spiritual care." (2 FG -H)

3) Lack of time

The participants lacked the time to perform spiritual care due to their busy work schedules. It was not easy from them to assess the spiritual care needs of each patient through a thorough discussion and to provide proper spiritual interventions accordingly as their high-priority workloads exceeded what was manageable.

"When one patient starts crying, saying, 'What is the point of living?' an alarm starts to go off from another patient. Then I have to leave the patient to go to turn off the alarm. We are not in an environment where we can talk sufficiently with patients to address their spiritual agony. I [find myself in a situation where I] have to hurriedly run for another patient after just pulling a blanket over an old patient. If only we had more time." (5 FG -S)

"Even if spiritual care is introduced, there's no time for us to do it. We are putting in extra hours to keep up with the workload at the university hospital intensive care unit. I doubt it would be possible for local hospitals to introduce it considering their understaffing problem." (4 FG -P)

4) Space constraints

The participants stated that single- and double-bed patient rooms conducive to privacy would be appropriate for providing spiritual care, whereas multi-bed patient rooms were not desirable for in-depth conversations between patients and nurses.

"There are times when caregivers bring in a pastor to a multi-bed patient room. When they surround a patient and pray loudly for a long time, the rest of the patients in the room can get stressed out. I think we really need to secure space for spiritual care." (1 FG -D)

5) Absence of a recording system

The participants performed spiritual care, but did not log it as spiritual care; instead, they recorded it as emotional care. Due to the lack of an organized recording system for spiritual care, its application was limited. The participants did not pay attention to recording spiritual care, considering it to be a

subjective area that would be inappropriate to enter into the nursing record.

"We learned from the beginning in the nursing course that we should only write objective facts, and I think records on spiritual care cannot be free from subjectivity. I don't record spiritual care." (4 FG –P)

DISCUSSION

In this study, we analyzed the spiritual care experiences of hospital nurses. The significance of this study is that it sets the groundwork for nurses to provide spiritual care at acute-care general hospitals in the future by confirming that perceptions of spiritual care are prerequisites for spiritual care practices. In the discussion, we will focus on the five categories of the spiritual care experiences of the participants in this study.

In this study, the participants recognized spiritual care as a concept synonymous with religious care, which is a finding echoed by Gallison et al. [7], who reported that 30% of acute-care nurses had difficulty distinguishing spiritual care from proselytizing. However, in a study on nurses' perception of patients' spiritual care needs, Narayanasamy and Owens [3] reported that there was a clear distinction between patients' religious needs and spiritual needs. Thus, they suggested that nurses should recognize patients' religious needs and respect their religious beliefs and traditions, while also recognizing and responding to spiritual care needs so that the patients can pursue meaning and purpose in life. Therefore, education is warranted for acute-care nurses to clearly distinguish spiritual care from religious care and to better meet the needs of their patients.

The participants in this study equated spiritual care with emotional care, in that spiritual care provides patients with relief from emotional and physical distress. Highfield [11] also reported that oncology nurses with a lack of knowledge on spirituality often confused socio-psychological needs with spiritual care needs. Emotional care and spiritual care share some similarities in that the relationship between the provider and the recipient underlies the therapeutic process. However, they have clear differences, in that emotional care values psychological phenomena occurring in connection with the external environment, whereas spiritual care promotes a relationship with the transcendent (God or supreme being) [1]. Considering that nurses' ambiguous perception of spiritual care can inhibit the provision of spiritual care [12], it seems necessary for nurses to clearly distinguish spiritual care from emotional care to improve their competence in the delivery of spiritual care.

Some participants in this study believed that spiritual care was not part of the nurse's role. Similarly, Ronaldson et al. [6] and Vance [10] found that 12% to 16% of acute-care nurses perceived spiritual care as an inappropriate professional behavior. However, as patients and their families, as well as nurses themselves, derive satisfaction from spiritual care, it can be viewed as a valuable component of nursing care [3]. Therefore, it is necessary to consider providing education on spiritual care (including the introduction of various cases) to nurses who consider spiritual care to be outside their role.

In this study, the participants who perceived spiritual care as part of the nurse's role observed and examined their patients to assess their spiritual care needs. Deal and Grassley [18] also claimed that the delivery of spiritual care relied on the nurse's recognition of patients' needs. Therefore, nurses need to closely attend to their patients in order to respond to their spiritual care needs and to provide direct assistance [19].

In contrast, the participants who believed that spiritual care was an additional task had difficulties recognizing their patients' spiritual care needs because patients resolved spiritual care needs on their own without expressing them to the nurses. Therefore, it is necessary for nurses to have a heightened level of attention to their patients' spiritual care needs to improve their competence in spiritual care. A nurse's own spirituality is a prerequisite for assessing the spiritual care needs of patients [8], and it is meaningful for nurses to evaluate their own religion, beliefs, and spirituality before assessing patients' spiritual care needs [11]. Therefore, nurses need to explore ways to improve their spirituality by self-examining their own spiritual status.

In this study, we observed that participants established rapport with their patients and maintained a close relationship with them prior to the provision of spiritual care. This finding is supported by the literature, which suggests that nurses need to be present close to and support their patients and to create a

https://doi.org/10.14475/kjhpc.2020.23.2.44

spiritual atmosphere so that patients think of receiving spiritual care as a natural part of life [18].

The participants in this study prayed directly for their patients, referred patients to clergy in the hospital, played religious music for patients, and provided time and space for religious activities, which are similar to the spiritual interventions described in the study by Kang [1], including encouraging dialogue with God, supporting religious activities, praying, conducting religious rituals, spiritual counseling, introducing religious practices, using religious symbols, and reading the Bible. According to a study by Park et al. [20] on patients with terminal cancer, patients realize the meaning of life and experience spiritual growth and maturity during their struggle with cancer through prayers, regardless of their religion. Therefore, for the spiritual growth of patients, nurses need to consider prayer as an active practice of spiritual care.

In this study, we found that spiritual care brought peace of mind to patients and their caregivers and satisfaction to nurses. This finding is consistent with a previous study finding that patients who received spiritual care perceived themselves as receiving better overall care than those who did not [21]. Canfield et al. [20] reported that 75% of nurses who provided spiritual care felt comfortable doing so. Based on these findings, we believe that spiritual care provides meaningful outcomes to both the provider and the recipient.

In this study, the lack of education, insufficient time, and space constraints were identified as barriers to spiritual care. Similarly, a noisy environment unconducive to privacy and a busy working environment with time constraints were reported as deterrents to spiritual care by Deal and Grassley [18]. Vance [10] and Canfield [19] also underscored the necessity of education for the provision of spiritual care. Therefore, to facilitate nurses' delivery of spiritual care, sufficient time and space should be allowed and spiritual care training and education programs should be organized systematically.

In this study, we found that spiritual care was perceived to be "confusing terms" and "an additional job" among hospital nurses. Moreover, their conceptualization of spiritual care was confirmed to affect their practice of spiritual care in the clinical setting. Based on these findings of this study, we make the following suggestions.

First, as nurses' perceptions of spiritual care is associated with their actual delivery of spiritual care, it will be necessary to provide nurses with education and guidelines so that they can accurately understand the definition of spiritual care and practice spiritual care accordingly in acute care settings.

Second, the barriers to provision of spiritual care identified in this study—negative perceptions of spiritual care, space and time constraints, and the absence of a recording system—need to be addressed to improve nurses' provision of spiritual interventions.

CONFLICT OF INTEREST

No potential conflict of interest relevant to this article was reported.

SUPPLEMENTARY MATERIALS

Supplementary materials can be found via https://doi.org/10.14475/kjhpc.2020.23.2.44.

REFERENCES

1. Kang SR. Concept analysis of spiritual care. J Korean Acad Nurs 2006;36:803-12.
2. Kim JN, Song MO. Effect of spiritual nursing intervention on spiritual well-being and depression of the hospice patients. J Korean Acad Community Health Nurs 2004;15:132-44.
3. Narayanasamy A, Owens J. A critical incident study of nurses' responses to the spiritual needs of their patients. J Adv Nurs 2001;33:446-55.
4. Oh PJ, Kim YH. Meta-analysis of spiritual intervention studies on biological, psychological, and spiritual outcomes. J Korean Acad Nurs 2012;42:833-42.
5. Florin J, Ehrenberg A, Ehnfors M. Patients' and nurses' perceptions of nursing problems in an acute care setting. J Adv Nurs 2005;51:140-9.
6. Ronaldson S, Hayes L, Aggar C, Green J, Carey M. Spirituality and spiritual caring: nurses' perspectives and practice in palliative and acute care environments. J Clin Nurs 2012;21:2126-35.

7. Gallison BS, Xu Y, Jurgens CY, Boyle SM. Acute care nurses' spiritual care practices. J Holist Nurs 2013;31:95-103.
8. Baldacchino DR. Nursing competencies for spiritual care. J Clin Nurs 2006;15:885-96.
9. McSherry W, Jamieson S. The qualitative findings from an online survey investigating nurses' perceptions of spirituality and spiritual care. J Clin Nurs 2013;22:3170-82.
10. Vance DL. Nurses' attitudes towards spirituality and patient care. Medsurg Nurs 2001;10:264-78.
11. Highfield ME. Providing spiritual care to patients with cancer. Clin J Oncol Nurs 2000;4:115-20.
12. McEwen M. Spiritual nursing care: state of the art. Holist Nurs Pract 2005;19:161-8.
13. Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. Qual Health Res 2005;15:1277-88.
14. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. Nurse Educ Today 2004;24:105 - 12.
15. Sung MH. Effects of spiritual well-being on spiritual nursing intervention. J Korean Oncol Nurs 2009;9:15-22.
16. Krueger RA. Focus groups: a practical guide for applied research. 2nd ed. Thousand Oaks, Calif.:Sage Publications;c1994.
17. Tanyi RA, McKenzie M, Chapek C. How family practice physicians, nurse practitioners, and physician assistants incorporate spiritual care in practice. Am Acad Nurse Pract 2009;21:690-7.
18. Deal B, Grassley JS. The lived experience of giving spiritual care: a phenomenological study of nephrology nurses working in acute and chronic hemodialysis settings. Nephrol Nurs J 2012;39:471- 81, 496; quiz 482.
19. Park SB, Lee WH, Oh KH. The prayer experiences of patients with end-stage cancer. Korean J Hosp Palliat Care 2017;20:26-36.
20. Canfield C, Taylor D, Nagy K, Strauser C, VanKerkhove K, Wills S, et al. Critical care nurses' perceived need for guidance in addressing spirituality in critically ill patients. Am J Crit Care 2016;25:206-11.
21. Daaleman TP. A health services framework of spiritual care. J Nurs Manag 2012;20:1021-8.

https://doi.org/10.14475/kjhpc.2020.23.2.44