A recent survey carried out by the Royal College of Nursing found that 80% of nurses believed spirituality should be a core element of pre-registration nurse training (Funning, 2010). This view is supported by the findings of a longitudinal study of pre-registration student nurses (McSherry et al, 2008) but, in this study, concerns were raised about lecturers influencing students with their personal views on spirituality.

Spirituality cannot be learnt solely from books or in a classroom; knowledge and understanding develop through experiences of caring for patients along with personal life experience. Therefore, post-registration education in spirituality may be beneficial as nurses gain experience in clinical practice.

The importance of meeting patients’ spiritual needs was discussed in part 1 of this series (Sartori, 2010). While definitions of spirituality vary, Speck (2005) described it as “a vital essence of our lives that often enables us to transcend our circumstances and find new meaning and purpose, and that can foster hope”. Nurses need to consider psychological, emotional, social, cultural and spiritual aspects of care to help patients understand the meaning of their experience.

In practice, spiritual needs should be given equal and sometimes greater precedence than physical needs. This may not occur for a number of reasons including:

- Time constraints;
- Excessive workloads;
- Clashes of beliefs between caregiver and patient;
- Lack of confidence and experience of caregivers;
- Lack of continuity of care and lack of privacy (Daaleman et al, 2008).

**ADDRESSING SPIRITUAL NEEDS**

Puchalski et al (2006) described one quality of spiritual care as compassionate presence. It is not prescriptive as spiritual needs usually become apparent once a rapport has been established with a patient. Nurses often deliver good spiritual care without actually realising it. Factors that enable good spiritual care include:

- Continuity of care;
- Active listening;
- Effective communication.

A prerequisite for providing good spiritual care may be the presence of someone with a caring attitude so that patients, and their relatives or friends in certain situations, feel reassured.

Spiritual care does not promote religion or spiritual practices or enforce beliefs on patients (D’Souza, 2007; Winslow and Wehtje-Winslow, 2007); rather, it provides opportunities for patients to express their values and needs, and empowers them to deal with their illness. The spiritual needs of patients and caregivers may conflict and it is important that caregivers have an open mind and tolerance of others’ views (Wilding, 2007). Patients may not disclose their spiritual beliefs and caregivers should gently ask about spiritual preferences as most patients will usually wait for support to be offered (Winslow and Wehtje-Winslow, 2007). These authors recommended that care staff should:

- Have a basic understanding of patients’ spiritual needs and preferences so they can deliver respectful care;
- Respect any wishes that patients express, for example a person who is a Jehovah’s Witness may refuse a blood transfusion;
- Be aware they should neither discourage

**PRACTICE POINTS**

- Spiritual needs vary according to individual patients;
- Models for spiritual assessment and care are available for use in different clinical situations;
- Incorporating spiritual care into pre and post registration education will enhance nurses’ confidence and improve patient wellbeing and satisfaction;
- Good spiritual care can benefit patients and caregivers.

Although meeting patients’ spiritual needs is important, many nurses are uncertain about what spiritual care involves and lack confidence in this area.

This second article in a two part series on spirituality considers ways of addressing spiritual needs and provides an overview of the principles of assessment and implementation.

Part 1 explored definitions of spirituality, the difference between religion and spirituality, and finding meaning in illness.
nor prescribe religious or spiritual beliefs and practices;

- Understand their own spirituality if they are providing spiritual care;
- Have integrity and genuinely attempt to understand patients’ needs. The goal of spiritual care should be to attain a sense of peace, contentment and develop a sense of purpose in life. Patients’ state of mind and belief systems may change drastically as a result of their illness and/or deteriorating health. Spiritual care should be supportive until changes in health have been integrated into patients’ lives (Rumbold, 2007).

ASSESSING SPIRITUAL NEEDS

The context of patient care influences how spiritual needs are assessed (if at all) and the importance of assessment.

The spiritual needs of patients attending the accident and emergency department for a laceration would differ from those recently diagnosed with cancer or in intensive care.

There are a number of specific spiritual assessment tools that nurses can use and these should be selected to meet patients’ needs in specific clinical areas (O’Connell and Skevington, 2009; Timmins and Kelly, 2008; McSherry, 2006; Daaleman and Frey, 2004; McSherry et al, 2002).

Spirituality helps to give meaning to people’s lives and, during assessment, caregivers should not impose their personal views (Rumbold, 2007). Ways of measuring spirituality include the following:

- Asking about religious participation;
- Identifying positive psychological characteristics (some patients may feel that illness has made them stronger);
- Discussing personal values, relationships to others, sense of peace and meaning in life (Koenig, 2007).

An assessment should identify whether patients need support from a particular member of the community or spiritual leader (Winslow and Wehtje-Winslow, 2007). During assessments it is important not to be intrusive and respect patients’ views. Although religious care may be provided by a member of a patient’s faith community, they may still have spiritual needs that differ from just their religious needs. It is therefore important that nurses are still open to providing spiritual care even if a patient has been visited by a religious leader.

The spiritual assessment of patients’ needs should be an ongoing process rather than simply a written record made on admission to hospital (Rumbold, 2007), and needs should be incorporated into care plans (Puchalski et al, 2006).

**BOX 1. CASE STUDY: “SHE HAD BEEN A CONSULTANT BUT WAS NOT IN CONTROL”**

Sally Smith is a hospital consultant and two days ago she had major surgery to remove a tumour.

It was 4am and Dr Smith could hear the nurses talking and a loud clattering of equipment. She could not get comfortable in the bed, her wound was painful and she was worrying about her elderly mother who was coping.

She called the nurse for something to help her sleep. The nurse was unsure if she should give the prescribed medication and called the doctor. The junior doctor would not give the medication as it was now 4.22am. Dr Smith became frustrated – the more they debated about this the less chance there was of getting any sleep. She had been a consultant for 35 years but was not in control. She began to cry and her wound ached even more.

Dr Smith was faced with a role reversal from doctor to patient. She was worried about the diagnosis of cancer and her social circumstances. The usually independent, highly respected consultant now relied on others and the person responsible for her care was someone with much less experience who had little insight into how she was feeling.

Simple measures such as minimising noise levels could have helped Dr Smith. The nurse or doctor could have asked her if she had anything on her mind that was stopping her from sleeping. Was she worried about anything? Did she have any concerns about her condition?

Staff could have acknowledged that it was difficult for her in the reversed role of a patient.

She could have been given reassurance that her wound was healing well and that she was making a good recovery. This would have provided Dr Smith with an opportunity to discuss her anxieties about a cancer diagnosis and what would happen to her mother if she needed further treatment.

Some spiritual needs may be beyond nurses’ scope or expertise but, once these have been identified, measures can be implemented to ensure they are met. Issues of spiritual concern should be recorded along with resources required to meet them and outcomes so that communication remains effective and issues can then be monitored.

If there is an assessment of spiritual needs for an unconscious patient, it is usually taken from previous medical/nursing notes. Relatives may not know how important spirituality is to patients at a time when the latter may need support.

The case study above illustrates how taking time to talk to a patient may uncover anxieties and concerns that are not immediately apparent (Box 1).

IMPLEMENTING SPIRITUAL CARE

Nurses can gain understanding of patients’ spiritual needs during conversation, especially if they have established a rapport with them.

Encouraging patients to recall memories and experiences that give them a sense of peace and serenity and some may benefit from reading books that support their feelings. Patients can be profoundly changed by their illness and are even inspired to use their experience to benefit others by writing about it and volunteering to help others with the same condition. It can be cathartic to write about their experience in a diary or journal (Moore, 2010).

Promoting spiritual wellbeing

Techniques such as meditation are thought to be conducive to promoting health and preventing disease (Nataraja, 2008) and can be used in the clinical setting.

Prayer is a popular part of spiritual practice, for both religious and non-religious patients. It is used as a coping mechanism in everyday life and has also been used at times of extreme stress such as in response to the terrorist atrocities on 11 September 2001 (Ai et al, 2005) and 7 July 2005. Levin (2001), in a review of prayer research, suggested prayer results in positive emotions that benefit health. Prayer can give comfort and help to relatives and patients (Robinson et al, 2006).

Nurses do not need to pray with patients; issues have been raised about whether this would be ethical. However, hospital chaplains are available if patients request prayer from a trained professional.
Healing the body through mind and spirit is a relatively new area of health-related research. Cunningham (2008) discussed a self-healing programme for patients with cancer in which psychological and spiritual practices help patients and relatives cope with disease, a process called The Healing Journey. Cunningham highlighted the benefits of this therapy and said more research should be carried out in this area.

The programme incorporates the use of spiritual literature and patients are encouraged to explore other forms of spiritual support such as yoga groups, Buddhism, Sufi or scriptural study groups.

**Chaplaincy services**

It is acknowledged that lack of time may limit nurses’ opportunities to provide spiritual care (Daaleman et al., 2008). In these circumstances, hospital chaplains can offer support to both patients and staff.

There are misconceptions about the role of the hospital chaplain; it is not to evangelise, preach or convert. It is a ministry of listening and presence, gives patients an opportunity to express their anxieties. Box 2 outlines a personal reflection of the chaplain’s role.

An innovative study addressing patients’ spiritual needs incorporated the hospital chaplaincy service into the Liverpool Care Pathway (LCP) (Pugh et al., 2010). Over six months, all hospital patients started on the LCP were referred to the hospital chaplains.

**REFERENCES**


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