SPIRITUALITY AND SPIRITUAL CARE

AMONGST PROFESSIONAL NURSES AT PUBLIC HOSPITALS IN KWAZULU-NATAL

By

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DECLARATION

I, Sandhya Chandramohan hereby declare that all the content within this dissertation is my own work. Researchers or authors that have contributed to this dissertation have been duly acknowledged within.

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Signature of student Date of signature

Approved for final submission

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Signature of Professor Bhagwan Date of signature

DEDICATION

This dissertation is dedicated to Source, Shridi Baba and the Ascended Masters, the Archangels, Spirit Guides and my Family Guides in spirit.

Thank you for Deemesh, Marsheel and Orika; and for encircling us with love and divine protection during this human experience.

"We are spiritual beings having a human experience; not human beings having a spiritual experience" (Newton 2009).

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"I know the plans I have for you declared the Lord" Jeremiah 29:11

ABSTRACT

INTRODUCTION

Empirical research pertaining to spirituality has grown in the Western context, with a myriad studies, that have documented the salience of spirituality to health and wellbeing in relation to a range of issues such as HIV/AIDS, cancer and heart disease (Koenig *et al.* 2001:1189). It is against this backdrop that nursing scholars have begun to research the role of spirituality and spiritual care in nursing practice, in the Euro-American context. In South Africa research in this field is sparse, hence prompting the need for the current study.

PROBLEM STATEMENT

There is a huge gap in the South African nursing literature on spirituality and spiritual care, grounding the need for research in this area. Internationally however studies have grown focussing on the views of practitioners and faculty with regard to spirituality and spiritual care in nursing practice.

OBJECTIVES

- To explore the views of nurses at public hospitals in KwaZulu-Natal regarding the role of spirituality and spiritual care in nursing practice.
- To investigate nursing practitioners' views on the salience of spirituality to patients.
- To investigate whether nurses utilize spiritually based activities in nursing.
- To investigate whether current nursing education and training has prepared nurses for spiritual care.

METHODOLOGY

The study utilized a descriptive survey utilizing a cross-sectional design. A quantitative research design was utilized to survey nursing practitioners at selected public hospitals through a process of multiphase random sampling. Data was collected using survey questionnaires.

FINDINGS

Findings of this study have shown that nurses do accept spirituality and spiritual care as being part of their role. Participants (n=385) acknowledged that spiritual care is a component of holistic patient care. This aspect of care, they agreed, lacks the attention it seriously needs. In addition, majority of nurses considered nursing to be part of their spiritual path. Results indicated that the more spiritual nurses viewed themselves, the more positive their perspectives were towards providing spiritual care.

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ACRONYMS AND ABBREVIATIONS

AIDS: Acquired Immune Deficiency Syndrome

ANC: African National Congress

DOH: Department of Health

DUT: Durban University of Technology

HIV: Human Immune Deficiency Virus

KZN: KwaZulu–Natal

RCN: The Royal College of Nursing

SANC: South African Nursing Council

SSCRS: Spirituality and Spiritual Care Rating Scale

WHO: World Health Organisation

DEFINITION OF TERMS

God: the creator and ruler of the universe, the source of all moral authority; the supreme being or a superhuman being or spirit worshipped as having power over nature or human fortune (Hutchinson 1998: 01).

Holistic care: Care of the mind, body and soul/spirit (Hutchinson 1998: 01).

Professional nurse: a nurse who is educated and competent to practice comprehensive nursing, assumes responsibility for independent decisions making and is registered and licenced as a professional nurse under the South African Nursing Act (SANC 2012).

CHAPTER ONE

INTRODUCTION

1.1 INTRODUCTION

"Spirituality is my being, my inner person. It is who I am - unique and alive. It is my expressed thoughts, through my body, my thinking, my feelings my judgements and my creativity. My spirituality motivates me to choose meaningful relationships and pursuits. Through my spirituality, I give and receive love, I respond to and appreciate God, a sunset, a symphony and spring. I am driven forward, sometimes because of pain, sometimes in spite of pain. Spirituality allows me to reflect on myself. I am a person because of my spirituality - motivated and enabled to value, to worship and to communicate with the holy, the transcendent"

Stroll (1989 cited in Goldberg 1998: 383).

Spirituality reflects an individual's search for meaning in life, wholeness, peace, individuality and harmony (Tanyi 2002 cited in Clarke 2009: 1667; Mahlungulu and Uys 2004: 01; Timmins and Kelly 2008: 125; Hussey 2009: 73; McSherry and Jamieson 2010: 1757; Swinton and Patterson 2010: 229; O'Brien 2011: 02; Hanson and Andrews 2012: 354). Derived from the Latin word "spiritus," it is "the essential part of a person that controls the mind and the body" (Lundberg and Kerdonfag 2010: 1121). It refers to the presence of a relationship with a Higher Power, a response to a deep and mysterious human yearning for self-transcendence and surrender, a yearning to find our place and the search for existential meaning (Zinnbauer, Pargament and Scott 1999: 892). The intrinsic human capacity for self-transcendence allows an individual to participate in the sacred and propels a search for connectedness, meaning, purpose and ethical responsibility.

Spirituality is experienced, formed and expressed through a wide range of religious narratives, beliefs and practices, and is shaped by influences in the family, community, society, culture and nature. It is often expressed as a relationship with God, but it can be found in nature, art, music, family, community or whatever beliefs that give a person a sense of meaning and purpose in life (Flanagan *et al.* 2012: 03; Eric *et al.* 2007: 23; Barlow 2011; Hanson and Andrews 2012: 354).

Most scholars therefore see spirituality as not limited to religious affiliation and practices but that which includes meaning, purpose and connection with self, others, the Universe and ultimate reality (Ojink 2009; McSherry and Jamieson 2010: 1757; O'Brien 2011: 04; Barlow 2011). Spirituality is particularly salient to nursing as it is often drawn upon when an individual faces emotional stress, physical illness and death (Nixon, Narayanasamy and Penny 2013: 10). Faith which is embedded in spirituality can be conceptualized as an omnipotent transcendental force, which is experienced internally and/or externally as caring interconnectedness with others, God or a Higher Power and is manifested as empowering, transformational and liberating. It is the means by which those facing adversity are inspired and fortified (Tjale and de Villers 2008: 105).

Despite the fact that humankind are spiritual beings and that spirituality is relevant to illness and recovery; it is only recently that contemporary nursing has begun to give attention to spirituality and spiritual care. Apart from the fact that more patients are bringing spirituality into the hospital context when faced with illness, there has also been a broadening of the traditional focus of nursing from the physical to include that of spirituality as part of a holistic approach to care (McSherry and Jamieson 2010: 1757; O'Brien 2011: 02; Lundberg and Kerdonfag 2010: 112). Simultaneously there has been a growth in empirical research on spirituality and health, and wellbeing (Koenig 2009: 283).

Whilst much of the literature on spirituality and spiritual care has grown in the Western context and is now an integrated part of nursing practice, empirical research in South Africa is sparse. Only one study on this topic was undertaken by Mahlungulu and Uys (2004: 15) in South Africa. This together with the growing

empirical evidence abroad regarding the need to consider spirituality in nursing practice led to the impetus for the current study. The purpose of the current inquiry was therefore to explore nursing practitioners' views on the role of spirituality and spiritual care in nursing, to investigate whether they currently utilize spiritual care practices, and whether education has integrated this dimension into teaching. To achieve this, a survey of nursing practitioners at selected public hospitals in KwaZulu-Natal was done through a process of multiphase random sampling.

1.2 PROBLEM STATEMENT

There exists a huge gap in the South African nursing literature on spirituality and spiritual care. Internationally, however, studies have grown focussing on the views of practitioners and faculty with regard to spirituality and spiritual care in nursing practice (McSherry and Jamieson 2010: 1757; Barlow 2011; Dunn 2008). Although nurses aim to deliver holistic patient care, taking into account the biological, psychological and physical needs of the patient, the spiritual dimension has been neglected (O'Shea *et al* 2011: 36; Taylor 2002 cited in McSherry 2006: 913; Stern and James 2006: 902). It is postulated that the failure to incorporate spirituality into nursing care by not addressing the spiritual needs of patients is unethical as spirituality is part of being human (Pettigrew 1990 and Wright 1998 cited in Miner-Williams 2006: 811). Furthermore, the lack of sufficient formal educational preparedness on spirituality and spiritual care renders nurses unprepared to deliver spiritual care (Barlow 2011).

1.3 RATIONALE FOR THE STUDY

In South Africa research in the field of spirituality is minimal, thus prompting the need for this study. An exploration of nursing practitioners' views on the role of spirituality in nursing, the salience of spiritual care to nursing practice and whether spirituality is being considered in current nursing education underpins the primary objectives. It is believed that through the integration of spirituality and spiritual care practices, nurses will be more aware of patients' spirituality and spiritual needs and be able to implement spiritual care activities in practice. Furthermore, spirituality will also be considered as an important pillar alongside the physical and

psychological dimensions in nursing care. Spiritual competence in nursing particularly is critical to empowering nurses with adequate knowledge and skills that will enable them to foster hope, purpose and meaning in the lives of those who are facing illness or a loss of life (Graham 2008: 06).

1.4 HISTORICAL DEVELOPMENT OF SPIRITUALITY IN NURSING

Spirituality has been present since the inception of nursing as a profession. Florence Nightingale (Lundberg and Kerdonfag 2010: 1122) said that nurses should see to the spiritual needs of patients regardless of their religious beliefs. She reasoned that if nature is the manifestation of God, then co-operation with nature, by facilitating healing, is co-operation with God (Macrae 2001 cited in Miner-Williams 2006: 812). In addition, she emphasized that the needs of the spirit are as critical to health as those individual organs which make up the body (Campbell 2008: 01).

According to Johnson *et al* (2006: 60), the pre-Christian era resulted in the development of the foundation and basis for caring and having charity for the infirm for generations to come. The Greeks considered nursing a noble art, and the Romans believed that prayer was important as they grappled with the ill (Johnson *et al* 2006: 60). The Israelites gift to nursing was their rules for the prevention of contagious diseases, and the idea of nursing being honourable and filled with respect dominated the Christian era (Johnson *et al* 2006: 60). It was the way Jesus attended to the infirm that set the standard for those who served to follow. Convents, monasteries and hospitals were established to care for the sick and this notion of spiritual care continued to develop into the eighteenth century (Carson 1989 cited in Johnson *et al.* 2006: 60).

“Nursing care was provided by the religious orders that cared for the poor, abandoned children and the others neglected by society” (Carson 1989 cited in Johnson *et al* 2006: 61).The nineteenth century saw nurses beginning to provide total care and doctors being called only when absolutely necessary. As time progressed, the early twentieth century witnessed the birth of formal nursing programmes. Nursing theorists during this era were prolific, conscientious and adamant about how patients were viewed. The concept of holistic care gained

sufficient strength that the total client (mind and body) was always considered. Research into spirituality led to the development of tools to enhance the various studies being conducted to promote spiritual care, and nursing programmes at the University of Maryland began to offer elective courses in spirituality (Johnson *et al* 2006: 61). Furthermore, nursing theorist Leinininger, after experiencing a miraculous spiritual occurrence based on the power of prayer spoke of including spirituality more explicitly in her theory on nursing (Johnson *et al.* 2006: 60), thereby allowing the interest in spirituality to grow.

Nursing in the late 20th century reached a consensus that the best care of patients is realized through focusing on the whole person, not only body and mind. An interest in the spiritual dimension of humankind and the relationship of spirituality to human health and wellbeing thus began to receive greater attention, both in practical settings, as well as the academic context (van Dover and Pfeiffer 2006: 213; Deal 2008: 06).

As nursing entered the twenty-first century, addressing the spiritual needs of patients was seen as an important goal for nursing care. The role of spirituality in promoting health and improving patients' responses to illness began receiving attention. Scholars concluded that spirituality was a natural part of nursing care and that following this approach enabled a nurse to care for the whole person (Vance 2001: 270; Mcclain 2008: 04; O'Brien 2011: 02; McSherry and Jamieson 2010: 1757). Since nurses spend more time with patients than any other health care provider; the role of the spirituality and spiritual care in nursing practice was addressed (Barlow 2008; Deal 2008: 06).

1.5 THE ROLE OF SPIRITUALITY AND SPIRITUAL CARE IN NURSING

"Nursing is really about being intuitive and spiritual and can be seen as a calling" O' Brien (2011: 02). Not only is nursing care spiritual in nature, but nurses who have a better understanding of their own spirituality may be more effective in providing quality patient care (Koren *et al* 2009: 124). Nurses are present day and night with their patients and hence are in a position to maintain a patient's wholeness and integrity (Lundberg and Kerdonfag 2010: 112). Since a nurse's

own personal spirituality permeates individual nursing practice; it is important that each nurse critically evaluates his or her own spirituality. Becoming aware of one's spiritual perspective will enhance personal awareness and contribute to the provision of spiritual care to patients (Dunn 2008; Graham 2008: 06).

Spiritual care, according to The Royal College of Nursing (Seymour 2009: 38) is care which recognizes and responds to the needs of the human spirit when faced with trauma, ill health or sadness, and can include the need for meaning, for self-worth, to express oneself, for faith, support and perhaps for rites, prayer, sacrament or simply for a sensitive listener. Spiritual nursing care begins with encouraging human contact in a compassionate relationship and moves in the direction the need requires. One reason for including spiritual care as part of the nursing curriculum is the belief that spirituality is a universal attribute; part of the condition of being human, which directly influences the health of us all (Seymour 2009: 38).

"At a foundational level, spiritual nursing care is a process that begins from a perspective of being with the patient in love and dialogue, which may emerge into therapeutically oriented interventions that take the direction from the patient's religious or spiritual reality" (Sawatzky and Pesut 2005 cited in Monareng 2012: 03). Spiritual care is a fundamental part of nursing that has been neglected (McSherry and Jamieson 2010: 1763). It includes nursing interventions such as listening, being with the patient, showing empathy, supporting the patient, showing concern, facilitating participation in patients rituals and referring to spiritual leaders when necessary (McSherry and Jamieson 2010: 1762; Khoshknab *et al*. 2010: 2939). Nurses are thus responsible for creating conducive physical, social and spiritual conditions for their patients' recovery.

Sawatzky and Pesut (2005: 19) saw spiritual care as an intuitive, interpersonal, altruistic and integrative expression that is contingent on the nurse's awareness of the transcendent dimension of life, and that which reflects the patient's reality. It could be argued that if nurses do not undertake a spiritual assessment of their patients there will be no consideration of their spiritual needs. Without assessment, there can be no planning, implementation or evaluation of spiritual

care, resulting in a lack of holistic care and neglect of the patient as a whole person (Ellis and Narayanasamy 2009: 886). This implies that the essence of spiritual care is that nurses interact and use themselves in the nurse-patient relationship rather than simply a set of nursing actions. Thus, spiritual care is 'being' as opposed to 'doing' (Sawatzky and Pesut 2005: 23; Baldacchino 2006: 887).

Spiritual care has also been viewed as that care that is embodied in the nurses' respect for patients' dignity, display of unconditional acceptance and love, honest nurse-patient relationship and the fostering of hope and peace (Sawatzky and Pesut 2005: 23). Existential perspectives view spiritual nursing care as care that extends to a more universal dimension that connects humans with a higher being, which may not necessarily be God as referred to by the religious perspective. Monareng (2012: 04) added that spiritual care includes activities that facilitate a healthy balance between the bio-psychosocial and spiritual aspects of the person, thus promoting a sense of wholeness and well-being. Earlier studies understood spiritual nursing as care engaged in; by identifying spiritual needs and concerns of patients and their families, and by responding appropriately based on careful assessment of each situation (Monareng 2012: 01).

Wu and Lin (2011: 250) and Chan (2009: 2128) pointed out that understanding the spiritual dimension of human experience is important to nursing, because nursing is a practice-based discipline that focuses on the human being. When a person is in tune with this vital and unifying force of the spiritual dimension, a more balanced state of physical, mental and social well-being may result, as it empowers the person to strive for meaning and purpose in life (Watson 1999 cited in Baldacchino 2006: 886). Spiritual care is that part of care which touches the unseen part of a person and gives that person faith, and a positive outlook on life even if the person cannot be cured (Dhamani, Paul, and Olson 2011: 03).

1.6 SIGNIFICANCE OF THE STUDY

Empirical research pertaining to spirituality has grown in the Western context with myriad studies that have documented the salience of spirituality to health and wellbeing in relation to a range of issues such as HIV/AIDS, cancer and heart disease (Koenig 2009: 283; McSherry 2006: 905; McSherry and Jamieson 2010: 1757; Moberg 2010: 99). It is in this context that nursing scholars have begun to research the role of spirituality and spiritual care in nursing practice in the Euro-American context.

A milestone towards health care was passed in 1978 when on the initiative of the Executive Board of The World Health Organization the definition of health was broadened to cover spiritual well-being in addition to physical, mental, and social well-being (Institute of Sathya Sai Education 2006: 03). Nurses today are being mandated by professional and regulating organisations such as The American Holistic Nurses' Association (2005) and The Joint Commission of Health-Care Organisations (2005) to incorporate spiritual assessment and interventions into their practice. In addition, it is postulated that failing to incorporate spirituality in nursing care by not addressing the spiritual needs of patients is unethical (Burkhart, Solari-Twadell and Haas 2008: 33; Helming 2009: 604). The Joint Commission on Accreditation of Healthcare Organizations policy stated that for many patients, pastoral care and other spiritual services are an integral part of health care and daily life.

Within the International Council of Nurses' Code of Ethics for Nurses spiritual care is included under "Nurses and people" as one of their four elements of standards of ethical conduct (Lind, Sendelbach and Steen 2011: 89). However, nursing education according to Pike (2011: 743) and the Royal College of Nursing (McSherry and Jamieson 2010: 1757) showed that there is a dearth of research into spirituality from the patients' perception, and that there is a need for education to allow nurses to deliver spiritual care. The Royal College of Nursing launched its Dignity in Care Campaign in 2008, emphasising the importance of treating patients

with dignity and respect. These initiatives further highlight the importance of providing care for the spiritual needs of patients.

In nursing literature, the need to educate nurses in spiritual care is widely recognized (Hanson and Andrews 2012: 354; Barlow 2011, Barber 2008; van Leeuwen *et al* (2007: 133). Spirituality is reflected in everyday life as well as in disciplines ranging from philosophy, literature, sociology and health care. The failure of the South African nursing curriculum to provide nurses with sufficient formal education on the spiritual dimension of nursing according to Dunn (2008) has merit as there are no specific nursing tools or programmes in the nursing curriculum that is reflective of spirituality in nursing. Other disciplines have however embraced the value of spirituality.

Barlow (2011) supported Dunn's view when he said that medical schools have begun offering courses in spirituality, religion and health. Several international schools of nursing have also incorporated into their programme issues of spirituality. Trends that appear to be driving this new interest in spirituality include many international studies that demonstrate the connection between spirituality and health improvement. Barlow (2011) added that there is a high demand from clients and patients that their spiritual needs be addressed along with their physical, mental and emotional needs. Doctors in the United Kingdom and United States are using spiritual healers. Whilst they do not replace traditional medical interventions, they can be used alongside regular medical treatment. A doctor healer network meets to discuss ways in which they can effectively work together (Barlow 2011).

In America, Care of the Human Spirit is currently taught as a Nursing and Health Studies elective. Students are graded on class participation, reflective journals, an experimental exercise involving engagement with an unfamiliar faith and a scholarly paper addressing spirituality and health (Becker 2009: 702). In contrast, the education on spiritual care in the South African nursing curricula appears lacking.

Nurses have provided spiritual care and support to their patients throughout the years with no formal training which attests to the importance of this level of care. Nurses also comfort patients who are suffering and dying. Many nurses pray with

patients and support their spiritual needs (Graham 2008: 06). Deal (2008: 858) conducted a descriptive phenomenological study in Texas with four nurses to explore their lived experience of giving spiritual care. Five themes emerged from the data. Spiritual care is patient-centred, spiritual care is an important part of nursing, spiritual care can be simple to give, spiritual care is not expected but is welcomed by patients and spiritual care is given by diverse caregivers including ward cleaners, doctors, ward clerks etc.

In this vein, spiritual care and spiritual care training is viewed as being an essential part of nursing care, not only in palliative care but also in many other areas of nursing care delivery (Narayansamy and Owen 2001: 446; Pike 2011: 748). Research has also suggested that nurses can promote patients' healing by supporting them to use spirituality as a coping mechanism. This could include prayer, meditation and reflection or mindfulness (Myers 2009: 22). It is critical that professional nurses are capable of responding to their patients' spiritual needs in a competent and sensitive way. This highlights the need for formal training on spirituality and spiritual care.

The lack of formal training in spiritual issues during basic nursing education renders the nurse virtually unprepared to meet the challenges of providing effective and therapeutic spiritual care for the client and the client's family (Sloma 2011: 11). They need to be informed of the rituals and beliefs of various religions and traditions which will help minimize embarrassing situations and avoid unintentional offensiveness. We cannot assume that all patients have the same religious or spiritual requirements and it is essential that health care professionals are provided with basic knowledge of the main religious traditions in South Africa. Traditional healers are after all consulted by our patients on a regular basis (Lubbe 2008: 17). It is also hoped that such knowledge will find its way back into the curricula of nurse training institutions (Lubbe 2008: 06).

It is envisaged that this study will create an awareness of the importance of spirituality in nursing practice. Motivation for nursing education to embrace spirituality can also be strengthened. This is significant as a new nursing curriculum is to be implemented in 2016 (SANC 2012).The bed of knowledge

uncovered by this study could also help nurses to become more comfortable with their own spirituality, which is the initial step in developing awareness and sensitivity to patients' spiritual issues (Graham 2008: 06).

The art of nursing practice is thus not only task orientated, but involves the establishment of a therapeutic interpersonal relationship that is based on caring, warmth, congruence and empathy (Watson 2002: 69). This study will help nurses recognize that patients are not only physical beings but spiritual beings as well.

1.7 CONCEPTUAL FRAMEWORK

Florence Nightingale, the "lady with the lamp", claimed that "the need of the spirit was as critical as those of individual organs" (Hutchinson 1998: 01). Her main concept was the patient which has since become part of many models allied to nursing.

A framework is a logical structure of meaning that guides the development of a study and enables the researcher to link the findings to the body of knowledge used in nursing practice (Burns and Grove 2008: 39). A theoretical framework refers to a study framework based on propositional statements from a theory or theories while a model is a copy, replica or analogy that differs from the real thing in some way (Bailey 1994 cited in de Vos *et al* 2005: 35). The current study has adopted the Human-To-Human Relationship Model of Travelbee (Hutchinson 1998: 01). Travelbee declared that a nurse does not only seek to alleviate physical pain or render physical care, she ministers to the whole person. She subsequently developed the Human-To–Human Relationship Model (Hutchinson 1998: 01; O' Brien 2011: 02), which rests on the notion that nursing is fulfilled through a human to human relationship. This model was based on Frankl's theory on Existentialism and Logotherapy (Frankl 2006: 121).

According to Logotherapy, nursing helps man to find meaning in the experience of illness and suffering and has the responsibility to help individuals and their families to find meaning. It further recognizes that a nurse's spiritual choices, ethical choices, perceptions of illness and suffering are crucial in helping to find meaning. According to Frankl (2006: 121), "the primary motivation of humankind is his search for meaning in life". He stated that this search for meaning helps man to

cope with suffering and stressful events of daily living. Puchalski (2001: 352) concurred, saying that one of the challenges nurses face is to help people find meaning and acceptance in the midst of suffering and chronic illness. Spirituality as a guiding paradigm forms the basis on which patients can find meaning through their illness and suffering.

1.8 RESEARCH OBJECTIVES

The primary aim of the study is to investigate nursing practitioner's views on the role of spirituality and spiritual care in nursing practice and whether this dimension has been considered in education. The objectives of the study are as follows:-

- To explore the views of nurses at public hospitals in KwaZulu-Natal regarding the role of spirituality and spiritual care in nursing practice.
- To investigate nursing practitioners' views on the salience of spirituality to patients.
- To investigate whether nurses utilize spiritually based activities in nursing.
- To investigate whether current education and training has prepared nurses for spiritual care practice.

1.9 PRESENTATIONS OF THE CHAPTERS

In Chapter one, spirituality was introduced and conceptual definitions presented. The problem statement, significance of the study and the research objectives were also elucidated. Chapter two covers an in-depth review of related literature on spirituality and spiritual care. In chapter three, the quantitative research paradigm is discussed as the guiding methodology, and aspects pertaining to sampling, data collection and data analysis are also discussed. Chapter four highlights the major findings of the study, and in chapter five an interpretation of the data and recommendations for further research is made.

CHAPTER TWO

THE LITERATURE REVIEW

2.1 INTRODUCTION

"I believe there is an important distinction to be made between religion and spirituality. Religion I take to be concerned with faith in the claims to salvation of one faith tradition or another, an aspect of which is acceptance of some form of metaphysical or supernatural reality, including perhaps an idea of heaven or nirvana. Connected with this are religious teachings or dogma, rituals, prayer and so on. Spirituality, I take to be concerned with those qualities of the human spirit — such as love and compassion, patience, tolerance, forgiveness, contentment, a sense of responsibility, a sense of harmony — which bring happiness to both self and others. While ritual and prayer, along with the questions of nirvana and salvation, are directly connected with religious faith, these inner qualities need not be, however. There is thus no reason why the individual should not develop them, even to a high degree, without recourse to any religious or metaphysical belief system. This is why I sometimes say that religion is something we can perhaps do without. What we cannot do without are these basic spiritual qualities"

Dalai Lama (1999).

A literature review follows a sequence of events that incorporates finding, reading, understanding and forming conclusions about the published scholarly research and theory on a particular topic (Burns and Grove 2008: 38). The process determines what is already known about the topic, the methodologies used and it forms a basis of comparison that serves to support or inform the study (Burns and Grove 2008: 90). The literature review is a critical summary of research on a topic of interest, often prepared to put a research problem into context, thereby enabling the researcher to constructively critique previous research (de Vos, Strydom, Fouche and Delport 2005: 124). Furthermore a search of literature prevents the duplication of a previous study, helps discover the current theorising about the subject/s and identifies the most recent empirical findings (Barbie and Mouton 2001: 127).

This chapter reviews salient literature in the areas that intersect with spirituality and nursing, the importance of spirituality to patients, spirituality in the presence of illness and terminal illness, spiritually based nursing interventions and spirituality and nursing education. Amidst the development of spirituality in health care, spirituality in nursing remains highly contested due to its huge range, diversity and its association with religion (Swinton and Patterson 2010: 226). The distinction between spirituality and religion forms the starting point of the literature being reviewed as illustrated in the opening quote to the chapter by the Dalai Lama (1999).

2.2 SPIRITUALITY AND RELIGION

Many definitions exist in the literature on spirituality due to its abstract and personalized nature. Potter and Potter (2006: 07) conceptualized spirituality as the opportunity to be part of something beyond ourselves, the purposeful changing of consciousness to provide more access to varying mental perspectives, subtler levels of experience, deeper awareness of self, the awakening of the heart, a wider array of emotional experiences and states of consciousness that connects with the subtle realm of being. It has therefore been conceptualized as an inner, intangible guiding force behind our uniqueness that acts as an inner source of power and energy (Ellis and Narayanasamy 2009: 886).

Clarke (2009: 1666) and Eric *et al.* 2007: 24) concurred that spirituality is a personal search for meaning and purpose in life which may or may not be related to religion. It entails connection to self-chosen and/or religious beliefs, values and practices that give meaning to life thereby inspiring and motivating individuals to achieve their optimal being. This connection brings faith, hope, peace and empowerment which results in joy, forgiveness of oneself and others, awareness and acceptance of hardships and mortality, a heightened sense of physical and emotional well-being and the ability to transcend beyond the infirmities of existence.

Although several writers posit that religion and spirituality are inseparable and both constructs can be used interchangeably (Thornton 2005: 106; Rieg, Mason and

Preston 2006: 249; Eric *et al.* 2007: 24; Penman 2012: 135), most others view spirituality as a broader concept that transcends culture and religion (D'Souza 2007; Lubbe 2008: 08).

Spirituality concerns our beliefs about our place in this world and seeks meaning and purpose in our lives; whereas religion can be likened to a container, rituals or liturgy that we use to express and focus these beliefs (Ojink 2009). Tokpah (2010: 63) affirmed that there was a difference between both constructs and said that spirituality rather than religion is an appropriate focus for the spiritual dimension of the nursing model. This difference is echoed by Maier-Lorentz (2004: 27); Barlow (2011) and Sloma (2011: 03) who all portrayed spirituality as referring to a universal concept of connection with a Supreme Being that does not require any religious belief. Religiosity on the other hand, they believed related to membership of and adherence to the practice of a particular faith, tradition or sect. Despite these differences Deal (2010: 852) and Barlow (2011) commented that using spiritual and religious resources gives patients and families strength to cope during crisis.

In a study with nurses, Narayanasamy (2006: 840) found that most participants understood spirituality as being religious. Similarly Dyson *et al.* (cited in Moberg 2010: 1184) reported that most American nurses defined spiritual well-being in terms of their religious faith. They said that viewing spirituality as a distinct entity from religion portrays a very narrow conception of it. Religion has definable boundaries and is more about a systematization of practice, doctrines and beliefs within which social groups engage (O'Connor 2001: 35; Pedrao and Beresin 2010: 87). Although religion is a social institution in which a group of people participate; it can be a rich resource for the expression of spirituality (O'Connor 2001: 35).

Being a member of a religious group however does not necessarily mean that one is spiritual (Hanson and Andrews 2012: 354). Spirituality is concerned with issues related to the significance and purpose of life, and spirituality is a broader construct which can be applied to all persons of both religious and non-religious orientation (Ross and Narayanasamy cited in Nixon and Narayanasamy 2010: 2260). With regard to understanding religion and spirituality in relation to patients

it has been said that patients' religious needs include making peace in one's relationship with God and others in one's life, readying oneself for the afterlife and attending to the ritualistic requirements of one's religion. A patient's spiritual needs however embrace finding meaning and a sense of control in one's life, forgiving oneself and others, obtaining forgiveness, reflecting on the course of one's life and one's accomplishments and saying goodbye to loved ones (Lubbe 2008: 08). The spiritual dimension tries to be in harmony with the universe, strives for answers about the infinite and comes into focus when a person faces emotional stress, physical illness or death (Wu and Lin 2011: 251). It is therefore important for nurses to understand spirituality and the pivotal role it occupies in a nursing context (Wu and Lin 2011: 250).

2.3 PERSONAL SPIRITUALITY AMONGST NURSES

O'Brien (2011: 02) wrote that nurses need to understand their own spirituality and their patients' spirituality, so as to provide holistic patient care. Nurses who have a better understanding of their own spirituality and its meaning may be less afraid to help patients address spiritual issues. Nurses who are more spiritually aware are more sensitive to their patients' spiritual needs. They are able to understand patients' spiritual distress and spiritual needs, and are able to listen to patients' thoughts and concerns about their spiritual feelings; hence demonstrating a higher level of spiritual care (Barber 2008; Dolamo 2010: 23; Wong, Lee and Lee 2008: 333). In a survey with American nurses (n=208) by Shores (2010: 08) it was found that 74% of nurses who had spiritual-awareness were better able to provide sensitive spiritual care as opposed to those who felt they had a lower level of spiritual care awareness.

A nurse's personal spirituality can help with managing his or her nursing role and its demands. Cavendish *et al*. (2004: 26) looked at the role of prayer as a performance enhancer for nurses (n=404). These scholars defined professional performance enhancement as nurses seeking guidance from a power beyond self in the provision of patient care, and in the implementation of the role and responsibilities of a professional nurse. Prayer was utilized by 18% of nurses for performance enhancement. These nurses used preparatory prayer in preparing for

their work and petitionary prayer when asking for guidance and support in their nursing activities. Cavendish *et al*. (2004: 31) suggested that prayer helps nurses to provide spiritual care to their patients. Prayer creates feelings of support and hope to assist meeting their patients' needs. Apart from prayer, there are other personal spiritual practices that nurses' use in their daily nursing practice.

Wehmer *et al*. (2010: 04) reported that nurses also used other spiritual practices such as playing or listening to music (99.2%), helping others (95.2%), exercise such as walking (92.9%), family activities (88.9%), praying alone (87.3%), relaxation (81%), recall of positive memories (81.5%), praying with others (70.6%), visiting a house of worship or quiet place (70.6%), reading spiritual material (51.6%), meditation (31.7%) and yoga (31.7%). The three most commonly used practices was playing or listening to music, exercise such as walking and praying alone.

It is inevitable that nurses will encounter patients with spiritual concerns or issues. A nurse will therefore have to have some understanding of spirituality to deal with such issues (Hussey 2009: 77). A holistic approach is an instrument of healing, a facilitator in the healing process and one who honours each individual's subjective experience about health, health beliefs, illness and death (American Holistic Nurses Association 2009 cited in Sessanna *et al* 2010: 252).

Barber (2008: 17) conducted a spirituality awareness workshop with senior nursing students (n=11). The workshop included an oral history project and interviews with patients which aimed to explore nursing students' perceived meaning of spirituality. It was found that through the workshop, nursing students became aware of their own spirituality and that it increased their comfort and understanding of the importance of providing spiritual care. The experience promoted personal awareness, professional awareness and spiritual awareness. All patients described the experience as meaningful, by offering a means to leaving their legacy and promote spiritual awareness. It is when patients are confronted with illness that their spiritual awareness comes to the fore. Seymour (2009: 38) expressed that when others are suffering, it is our own personal spirit that helps us respond with care and compassion and it is important that we nurture patients in

spirit as well. Caring for others requires knowledge about spiritual care and spiritual interventions in nursing practice. The following section highlights this.

2.4 SPIRITUALITY AND SPIRITUAL CARE IN NURSING PRACTICE

Nurses should provide spiritual care simply by their caring presence and empathic approach, irrespective of their own personal spiritual beliefs and faiths. Setting standards for spiritual care practice will help nurses not only to recognize the spiritual needs of their patients, but also to develop the necessary skills, knowledge and attitudes to deliver spiritual care whenever and wherever it is needed (Glasper 2011: 317). Since nurses are in a position to work closely with human beings they have access to their most intimate elements of human experience. Many nurses, however have difficulty addressing spirituality with their clients. (Taylor 2007: 585).

The literature reviewed has found that research on spirituality in a nursing context has proliferated abroad with strong attention being paid to holistic patient care (McSherry and Jamieson 2010: 1757; O'Brien 2011 :02; Koenig 2009: 283; Taylor 2007: 585). In contrast, there is a dearth of empirical work on spirituality in nursing in South Africa. After an extensive literature search, the researcher was able to locate only one South African study which described the phenomenon of spirituality from the perspective of nurses and patients. Mahlungulu and Uys (2004: 15) utilized a qualitative approach with nurses (n=40), patients (n=4) and family relatives (n=4) to derive a definition of spirituality. They concluded that spirituality was a unique individual quest for establishing and/or maintaining a dynamic relationship with self, others and with God; having faith, trust and hope, inner peace and a meaningful life. Studies abroad provided a richer understanding of spirituality in nursing.

Ross (2006: 855) undertook a systematic review of 45 articles on spirituality (1983-2005) in nursing practice. They included 14 articles on nurses' perception of spirituality and spiritual care in nursing, 23 articles on patients' views of spiritual care in nursing, five articles that compared nurses and patients' perception of the meaning of spirituality and spirituality in nursing, and three articles on spirituality in nursing education. The review identified three areas in which nurses can address

the spiritual needs of patients viz. (1) assessing end-of-life spiritual needs, (2) spiritual environments such as quiet/private spaces, multi-faith rooms and chapels, (3) competency frameworks to help staff recognize and support spiritual needs and (4) qualities, skills and caring attributes of nurses such as the use of silence and touch. The results included learning techniques of active and compassionate listening and companioning; where the nurse moves beyond notions of expert carer to a role which includes accompanying the dying person throughout their spiritual journey. Non-denominational spiritual practices such as prayer, contemplation and meditation were techniques identified that may help nurse augment their patients' peace and well-being.

Glasper (2011: 316) also published a systematic review of literature on spiritual care which aimed to collate knowledge on spiritual care. The analysis revealed the following themes: (1) identification of the spiritual need of patients as part the of the patient's assessment, (2) a humanistic approach where psychosocial needs help nurses explore facets of spirituality. These Include an exploration of a person's attitudes, beliefs, ideas, values and concerns about their own life and death issues including hopes and fears, (3) spiritual distress arising from loneliness of dying and (4) contemporary practice suggesting that spiritual needs must be assessed more regularly.

In order to meet spiritual needs nurses must be competent. Baldacchino (2006: 889) used a two stage exploratory study to investigate nurses' competencies in the delivery of spiritual care. A survey using open-ended questions was used to ascertain the views of registered Maltese nurses (n=215). This was followed by in-depth interviews with 14 nurses from the same sample. The questionnaire incorporated nursing education, religious affiliation and spiritual care. The following four main themes emerged: the role of the nurse as a professional, the delivery of spiritual care, communication with patients, inter-disciplinary team and clinical/educational organisations and safeguarding ethical issues in care. These findings confirmed the pivotal role nurses play with regard to providing spiritual care.

In a similar study, Lundberg and Kerdonfag (2010: 1124) used a qualitative design to explore Thai nurses (n=30) provision of spiritual care. In-depth interviews were conducted using the following three semi structured open ended questions: “how do you perceive the spiritual needs of your patients and their families?”, “what kind of spiritual care do you provide to your patients and their families?” and “how do you think spiritual care could be improved at hospitals?” Five themes emerged, namely: “giving mental support, facilitating religious rituals and cultural beliefs, communicating with patients and patients’ families, assessing the spiritual needs of patients, showing respect and facilitating family participation in care”. Lundberg and Kerdonfag (2010: 1126) concluded that spirituality was important when meeting the needs of their patients and patients’ families, which supports the need for providing competent spiritual care.

Nurses, however, may be hesitant to provide spiritual care for the following reasons: failure to be in touch with their own spirituality, confusion about the nurse’s role in providing spiritual care, lack of knowledge, hesitancy to invade a patient’s private “space”, fear of imposing their own philosophy or religious preference on patients who may be vulnerable or in crisis and lack of time (Callister *et al.* 2004: 160). In response Monareng (2012: 08) suggested that nurses develop a caring presence by encompassing the concepts of being available, listening, touching and providing spiritual support. The salience of spirituality to patients is dealt with in the section that follows.

2.5 SALIENCE OF SPIRITUALITY TO PATIENTS

Confronted with the helplessness and anxiety experienced with illness, patients seek meaning, hope, love and comfort through human relationships or a transcendent dimension with God (O’Brien, 2011: 02). Nixon, Narayanasamy and Penny (2013: 07) asserted that spirituality comes into focus when an individual faces emotional stress, physical illness or death. Being spiritual decreases fear of death, increases comfort and supports a positive perspective of death in gravely ill patients (Laukhuf and Werner 1998 cited in Nixon and Narayanasamy 2010: 2260).

Bullis (cited in Bhagwan 2002: 06) wrote that the spiritual issues clients bring to the helping situation are as diverse as the clients themselves. For some grief over the loss of a loved one, a job or career, a marriage or a child is spiritual. For some, decisions over pregnancy, marriage, separation and divorce, disease, terminal illness or debilitating illnesses are spiritual. Spirituality thus permeates most of a person's biopsycho-social problems.

A study of 921 patients by Molzahn and Shields (2008: 25) found that 83% of patients wanted nurses to ask about their spiritual beliefs, 77% when faced with life threating illness, 74% when experiencing serious medical conditions and 70% when dealing with the death of a loved. Similarly an Australian survey with 228 patients by Hilbers, Haynes and Kivikko (2010: 04) found that 80% of patients believed that their health was affected by spiritual beliefs and that those beliefs become more important when a person is sick. Seventy percent of participants added that it was helpful when nurses asked about their spiritual/religious beliefs. Patients agreed that this knowledge is important for building relationships between nurses and patients and served an important role in responsive health care (Hilbers, Haynes and Kivikko 2010: 04).

Since nurses are seen to be trustworthy, many patients turn to them to talk about spiritual/religious beliefs (Molzahn and Shields 2008: 25). O'Connell and Landers (2008: 350) stated that spiritual needs are often more acute during illness, especially with children. It is therefore important that nurses be aware of their patients spirituality and be knowledgeable about how to provide spiritual care to patients such as children, adolescents, the elderly, those with chronic illness, psychiatric illness and terminal illness. The following sections address this.

2.5.1 Meeting the spiritual needs of children

To meet the holistic needs of the child, spiritual interventions are mentioned frequently in nursing literature in addition to bio-psychosocial needs. Spirituality is advocated frequently in literature with respect to care of children, with terminal diseases and end of life care (Smith and McSherry, 2004: 307). This care includes

the extended family, community and pastoral support for parents during an impending death and continues during the period of mourning. Alternative therapies such as therapeutic touch, imagery, music and prayer are offered in providing for the psychological and emotional well-being of the patient as well as in pain management in terminal illnesses (Bodkin 2003: 133).

2.5.2 The adolescent patient

Cotton *et al.* (2012: 120) studied spirituality amongst American adolescents patients (n=151). One hundred and twenty one patients (81%) reported being religious and spiritual, 74 (49%) reported praying once a day, 55 (36%) reported praying once a month and 29 (19%) reported having meditated at least once in the last 30 days. Seventy six percent reported feeling a sense of purpose in their life and 138 (92%) found at least a little comfort in their faith or spiritual beliefs, 113 (75%) reported that their relationship with a Higher Power contributed to their well-being, 125 (83%) had a sense of mission or calling and 67 (45%) indicated that spiritual or religious beliefs helped them cope with their illness.

Seventy eight adolescents (52%) felt that the nurse should be aware of their spiritual beliefs and 42 (28%) reported having told their nurse about their spiritual beliefs. Of the 78 patients, 55 (71%) said that nurse awareness about spiritual care was important in order for the nurse to understand how their beliefs influence how they deal with asthma and 53 (68%) patients said it was so that the nurse could better understand how they make decisions. Seventeen percent of adolescents wanted the nurse to discuss spiritual issues with them. Only 26 adolescents (17%) answered ‘‘yes’’ when asked if they had spiritual beliefs that would influence future health care decisions. As the severity of the clinical situation increased, adolescents endorsed wanting their spiritual issues addressed. Forty seven patients (31%) reported that nurses should ask about their religious beliefs during a visit, this number increased to 63 (42%) if they were hospitalized and to 76 (51%) if they were dying. Similarly, 47 (32%) said that the nurse should pray with them compared with 70 (47%) if they were hospitalized, and 98 (65%) if they were dying.

2.5.3 The psychiatric patient

The role of spiritual care in mental illness has only begun to receive attention recently (Tokpah 2010: 28). A study of 79 psychiatric patients in New South Wales found that 79% patients rated spirituality as very important, 82% patients thought that their health caregiver should be aware of their spiritual beliefs and needs and 67% indicated that spirituality helped them to cope with psychological pain (D'Souza 2002 cited in Koenig 2009: 283).

In another study in Taiwan, Yang, Narayansamy and Chang (2012: 359) explored 22 psychiatric patient's perspective of their spirituality during hospitalization. Two main themes emerged: "I am a normal person" and "I want my life back." Findings revealed that seeking spiritual revival and transcendent spiritual resources could restore meaning in life and could help rebuild personhood and empowerment. Implications for practice were that nursing education needs to prepare nurses to be sensitive to patients' spiritual needs. Another survey of 406 psychiatric patients at a Los Angeles mental health facility found that 80% of patients used religion/spirituality to cope (Tepper, Rogers, Coleman *et al* 2001 cited in Koenig 2009: 283).

One hundred and fifty seven patients at the Center for Psychiatric Rehabilitation, Boston University, found that 41% of patients with schizophrenia and mood disorders reported that the most beneficial alternative practice was a religious or spiritual activity, and 54% of patients with bipolar mood disorder stated that only meditation surpassed religious/spiritual activities (Koenig 2009: 283). This was the first study in nursing which investigated meditation as a spiritual coping technique.

Meditation is an ancient spiritual practice defined as the control of fluctuations of the mind (Awasthi 2012: 613; Baerentsen *et al.* 2010: 57). A 2011 study at Massachusetts Hospital found that eight weeks of meditation significantly increased cortical thickness of brain regions associated with memory, sense of self, empathy and stress (Clark 2012: 625). Puchalski (2001: 353) also found that 10 to 20 minutes of self-transcendental meditation twice a day, resulted in decreased metabolism, decreased heart rate, decreased respiratory rate and

slower brain waves. He referred to this as the relaxation response which is effective therapy for any stress induced illness. When the brain perceives an image as peaceful, it alerts parasympathetic arousal that slows heartbeat, lowers blood pressure, slows breathing and shifts the body into deep relaxation (Lane 2005: 122). Reduction in neural activity was consistent with meditators' experience of merging with what they sensed as timeless, without boundary and infinite (Wang et al. cited in Clark 2012: 625). Meditation can therefore be seen as a salient spiritual intervention with both physical and spiritual benefits. (Ojink 2009; Barlow 2011)

2.5.4 The patient with chronic medical conditions

Koenig, McCullough, Larson (2001) cited many studies which documented that spirituality was associated with lower rates of coronary heart disease, hypertension, stroke and enhanced ability to cope with cancer, lower mortality and an important beneficial influence on survival following coronary artery bypass graft surgery. It has therefore been suggested that spiritual beliefs and practices may impact on cognitive and emotional processes which then influence biological mechanisms (Rippedtrop *et al* 2005 cited in Wachholtz; Pearce and Koenig 2007: 311).

A qualitative phenomenological study by Nabolsi and Carson (2011: 719) explored the experience of Jordanian Muslim men (n=19) with coronary artery disease. Four themes emerged regarding acceptance of illness and coping strategies: (1) faith facilitates acceptance of illness and enhanced coping, (2) medical treatment does not conflict with the belief in fate, (3) spirituality enhances inner strength, hope and acceptance of self-responsibility, (4) finding meaning and purpose in life as illness is one form of experience by which humans arrive at the knowledge of God.

Watson (1999: 41) explored the role of spirituality with 13 patients who were recovering from an acute myocardial infarction. Interviews revealed that a person's spirituality influenced their recovery by decreasing fear and anxiety, providing comfort and peace, enhancing coping, developing inner strength; courage; positivity; hope and giving participants a sense of wellness and wholeness.

Spirituality was a life-giving force that came from within each patient. This life-giving force was nurtured by receiving the presence of God, nature, friends, family and community and was based on developing faith, discovering meaning and purpose and the gift of self. Participants also said that nurses and doctors who voiced positive words of encouragement and concern provided participants with a sense of hope and comfort.

During a workshop in 2000, UNAIDS emphasised that HIV/AIDS communication programmes should harness peoples spiritual domain. Individuals must be able to believe that there is value and purpose in illness/disease (Cobb 2008: 06). How well a patient discusses his or her spirituality is dependent on the nurse. A caring, empathic nurse is more likely to develop and maintain a holistic rapport and trust with the patient if she incorporates spiritual activities into her nursing care plan.

2.5.5 The cancer/ oncology patient

Walton and Sullivan (2004: 139) explored the role of spirituality in 11 older men with prostate cancer. He found that spirituality was a vital process that permeated all aspects of the cancer and that a person's spiritual beliefs, personal prayer and the prayers and support of others can help the patient to feel loved and to cope with his illness. Anxiety and depression are common in seriously ill patients and may be associated with spiritual concerns. Touhy (2001: 45) investigated the correlation between spirituality, well-being, religiosity, hope and depression in 100 cancer patients facing death. The presence of spirituality was identified as a hope-fostering strategy, giving pleasure and hope in this study.

In another study, Nixon and Narayanasamy (2010: 2261) probed the spiritual needs of 23 neuro-oncology patients. Patient spiritual needs identified included reassurance, family support, need to talk, solitude, emotional support, need for connection/loneliness/ depression, plans for the future and a sense of normality, spiritual needs, religious needs, thoughts about meaning of life, anxiety, solitude, denial, end of life decisions and discussion of beliefs.

Dr Remen, founder of the Commonwealth Retreat for People with Cancer said that helping, fixing and serving represent three different ways of seeing life (Puchalksi

2001: 352). She added that “when you help, you see life as weak, when you fix, you see life as broken and when you serve you see life as whole. Serving patients involve spending time with them, holding their hands and talking about what is important to them” (Puchalksi 2001: 352). The questions often asked by patients are: “is this happening to me now?”, what will happen to me after I die?, will my family survive my loss?, will I be missed?, will I be remembered?, Is there a God?; if so, will he be there for me? will I have time to finish my life’s work?” (Puchalksi 2001: 352) True healing requires answers to these questions. Although a cure is not always possible, there is always room for healing. Healing can be experienced as an acceptance of illness, and peace with one’s life, and spirituality is at the core of this healing (Puchalksi 2001: 352).

2.5.6 The terminally ill or dying patient

There is scientific evidence that the spiritual well-being of a person can affect the quality of life and the response to illness, pain, suffering and even death (Mahlungulu and Uys 2004: 15). Death awakens grief responses that can manifest themselves in unpredictable personal expressions and needs. When patients die in hospital, nurses must try to help the family cope with this reality. Whilst there are physical and social losses, people suffer spiritual losses that also require assistance (Kulder 2007: 60).

Health professionals should be aware and supportive of the spiritual needs of the dying at the terminal phase (Amoah 2011: 353). Spirituality transcends dealing with ‘here and now’ issues to incorporate ‘here and after’ issues as well. Frankl (2006: 121) suggested that quality of life is tied to perceptions of ‘meaning’ and that searching for meaning is central to people’s existential issues. According to Amoah (2011: 357) spirituality in whatever its shade and form, helps many of those facing terminal illness to make sense of life during this challenging time. It is therefore appropriate for nurses to incorporate spiritual care into their care; not just to meet National and organizational policies, but also as something fundamental to the wellbeing of patients and families. A similar survey by Koenig (2009: 283) of 52 terminal lung cancer patients in Ontario found that the most commonly reported support systems were family (79%) and religion (44%).

During these times, families often resort to measures that would give them purpose and strength to continue with predetermined life goals. End of life period or death of a child imposes some functional constraints to some family goals and this brings some challenges that need redefining of those goals (Mystakidou *et al*. 2008: 1780). If an individual is unable to find meaning, all domains of life may be affected and spiritual distress/pain will be experienced (Kobasa 1983 cited in Dyson *et al.* 1997: 1183).

The significance of spiritual pain is of increasing interest in the field of palliative care (Pike 2011: 745). Spiritual pain derives from the deep anxiety associated with the prospect of the elimination of one's personal existence. It can be described as the loss of meaning and purpose in life caused by loss of self-integration (Mystakidou *et al.* 2008: 1782). Amongst the medically ill, and terminally ill in particular, patients struggle with questions about their mortality, the meaning and purpose of life, and whether a greater power exists; forcing them to grapple with issues that they have previously ignored (Mystakidou *et al*. 2008: 1872). Because psychological distress happens frequently at the end of life, maintenance or development of a sense of spiritual well-being might be a crucial aspect of coping with terminal illness (Pessin *et al*. 2002 cited in Mystakidou *et al*. 2008: 1780).

In an American study of 210 terminally patients, Johnson *et al* (2011: 752) examined the relationship between anxiety and depression within the two domains of spirituality viz. past spiritual experiences and current spiritual well-being. Patients were questioned monthly for four years or until death. The study found lower levels of anxiety and depression in patients with higher levels of spiritual well-being; which suggests that the search for meaning, peace and purpose in life, and the role of faith in illness are important to the spiritual experience of many patients facing serious illness regardless of their specific diagnosis.

2.5.7 The older adult patient

According to Erikson (Ellis and Nowlis 2005: 390) spirituality becomes more important in the older stage of the life cycle. Older people face not only the reality

of their own deaths but also those of their partners, family members and friends. They have to deal with frail bodies, frail minds and pain. Seeking a purpose and maintaining hope are spiritual tasks of importance that require spiritual resources developed over a lifetime (Perkins 2010: 78). Bohman, van Vyk, and Ekman (2011: 187) used an ethnographic study with a group of 16 South Africans patients aged 52-76 years to understand their experiences of being old and of care and caring in a transitional period. Data were collected through group and individual in-depth interviews and participant observations. Two interrelated themes emerged i.e. (1) Reflection on life, experiencing disappointments in life, times of enjoyments, expectations of the future, the importance of spiritual beliefs and Ubuntu. (2) Orientation towards others with sub-themes, ancestors influencing relationships and care for your next of kin.

In addition, Bauer and Barron (1995: 268) investigated the spiritual nursing care preferences among 50 patients aged 61-98. The study revealed that older patients wanted their nurses to be attentive, respectful, caring and hopeful. They noted that more research was needed to determine whether older adults valued these spiritual interventions to a lesser degree than they valued caring and communicational interventions, or whether they valued the former spiritual interventions but perceived the interventions as not within the domain of nursing.

In Pennsylvania and North Carolina, King and Bushwick (1994: 349) surveyed 203 patients between the ages of 61 and 48 years. Forty eight percent of the participants wanted nurses to pray with them, 23% were uncertain, whilst 28% disagreed. A majority of the participants (77%) thought that health care givers needed to consider the spiritual needs of their patients and 68% reported that their physicians had never discussed religious beliefs with the patients. The results demonstrated that 98% of the participants acknowledged a belief in God and 94% thought that spiritual health was as important as physical health.

There is growing acceptance that understanding patients spiritual beliefs and practices can be a vital source of information regarding the following: how patients understand health, illness and diagnosis, recovery and loss, strategies patients

use to cope with illness, patients resilience, resources and sense of support, decision making about treatment, medicine and self- care, expectations and relationship with health staff, day to day health practices and overall health outcome (Hilbers, Hayes and Kivikko 2010: 04). Spiritual needs become more enhanced with age, and when faced with terminal illness, and in times of death and dying.

A 2001 report by the Joint Commission in London found that patients placed a high value on emotional and spiritual needs, and that there is a strong relationship between the care of a patient's emotional and spiritual needs and overall patient satisfaction. King and Bushwick (1994: 349) stated that 77% of American patients want spiritual issues to be considered as part of their care regime. They added that spiritual or compassionate care involves serving the whole person.

The illness experience is shaped by a patient's perceptions, experiences and emotions concerning the condition, and various culturally prescribed holistic health-seeking strategies. Healing focuses on both the emotional and somatic aspects of a patient's condition, and their relation to the patient's health-belief system is recognised and addressed. Healing is therefore more than merely a physiological process. It implies restoration of the wholeness, balance or equilibrium which constitutes good health. Addressing illness through holistic treatment involves re-establishment of good relationships with the social and natural environments, as well as the supernatural worlds, rather than treatment of specific disease symptoms (Herselman 1997 cited in Tjale and de Villiers 2008: 02; Lubbe 2008: 07). In addition, spiritual beliefs might help patients cope with their suffering and may enhance the nurse patient relationship (Masel, Schur and Watzke 2012: 309; du Toit and van Staden 2009: 184).

2.6 ASSESSMENT OF PATIENTS' SPIRITUAL NEEDS

The key emphasis on a spiritual assessment is to be able to obtain patients information regarding spirituality in order to plan nursing care (Dameron 2005: 14). In addition, a spiritual assessment assists the nurse in planning holistic nursing care. Whether the nurse is unclear about the patient's spiritual belief or the patient

has a spiritual belief unfamiliar to the nurse, acronym models such as the SPIRIT, FICA or the HOPE model provide the basis for an organized, open and non-biased assessment. These models can be used for assessing patients' spiritual needs by asking questions according to the letters of the acronyms. Spirituality models as cited by Reig, Mason and Preston (2006: 251) are summarised as follows: Magans' S.P.I.R.I.T model, Anandarajah and Hight's H.O.P.E. model and Puchalski and Romer's F.I.C.A. model (see Table 1).

Table 1: Various spirituality models

Model	Questions asked
S.P.I.R.I.T MODEL (Magans)	S- spiritual belief system of patient P- personal spirituality of patient I- involvement with a spiritual community R- rituals practiced by patient T- terminal events planning
F.I.C.A MODEL (Puchalski and Romer)	F- faith or beliefs of patients I- important influences that give the patient support C- community support A- addressing someone or something that can assist the patient
H.O.P.E MODEL (Anandarajah and Hight	H- hope, meaning, comfort, strength, peace, love and connection O- organized religion P- personal spirituality and practice E- effects on care

2.7 SPIRITUAL CARE INTERVENTIONS

A person's spirituality can help him or her cope with difficult health care problems (Ray and McGee 2006: 666; Touhy, 2001: 45; Watson 1999). Spirituality can be expressed through visualization, meditation, prayer, nature and art therapy or other rituals, all of which bring meaning to patients who are facing anxiety and helplessness in the face of ill-health (Ojink 2009; Barlow 2011; Clark 2012: 1666). Consequently, spiritual care interventions are important in the holistic care of patients. Nurses however are often unsure how to implement spiritual care (Sellers and Haag 1998: 25).

During the 50th anniversary of the Brigham Young University College of Nursing, students were asked to journal spiritual interventions that they provided during their clinical experience. Nursing interventions indicated were (1) establishing a

trusting nurse-patient relationship, (2) providing and facilitating a supportive spiritual environment, (3) responding sensitively to the spiritual and cultural belief systems of patients and families, (4) acknowledging the importance of “presence” or therapeutic use of self, (5) demonstrating caring by practical nursing care and (6) integrating spirituality into the care plan (Callister *et al.* 2004: 160).

Grant (2004 cited in Deal 2008: 23) looked at the spiritual care interventions offered by nurses (n=299). He reported that almost every nurse believed that spirituality could give their patients inner peace, strength to cope, bring about physical relaxation and self-awareness, and help them forgive, connect and cooperate with others. The ten most common spiritual interventions used by nurses chosen from a list of 24 interventions were: holding a patient’s hand (92%), listening (92%), laughter (84%), prayer (71%), being present with a patient (62%), massage (49%), therapeutic touch (43%), music therapy (38%), guided imagery (36%) and meditation (34%). The nurses also responded to questions regarding when they felt spiritual care interventions were appropriate. The ten most selected circumstances were when a patient requests spiritual support (98%), is about to die (96%), is grieving (93%), receives bad news (93%), is crying (86%), asks about the meaning of life (82%), often prays or seems close to God (81%), seems depressed (78%), is a victim of abuse (75%) or is expecting to be healed by God (74%).

Sellers and Haag (1998: 338) studied spiritual care interventions used by Canadian nurses (n=208). Identified nursing interventions were referrals to a minister, chaplain or spiritual advisor, prayer, active listening and therapeutic communication, conveying acceptance, regard, respect and a non-judgmental attitude, instilling hope, clarifying spiritual values and experiences with spiritual history and assessment, presence, touch and referrals to community resources. The most frequently implemented nursing interventions included listening, conducting a spiritual history and assessment, conveying acceptance, respect and a non-judgmental attitude, therapeutic communication, affirming the value of belonging to a religious community, touch, conducting self-assessment of own spirituality, presence, prayer and health education. Nurses have to be willing to be

with their patients spiritually by praying with them, being willing to talk to them, listen to their spiritual and religious concerns and trying to relieve their suffering (Kiley 2008: 02).

A quantitative study with terminally ill French patients reflected their needs as being a reinterpretation of life, search for meaning, a connection to the world, to loved ones and a relationship with the transcendental (Bussing and Koenig 2010: 18). Similarly, interviews with 22 German chronically ill patients found that prayer, participation in religious ceremonies, reading spiritual/religious books, turning to a higher presence and the need for inner peace were an important part of their healing (Bussing and Koeing 2010: 18). In addition, an American qualitative cross sectional descriptive study using 28 cancer patients found that patients identified kindness and respect, talking and listening, and prayer as important aspects of their spiritual care (Taylor 2007: 585).

Chan (2009: 2130) surveyed Hong Kong nurses (n=110) to determine their attitudes regarding practising spiritual care. Findings showed that there was a positive correlation between spiritual care perceptions and spiritual care practice among nurses which means that the greater the nurse's spiritual care perceptions, the more frequently spiritual care is included in that nurse's practice. In addition, the findings revealed that nurses can provide spiritual care by praying with or for the patient, reading holy books, playing music that lifts the patient's spirit and calling in spiritual advisors to talk with the patient. Other interventions were listening to the patient, holding their hand, arranging for communion or other religious or spiritual rituals (Deal 2008: 04).

In this vein Deal and Grassley (2012: 479) argued that nurses should use spiritual and religious resources to give patients and families strength to cope during illness and spiritual crises. Barlow (2011) advocated the incorporation of spiritual assessment tools, such as listening; silence and touch. Khoshknab *et al.* (2010: 2939) added that spiritual care includes those interventions which addresses spiritual needs of patients like respecting patients' religious and cultural beliefs, communicating by listening and talking with clients, being with the patient by

caring; supporting; showing empathy; facilitating participation in religious rituals; promoting a sense of well-being and referring to chaplains and other professionals.

Balducci (2011: 479) emphasised that the best environment for use of spiritual interventions are when nurses acknowledge that it is a unique privilege to be trusted with a human life, plans by the nurse to take care of a person; not just manage a disease, an understanding of exactly what the patient wishes as an outcome of his/her disease, being truthful and compassionate which is the basis of mutual confidence in any relationsh2ip, acknowledge the role of homecare-givers as they assist patients with compliance to treatment regime and finally an inclusion of prayer with the patient, their family and hospital staff. Other strategies that nurses could use to meet patients spiritual needs are putting aside personal bias, recognizing patient's cues and verbal communication, making spiritual care resources such as private space for prayer/meditation; being empathic and including patient and family in health care decisions (Emmamally 2013). The most common spiritual interventions include prayer, touch, and self-transcendence. These will be discussed as follows.

2.7.1 Spiritual activities used by patients

2.7.1.1 Prayer

The use of conventional spiritual practices such as prayer is consistent with the recent research of Shores (2010: 09), who found a high level of spirituality among nursing students. Prayer is the communication between human beings and God and is recognized as the main method of coping during illness (du Toit and van Staden 2009: 184). Prayer is acknowledged in both ancient and modern times as an intervention for alleviating illness and promoting good health (French and Narayanasamy 2011: 1198).

Callister *et al*. (2004: 160) regarded prayer as the main method by which the spiritual needs of patients can be met. Dunn and Horgas (2000: 337) agreed, adding that prayer was used as a coping strategy by 96% of participants (n=50) aged 65-85. Dunn and Horgas (2000: 337) suggested that nurses need to be

aware of the importance of prayer as a coping strategy for their older adult patients.

In a qualitative study of 100 pre-operative cardiac patients Smith (2006: 41) found that 96 patients prayed the night before surgery, two had others pray for them and two had no prayer. The metaphor “Men of prayer” was developed during a qualitative study of patients with prostate cancer patients by Walton and Sullivan (2004: 131). These patients identified prayer as most important in giving them assurance, comfort and inner strength. Another survey of 292 outpatient cancer patients found that amongst all coping strategies prayer was the highest coping strategy used by 64% of patients (Koenig 2009: 283).

A cross-sectional, multisite American, mixed-methods study of advanced cancer patients (n=70), oncology physicians (n=206), and oncology nurses (n=115) was used to describe the viewpoints expressed by patients with advanced cancer, oncology nurses, and oncology physicians concerning the appropriateness of clinician prayer (Balboni *et al.* 2011: 836). Semi structured interviews assessed participants attitudes toward the appropriate role of prayer in the context of advanced cancer. Most advanced cancer patients (71%), nurses (83%), and physicians (65%) reported that patient-initiated, patient-practitioner prayer was occasionally appropriate.

Balboni *et al.* (2011: 836) agreed that clinician prayer was viewed as occasionally appropriate by 64% patients, 76% nurses and 59 % physicians respectively. Sixty one percent of patients could envision themselves asking nurses for prayer and 86% of these patients would find this form of prayer spiritually supportive. An additional 80% of the same patients viewed practitioner-initiated prayer as spiritually supportive. Open-ended responses regarding the appropriateness of nurses praying for advanced cancer patients revealed six themes shaping patients viewpoints: necessary conditions for prayer, potential benefits of prayer, critical attitudes toward prayer, positive attitudes toward prayer, potential negative consequences of prayer and prayer alternatives.

Griffin (2012: 245) concurred after he interviewed seven nurses in order to describe the lived experiences of preoperative Illinois patients. The findings revealed four themes: a point in time within the context of their journeys along the health/illness continuum, a sense relationship with another “holy other”, a feeling of vulnerability and appraisals of uncertainty. He further stated that nurses can contribute to spiritual care by developing an understanding of patients overall experience, understanding the patient’s goals and supporting the patient’s own coping mechanisms and resources.

A pain score survey by The American Pain Society revealed that 76% of patients used prayer as the most common non drug method of pain control. This was followed by relaxation (33%), touch (19%) and massage (09%). Administration of intravenous pain medication was used by 66% of the sample and pain injections by 62% (Puchalski 2001: 353). Health and illness become part of the continuum of being and prayer remains the salvation in both health and in sickness (Rassool 2000: 1476). A study by Meraviglia (1999 cited in Barber 2008: 136) found that patients with lung cancer incorporate aspects of spirituality, meaning in life and prayer in their daily life. This had positive effects on the disease process in relation to psychological and physical well-being.

2.7.1.2 Therapeutic touch

The American Holistic Nurses Association (Vitale 2008: 130) endorses the use of energy-based touch therapies by nurses as part of the scope and practice of holistic nursing. Therapeutic touch is an act of bringing a part of one's body, typically one's hand, into contact with someone. Touch practices are embedded in nursing’s roots in holism with visionary guidance from Florence Nightingale who alluded to the healing effects of the energetic environment on the human energy pattern (Dossey 2005: 57). Touch communicates a message of support and bonding, whereby the patient feels that the nurse is close and committed (du Toit and van Staden 2009: 180). Touch relates caring and compassion for the patient, brings comfort in times of illness and pain and is welcome when patients are facing terminal illness or eminent death (Barlow 2011). Several authors felt that touch was a critical aspect of physical, emotional and spiritual care (O’Brien 2011: 02; 2009; Ojink 2009 and Barlow 2011). This connectedness is an important

antecedent so that patients are able to view the nurse as honest, open and concerned (Monareng 2012: 99).

2.7.1.3 Privacy for Self- transcendental reflection

A nurse should allow privacy and time for the patient to reflect on his condition. This will allow the patient time and space for self-transcendence. Self-transcendence is experienced as growth into one's unfulfilled potential. It is the process of extending oneself both inwardly in introspective activities and outwardly in relationships with others. Self-transcendence means to be able to reach out beyond one's self, to encounter a higher being or other human beings and to fulfil meaning and purpose (Monareng 2012: 04). The benefits of self -transcendence are that it helps patients find meaning in suffering and allows for self-reflection. This can result in acceptance of illness and a feeling of peace (Levenson *et al.* 2005: 127).

2.7.1.4 Empathic listening and being present

Writing in a nursing context Ojink (2009) and O'Brien (2011: 02) found that there are three activities that underpin spiritual care. These include being with patients in their experiences of pain, suffering or need, listening to patients express their emotions and anxieties such as depression; sorrow; fear or loneliness, which may hinder their wellness and touching patients to assure them physically; emotionally and spiritually. The act of being present results in a meaning exchange between a nurse and the patient (Zyblock 2010: 121).

Providing a committed presence implies one' own commitment to life and to the patient by being a physical and spiritual presence to the patient (du Toit and van Staden 2009: 180). Barlow (2011) noted that whilst spiritual care might appear nebulous merely being empathic, being present, active listening, reading spiritual literature, touch and referrals for religious support are all part of integrating spirituality into nursing care. To this end O'Brien (2003: 01) agreed that spiritual care should be a natural part of the nursing process of assessment, diagnosis, planning and intervention.

The primary goal of spiritual care then is to mobilize the patients spiritual resources based on expressed need in a sensitive manner that involves awareness of the patients' spiritual beliefs and practices, and to make referrals for such care as part of the nursing plan. When nurses are sensitive to patients' spiritual concerns, their compassionate and empathic care is healing to patients even if a cure is not possible (Kiley 2008: 01).

Identified benefits of spiritual care by Grant (2004 cited in Deal 2008: 07) included inner peace (100%), coping strength (98%), physical relaxation (97%), self-awareness (96%) and connectedness to others (94%). Grant (2004 cited in Deal 2008: 23) noted that although the study indicates that nurses are aware of the benefits of spiritual care interventions they are unsure when to implement spiritual care measures for their patients, as demonstrated by the fact that only 41% of nurses provided spiritual support when a patient is having problems with forgiveness. Nurses acknowledge that providing spiritual care is essential if a nurse is to provide complete holistic nursing care however nurses need education on how to provide such care.

2.8 SPIRITUALITY AND NURSING EDUCATION

To meet the various spiritual needs of patients a nurse must be knowledgeable about the various tenets of faith; especially those that influence health and illness. Nurses need to be effectively prepared to deal with the complexity of providing personalised care in an increasingly diverse society. Nursing is about attending to the holistic needs of each patient's body, soul and spirit. When we provide holistic care, we achieve quality care that is at the heart of good nursing (Myers 2009: 22).

2.8.1 Spirituality and spiritual care within a South African context

Current South African legislation fosters comprehensive health care by encouraging facilitative measures between magico-religious paradigms (National Health Care Plan 1994: 72). Tjale and de Villers (2008: 34) identified two dominant

and different paradigms in South Africa. The biomedical and the magico-religious/spiritual paradigms are based on health care values that are culturally and religious/spiritually diverse. Tjale and de Villers (2008: 03) stated that South African patients would first consult their traditional healers before presenting themselves at hospitals. To this end, the African National Congress (ANC) made provision in the National Health Care Plan (1994: 72) to recognize the traditional indigenous health care practice as legitimate for those people who prefer to utilise this health care system. Guidelines of the National Health Care Plan (1995: 72) have since been translated into a South African National Health Act of 2005 (Tjale and de Villers 2008: 05). According to Pera and van Tonder (2012: 206) the efforts of traditional practices incorporated in basic health care should be encouraged and acknowledged.

The South African Nursing Council (SANC: 2012) philosophy of nursing education does not give a specific definition of holistic nursing care and this has led to different interpretations and meaning in the application of this concept at patient care level. The basic premise underlying the Scope of Practice of the professional nurse (R2598 of November 1998, as amended) is that nurses are concerned with the human being as a holistic being (Searle 2000 cited in Tjale and be Villers 2008: 10). According to the Scope of Practice, the expected outcome of the nurse-patient encounter is that the professional nurse will render comprehensive nursing care as stated in the White Paper (Department of National Health 1997 cited in Tjale and de Villers 2008: 11).

2.8.2 Spirituality and spiritual care within an international context

Firth (2011 cited in Amoah 2011: 355) warned against stereotyping individuals based on their ethnic outlook. She recommended valuing their spiritual experience, which is shaped by their culture and world view. Issues that may arise owing to the culture and religious background of the patient and family may relate to code of dressing, dietary issues, bodily touch, views about treatment; festivals and prayers, rituals; sacraments; symbols and holy books, rituals after death and emotional expressions. Thus nurses serve as companions on a journey to

engender hope and facilitate healing in the face of hopelessness. Nurses should regard themselves as frontline spiritual care givers (Gordon and Mitchell 2004: 646).

Caramanzana and Wilches (2012: 295) developed and implemented an in-hospital educational programme on the cultural and religious dimensions of caring. Islamic, Christian, Jewish and Hindu religions and their associated spiritual beliefs were included as part of the programme objectives. Its purpose was to prepare nurses to provide holistic care. Forty classes with a total of 561 nurses attended the programme over a three month period that was conducted at a New York training hospital. Ninety eight percent of the nurses strongly agreed that the educational programme left them feeling knowledgeable and empowered to care for patients of varied religious/spiritual orientation, adding that they were able to reflect on their practice and acquire new coping skills. This validates the need for education to include spirituality as important aspect of the tapestry of holistic health care.

Despite a growing body of evidence that shows the importance of spiritual care to nursing, there is a paucity of literature on spirituality in nursing education (Chism and Magnan 2009: 603; Callister *et al.* 2004: 160). A sample of student nurses (n=223) in Michigan were surveyed in an attempt to investigate students personal level of spirituality and spiritual training received. Results revealed that 96 (43%) nurses considered themselves spiritual, only 23 (13%) were satisfied the spiritual training they received and 190 (85%) acknowledged having a religious affiliation (Chism and Magnan 2009: 600).These findings are indicative of the need for more education on spiritual care.

Kiley (2008: 01) stated that the Deans of American Catholic nursing schools were concerned about a heightened emphasis on technical proficiency and scientific acumen that has had the unintended consequence of de-emphasizing the spiritual essence of compassionate nursing care. Kiley (2008: 01) argued that a good nurse needs both technical and spiritual proficiency and that the both can be incorporated in the nursing curriculum. The Deans recognized this and have made efforts to inject spirituality into their nursing curriculums. The American Association of Colleges of Nursing is collaborating with the George Washington Institute for

Spirituality and Health at the George Washington University, to develop learning objectives and curricula on spirituality and spirituality nursing care (Kiley 2008: 02).

There is a need for greater training and professional development in spiritual care for nurses working in the palliative setting. This includes making spiritual care resources available to patients and families (Hanson and Andrew 2012: 354). It is ethically and legally wrong to neglect the spiritual needs of patients and families. Whether such neglect should carry the same consequences as neglecting physical pain, for example, is open to debate.

A quantitative study by Pedrao and Beresin (2010: 86) was conducted with Brazilian nurses (n=30) to evaluate their spiritual well-being and to ascertain their opinions regarding the importance of offering spiritual assistance to patients. It also checked whether nurses had received any formal professional training for giving patient's spiritual assistance. Eighty three percent of nurses (n=25) answered affirmatively regarding the importance of offering patients spiritual assistance. Of the five nurses who responded negatively, 60% justified their answer saying that it was not the responsibility of the nurse to interfere in this subject. About 67% reported not having received professional training during their undergraduate nursing course, 93% of them received no training during their graduate course, and 87% responded that they had received no professional training in other nursing courses for giving spiritual assistance to patients (Pedrao and Beresin 2010: 86).

Seymour (2009: 02) conducted a study with three groups of nursing students (n=49) to explore their understanding of spirituality and spiritual care and to evaluate the impact of educational intervention on their understanding of spirituality and spiritual care. Group one used phrases such as "to love and be loved, a feeling of belonging to someone and being understood". Group two highlighted "love, family and friendship, and the need to belong and be accepted." Group three concurred by signifying "friendship and love, and supportive relationships as key spiritual needs". The study indicated that students were able to identify spiritual needs and collectively the group demonstrated common

understanding of the spiritual dimension, and that it was possible to learn about spiritual care in the classroom.

There were several inquiries into whether spiritual care is being integrated in nursing and nursing education. A survey in the United Kingdom by McSherry and Jamieson (2010: 1757) with nurses (n=4054), found that they were aware that providing spiritual care enhanced the overall wellbeing of patients. They however felt that they needed more guidelines and support to provide this level of care. Other studies also reported the need to integrate spirituality and spiritual care into nursing practice (Koren *et al.* 2009: 120; Dhamani, Paul and Olson 2011: 48). This was only possible, if nurses acknowledged the importance of linking spirituality to nursing.

Others such as Wong, Lee and Lee (2008: 333) used a cross-sectional descriptive survey to investigate nurses' perception of spirituality and spiritual care in Hong Kong. A total of 391 nurses completed McSherry's (1998: 36) Spirituality and Spiritual Care Rating Scale (SSCRS). The findings revealed that there were significant differences in the mean score of the existential search, universality and perception of spirituality amongst the subjects with different educational levels. The highest performing group was the group which had attained a degree at educational level. Nurse's educational level appeared to have a positive impact on their perception of spirituality and provision of spiritual care. Those that lacked adequate educational training on spirituality performed poorly as compared to those who had more training.

Despite this evidence, nursing education appears to provide few opportunities for the discussion of spirituality and spiritual care (Molzahn and Shields 2008: 25). Sloma (2011: 04) and Barlow (2011) concluded that the lack of formal training in spiritual issues during basic nursing education renders the nurse unprepared to meet the challenges of providing effective, therapeutic spiritual care for clients and their families. Lubbe (2008: 66) supported this arguing that the need for such knowledge to be included into the nursing curricula whilst Dunn (2008: 04) called for specific knowledge about spiritual assessment and care.

2.8.3 Teaching strategies on spirituality and spiritual care in nursing education

Nathan (2001 cited in O'Brien 2011: 01) added that there are fundamental difficulties that nurses' experience when meeting patients' spiritual needs, which is rooted primarily in the ignorance of what spirituality is and how to deal with problems when they arise. He felt that nurses are good at dealing with ritualistic aspects like dietary needs and what to do in the event of death but are very poor in meeting spiritual demands like "why is this happening to me?" and "how will I cope?" Hence the need for knowledge on how to identify and render spiritual care should be at the core of quality nursing practice. Nurses who are hesitant to provide spiritual care have listed the following reasons: failure to be in touch with one's own spirituality, confusion about the nurse's role in providing spiritual care, a lack of knowledge regarding what spiritual care is, and fear of imposing their own religious preference on patients (Callister *et al.* 2004: 106 and Greenstreet 1999: 649).

A cross sectional survey by Koren *et al* (2009: 120) using a convenience sample of 86 Illinois nurses showed that nurses reported an average level of spiritual well-being, and that there was a need to learn more about spirituality. Interviews with Tanzanian student nurses (n=15) by Dhamani, Paul and Olson (2011: 48) found that nurses showed a desire to provide spiritual care and would like to expand this knowledge base. A Taiwanese study by Shin *et al*. (1999: 11) yielded similar results. Professional nurses (n=04) were interviewed followed by a survey of nurses (n=64). The survey showed that nurses (92%) considered lectures on spirituality to be useful. Three types of educational needs were identified. These were viz. to clarify the concept spiritual care, to help nurses disclosing spiritual beliefs and to learn how to provide spiritual care.

Ojink (2009) and Barlow (2011) advocated the use of spiritual assessment tools such as listening, silence and touch. Even though a nurse has a spiritual base, it cannot be assumed that the nurse will provide spiritual care. Nurse educators must include spiritual assessment/care within the nursing curricula. Including spiritual content such as guidelines, models and frameworks will help ensure that nurse graduates have a basic understanding of the relationship between

spirituality and health, and would have been afforded opportunities for personal spiritual awareness (Dunn 2008: 04).

Tiew, Drury and Creedy (2011: 01) used in-depth interviews with pre-registration nursing diploma students (n=16) in Singapore to investigate their perceptions and attitudes about spirituality and spiritual care in practice. It was found that students perceived spirituality as an innate characteristic of an individual's spiritual awareness which developed across the lifespan and was an essential element for spiritual well-being. Participants identified that nurses need to connect with patients in a unique spiritual care-giving relationship. Education and professional development for effective spiritual care therefore needed to be offered to nurses.

In a survey of Midwestern nurses by Callister *et al.* (2004: 160), only 15% of nurses felt that they received adequate information about spiritual interventions during their nursing education. An additional survey of American baccalaureate nursing programmes (n=250) by Callister *et al.* (2004: 161) revealed that while the concept of spirituality was part of the majority programmes, definitions of spirituality and spiritual care were frequently lacking. Teaching strategies included classroom activities (91.5%), and content covered prayer, use of scripture and the spiritual needs of atheists and agnostics. The survey revealed that spirituality is inadequately addressed.

A mixed method study by Graham (2008: 33) examined nursing students (n=24) perception of how prepared they are in assessing patients' spiritual needs. Quantitative data were collected before and after they participated in a four hour spirituality seminar. A qualitative phenomenological approach followed examining senior nursing students (n=12) from the original sample using an interview format. Results of this study identified five themes: 1) nursing students' personal spiritual beliefs, 2) spiritual interventions, 3) assessing patients' spiritual needs, 4) personal beliefs impacting nursing care and 5) spirituality in nursing education. The findings of this study suggest that greater emphasis should be placed on the spiritual domain in nursing education.

A spiritual education programme for nurses (n=37) was conducted at a Minneapolis hospital to evaluate the effects the programme has on patient care and satisfaction. A follow up survey solicited feedback from nurses regarding resources they may require to meet patient's spiritual needs. The primary outcome of patient satisfaction was evaluated by a further patient satisfaction survey. The conclusion was that patients want their spiritual needs addressed and that nurses can be positioned to address the spiritual needs of patients appropriately if given proper resources, which was found to be lacking (Lind, Sendelbach and Steen 2011: 89). They added that in addition to lack of education and training other reasons for not providing care included lack of time and resources, lack of privacy, personal attitudes/sensitivities on the part of the nurse and some nurses may not be comfortable to broach what is considered a private subject.

Vlasblom *et al.* (2010: 790) provided a pre-test spirituality and nursing care training course to nurses at a Christian 330 bedded hospital in a Rotterdam. Prior to training and six weeks thereafter 49 nurses and 187 patients filled a questionnaire that examined the patient's characteristics concerning health views, quality of life, and experiences at the hospital. The patients from the intervention wards experienced more receptiveness and support when asking questions about illness and meaning. There were also specific changes in nurses' attitudes and knowledge, and changes in clinical practice such as documenting spiritual needs, and an increase in the number of referrals to the chaplains. Results indicate that training in spiritual care for nurses may have positive effects on patient health care.

In an exploratory descriptive study by Wehmer *et al*. (2010: 05), 241 nurses were surveyed in the United States. This survey asked the following: "what are the spiritual experiences of nursing students, what is the level of spiritual well-being among nursing students, and what spiritual practices do nursing students use?" The highest daily spiritual experience was being thankful for blessings which occurred many times per day. The next highest daily spiritual experience reported included: (1) desire to be close to God, (2) selfless caring for others, (3) comfort in religion and spirituality, (4) asking for God's help and (5) accepting others. The

majority of students reported these spiritual experiences as occurring every day or most days.

The most frequently reported spiritual practice was playing or listening to music (n=125) followed by helping others (n=120), exercise (n=117), family activities (n=112) and praying alone (n = 110). The least often used spiritual practices were meditation (n=40) and yoga (n=40). The three spiritual practices used the most often were listening to music or playing music (n=80), exercise such as walking (n=58) and praying alone (n=54) (Wehmer *et al*. 2010: 05).

Lovanio and Wallace (2007: 42) found that the use of spiritual practice interventions such as prayer, reminiscence and chapel visits enhanced the students' spiritual attitudes. In a follow up study which focused on integrating spirituality content into the undergraduate curriculum Lovanio and Wallace (2007: 42) concluded that spiritual knowledge and attitudes were more positive after the educational intervention. Similar changes were found in spiritual experiences following the introduction of a specific educational programme on spiritual care (Wehmer *et al.* 2010: 09).

2.8.4 The challenges of spirituality and spiritual care in nursing education

Spiritual care training is expected to increase the nurses' competencies as well as the spiritual support that patients will experience in their illness (Narayanasamy and Owen 2001: 446; Ross 2006: 852, Vlasblom *et al.* 2010: 790). For effective delivery of spiritual care, education on spirituality is emphasized so as to meet patients' needs (Baldacchino 2006: 892). According to Baldacchino (2006: 892) nurses considered themselves incompetent because of lack of preparation in their pre and post nursing registration education. Consequently, nurses recommend further continuing education to ameliorate their nursing care by integrating the spiritual dimension in care. If nurses are to deliver care that is truly spiritual, nursing education needs to provide sufficient information to assist nurses to develop this art of spirituality. It is for this reason that spirituality and spiritual care becomes an essential component of nursing. Furthermore, understanding

spirituality in nursing raises issues of how nurses can be taught spiritual care and more precisely what should be taught (Swinton and Patterson 2010: 231).

Nurse educators are challenged to include a wide range of content and experiential learning in the basic nursing curriculum (Deal 2008: 04). Spiritual aspects of patient care and basic understanding of one's own spirituality are often overlooked as curricula have become crowded with an emphasis on new technologies and care. Since 2000 there has been a resurgence of interest in teaching spirituality and spiritual care to nursing students. Prior to implementing an educational programme focused on teaching spirituality and spiritual care, it was thought that baseline assessment of nursing students' spiritual experiences, spiritual well-being, and spiritual practices was an important first step. This baseline assessment is considered essential prior to designing educational interventions to enhance nurse's understanding of the various dimensions of their own spirituality and the spiritual needs of their patients. (Pesut *et al* 2009: 343).

2.9 CONCLUSION

This chapter reviewed literature on spirituality and spiritual care in nursing. Spirituality and religion were first defined. Nurses' personal spirituality, spirituality and spiritual care in nursing, the salience of spirituality to patients and spiritual nursing interventions was reviewed. Spirituality and nursing education formed the concluding part of the chapter. Chapter three will look at the research methodology of the study

CHAPTER THREE

RESEARCH METHODOLOGY

3.1. INTRODUCTION

"Why are we in this field, when it often seems like we are only there to fix the body, to give physical diagnosis and treatment?

Healing is much more than that... it's about honouring your presence, your connectedness with another person.

It is that caring moment that can be a critical turning point in your life and in another person's life, as we touch another person's humanity... This is what healing is all about.

What if we began to pause, and to realize that, maybe, this one moment, with this one person, is the very reason we are here on Earth at this time?

When we hold them in their whole-ness, we hold their healing for them, and we help to sustain them when they are most vulnerable... and as we sustain another person, we are sustaining ourselves."

Watson (1999).

The researcher can be conceptualized as an artist who meticulously drafts a sketch, choosing the best design and pattern to create a true reflection of the research portrait. Amidst the reservoir of research approaches, the best approach aligned with the objectives of the study has to be selected. Given that the broad aim of the study was to explore whether spirituality has a place in nursing and whether current nurse educational training has prepared nurses for spiritual care practice, a quantitative, descriptive design was deemed most suitable to guide the research process.

This chapter outlines the methodology used to investigate spirituality and spiritual care amongst professional nurses at public hospitals in KwaZulu-Natal. It delineates the research design used, population and sample selected data

collection and analysis procedures, issues of reliability and validity and the ethical considerations in the study.

3.2 THE QUANTITATIVE RESEARCH PARADIGM

Research is a systematic process of data collection, analysis and interpretation that ultimately increases our understanding of the phenomenon of interest (Brink, van der Walt and van Rensburg 2012: 02). The research design offers a blueprint for recruiting and selecting participants, research sites and data collection procedures to answer the research question (McMillan and Schumacher 2006: 117; Burns and Grove 2008: 41; Mouton 2001 cited in de Vos *et al.* 2005: 132). Burns and Grove (2008: 41) concurred that "the type of research design directs the selection of a population, sampling procedure, method of measurement and a plan for data collection and analysis." In other words the research design focuses on the end product, formulates a research problem and focuses on the logic of research (de Vos *et al.* 2005: 132). Within the context of the research objectives, the researcher concluded that adopting the post positivist philosophy as a blue print was the best design.

Research undertaken within a positivist paradigm follows an established plan. Within a positivist paradigm, data is gathered according to an established plan, using structured instruments to collect the necessary information (Polit and Beck 2008: 16; de Vos *et al.* 2005: 132). In accordance with post positivist philosophy a quantitative as opposed to a qualitative research design was embraced. Quantitative research designs adopt rigorous and systematic strategies for generating and refining knowledge. Primarily, deductive reasoning and generalizations are used.

Deductive reasoning is the process by which the researcher starts with an established theory or framework, where concepts have already been reduced into variables, and then gathers evidence to assess or examine whether the theory or framework has merit (Brink, van der Walt and van Rensburg 2012: 11). The quantitative approach has its roots in logical positivism and focuses on measurable aspects of human behaviour that involves manipulation of numerical data through statistical procedures for the purpose of describing phenomena or

assessing the magnitude and reliability of relationships among them (Polit and Beck 2008: 16; Brink, van der Walt and van Rensburg 2012: 11; Burns and Grove 2008: 22).

In addition, quantitative research gathers empirical evidence that is rooted in objective reality and gathers numerical information that has resulted from formal measurement that is analysed using statistical procedures (Polit and Beck 2008: 16). After numerical data is gathered, the operationalization of statistical analysis ensures that these numbers are systematically interpreted and verified. The strength of quantitative research is that it allows an understanding of patterns. This highly structured research process uses statistical analysis and objective instruments such as questionnaires, checklists, indexes and scales for data collection (de Vos *et al.* 2005: 166).

In contrast, a qualitative approach attempts to understand phenomenon in its entirety (Brink, van der Walt and van Rensburg 2012: 11). The qualitative approach does not include numerical analysis as description using numbers may be difficult. Solving problems is likely to require the use of quantitative approaches (Willemse 2009: 6). Furthermore qualitative approaches use sustained interaction with the participants and infers that subjectivity and inductive and dialectic reasoning is paramount (Brink, van der Walt and van Rensburg 2012: 11; de Vos *et al.* 2005: 47).This intense level of interaction, although important, would have been difficult considering the large number of professional nurses and the structured approach that was needed for this study. Hence the qualitative approach was not considered; instead the researcher adopted the quantitative design.

The researcher's decision to adopt a quantitative design as opposed to a qualitative design was also guided by the primary objectives which were to conduct a survey with professional nurses and to explore their views with regard to spiritual care. The specific and detailed nature of the research objectives could be best achieved by the use of structured questions regarding spirituality and spiritual care. Data collection using a survey questionnaire allowed for standardized information and control over the amount and type of information collected (Saunders *et al.* 2007: 01).

Since the research objectives for the current study required a structured formal instrument, quantitative methodologies were seen to be most appropriate to meeting the research objectives. The main aim of this paradigm is to explore issues and reflect the collected data through frequencies and percentages in tables and figures (Meyer *et al.* 2009: 346).

A descriptive survey of professional nurses with a cross-sectional design was adopted. According to Burns and Grove (2008: 22) descriptive studies offers researchers a way to discover new meaning, to describe what exists, determine the frequency with which something occurs and to categorize information. Descriptive research aims to portray the characteristics of persons, situations, or groups and the frequency with which certain phenomena occur (Polit and Beck 2008: 752). Brink, van der Walt and van Rensburg (2012: 97) described survey research as being non-experimental, with a focus on gathering information of people related to activities, beliefs, preferences, and attitudes using direct questioning of the participants.

A self-administered survey questionnaire on spirituality was constructed to collect data (Appendix 1). This tool was used to gather information from professional nurses regarding aspects of spirituality and spiritual care at select public hospitals in KwaZulu-Natal. Polit and Beck (2008: 740) defined a questionnaire as “a document used to gather self-report data via self-administration of questions”. Survey studies emphasise that data collection must have used structured indirect observation, questionnaires and/or interviews. The researcher merely searches for accurate information about the characteristics of particular subjects, groups, institutions or situations or the frequency of a phenomenon’s occurrence (Brink, van der Walt and van Rensburg 2012: 97). In this study, the researcher wanted to explore the views of professional nurses regarding the role of spiritual and spiritual care in nursing, the salience of spirituality to patients, spiritual nursing activities and the academic preparedness of professional to deliver spiritual care.

A qualitative approach would have not been suitable as the researcher required the views of a large number of professional nurses, in order for the findings to be generalized. It was these professional nurses who made up the population for this study and from whom the relevant sample was drawn.

3.3 STUDY POPULATION AND SAMPLE

3.3.1 Population

A population refers to “the entire set of individuals having common characteristics” (Polit and Beck 2008: 67) and the total aggregation of cases in which the researcher is interested in (Polit and Beck 2008: 67; de Vos *et al.* 2005: 193). It is also the total collection of participants about whom conclusions are drawn (Cooper and Schindler 2001: 163). The population for this study included all 25 440 professional nurses in KwaZulu-Natal that are on the register of the South African Nursing Council (SANC 2012). The study was conducted at selected public hospitals that are accredited by the South African Council (SANC 2012) to provide practical training in the nursing diploma programme, within the 11 districts of Kwa Zulu–Natal. These hospitals are also affiliated to the KwaZulu-Natal College of Nursing. As it was impossible to survey all 25 440 professional nurses due to time and financial constraints an appropriate sampling strategy was determined in consultation with a registered statistician. Sarantakos (1983 cited in De Vos *et al*. 2005: 194) argued that the main reason for using a sample as opposed to the entire population is feasibility, as a total coverage of the entire population is seldom possible.

3.3.2 Sampling

“Sampling is a complex and technical process. Patients often generalize about nurses’ friendliness or behaviour at a particular hospital based on the care they receive from a particular sample of nurses” (Polit and Beck 2008: 337). Hence, conclusions about phenomenon based on our exposure to a limited portion of that phenomenon can be drawn. This process of sampling selects a portion of the population that will represent the entire population (de Vos *et al.* 2005: 192). In addition, sampling ensures the selected sample accurately reflects the characteristics of the population under study, from whom conclusions can be made and subsequently inferred to the total population (Burns and Grove 2008: 349). A sample also refers to as a subset of subjects from the population of interest (Burns and Grove 2008: 343; Polit and Beck 2008: 337). There are two

basic sampling approaches viz: probability or random sampling and non-probability sampling as explained below (Polit and Beck 2008: 340).

- **Probability sampling/ Random sampling**

This is where every item has a calculable chance of selection (Steyn *et al.* 1994: 22). There are two types of probability sampling/ random sampling. A simple Random Sample is obtained if each element of the population that has not yet been included in the sample stands an equal chance of being selected in the next draw (Steyn *et al.* 1994: 22). Stratified sampling involves dividing the group into subgroups or strata. Each stratum is homogeneous with respect to the characteristics being studied (Steyn *et al*. 1994: 25).

- **Non-probability sampling/ non-random sampling**

Non-probability sampling or a non-random sample is where there is a choice in whom or what is selected. Quota sampling and convenience sampling are examples of non-probability sampling/ non-random sampling. The method amounts to the formation of reasonably homogeneous subpopulations or cells by using so called control characteristics for which census figures of the population are available (Steyn *et al.* 1994: 39). In addition in non-probability sampling, the chance of choosing a particular participant is not known as the researcher has little knowledge of the population size or who the members of the population are (de Vos *et al*. 2005: 201).

Brink, van der Walt and van Rensburg (2012: 98) and Meyer *et al*. (2009: 380) wrote that probability sampling results in a population that is more certain of being representative of the population. Leedy and Ormrod (2005: 206) concurred, adding that non-probability sampling has no way of guaranteeing that each element of the population will be represented while probability sampling ensures that each element is given a known equal chance of being selected. In light of the large population of professional nurses, probability sampling was seen as the most appropriate strategy to be utilized in this study.

As indicated the population constituted a total of 25 440 professional nurses (SANC 2012) who worked at the 75 provincial hospitals within the 11 districts of

KwaZulu-Natal (see Table 2). Within these 11 districts are 10 hospitals (see Table 2) that are also affiliated to the KwaZulu-Natal College of Nursing (SANC 2012). These training hospitals offer practical training for the R425 comprehensive nursing diploma programme (SANC 2012). Multistage random sampling was selected as the sampling strategy after consultation with a statistician.

According to Yale (1997), a multistage random sample is constructed through selecting a series of simple random samples in stages. At first, a large area is first divided into smaller regions, and a random sample of these regions is collected. In the second stage, a random sample of smaller areas is then taken from within each of the regions chosen in the first stage. Then, in the third stage, a random sample of even smaller areas is taken from within each of the areas chosen in the second stage. If these areas are sufficiently adequate for the purposes of the study then the researcher stops at this stage. This is the successive random sampling of units starting with the largest group and progressing to smaller units (Polit and Beck 2008: 347; Burns and Grove 2008: 351).

In this study multistage random sampling was operationalized in the following way: In stage one of these studies KwaZulu- Natal was divided into its 11 districts: eThekwini, uMgungundlovu, UGu, uThukela, uMzinyathi, Amajuba, Zululand, uThungulu, iLembe, Sisonke and uMkhanyakude. Seven of these 11 districts were selected as they have public hospitals that offer practical training for the nursing diploma programme via: eThekwini, uMgungundlovu, UGu, uMzinyathi, Amajuba Zululand and uThungulu (see Table 2).

In stage two, five of these seven districts identified in stage one was selected as these districts have regional/tertiary level public hospitals: eThekwini, uMgungundlovu, uThungulu, UGu and Amajuba. All public training hospitals are affiliated to the KwaZulu-Natal College of nursing (see Table 3). Only one hospital per district would be utilized. In the final stage a sample of 37 percent professional nurses per hospital accredited with SANC for practical nurse training was surveyed (see Table 4), as per consultation with a professional statistician. This 37% ensured a total sample of 550 nurses which then resulted in an approximate 77% return rate of 385. Since the norm for a response rate is 50% to 60% (Polit

and Beck 2008:187), a selection of 385 participants has an acceptable error margin of five percent, as per consultation with the statistician (Appendix 8).

Table 2: Public hospitals within the 11 districts of KZN accredited by SANC for practical nurse training in the comprehensive diploma programme

District	Public-hospitals
1.eThekwini	Addington; Prince Msheyeni; R.K.Khan
2. uMgungundlovu	Edendale; Greys
3. UGu	Port Shepstone
4. uThukela	-
5. uMzinyathi	Charles Johnson Memorial
6. Amajuba	Madadeni
7. Zululand	Benedictine
8. uThungulu	Ngwelezane
9. iLembe	-
10. Sisonke	-
11. uMkhanyakude	-

Table 3: Tertiary/Regional level public hospitals within KZN accredited with SANC for practical nurse training in the comprehensive diploma programme

District	Tertiary/ Regional public training hospital
1.eThekwini	Addington; R.K.Khan; Prince Msheyeni
2. uMungungundlovu	Greys; Edendale
3. UGu	Port Shepstone
4. uThungulu	Ngwelezane
5. Amajuba	Madadeni

Table 4: Population and sample

District	Public training hospital	Number of professional nurses per hospital	37% of total no. of professional nurses
1. eThekwini	Addington	233	86
2. uMungungundlovu	Greys	430	159
3. Ugn	Port Shepstone	258	95
4. Amajuba	Madadeni	288	107
5. uThungulu	Ngwelazane	279	103
Total		1488	550

Summary

A total population of 1488 professional nurses working within the five hospitals was identified. The researcher distributed 550 questionnaires and secured 385 questionnaires on return (77% return rate).

3.4 INCLUSION AND EXCLUSION CRITERIA

3.4.1 Inclusion criteria

- All professional nurses at the selected regional/tertiary level public hospitals that were accredited by the South African Nursing Council (SANC) to provide practical nurse training in the nursing diploma programme.
- Professional nurses who were willing to participate in the study.

3. 4.2 Exclusion criteria

- Professional nurses employed at private hospitals. Private hospitals in KwaZulu-Natal are not accredited by the SANC to provide practical training in the comprehensive nursing diploma programme and hence may not be able to comment on the course effectively.
- Enrolled and auxiliary nurses due to their limited training and practice.
- Student and pupil nurses for reasons of incomplete training.
- District level hospitals due to the basic level of care provided.

Once the study sample was finalized the data collection tool was selected.

3.5. THE DATA COLLECTION INSTRUMENT

In keeping with the quantitative research approach, the data was collected using self-administered survey questionnaires. According to Polit and Beck (2008: 14) self-administered questionnaires require participants to read the questions on a written form and give their answers in writing. A questionnaire is thus a set of questions on a form which is completed by the participant in respect of a research project (de Vos *et al.* 2005: 167; Burns and Grove 2008: 406). Although the participant completes the questionnaire alone, the researcher is still available should problems or queries arise (de Vos *et al.* 2005: 167). Other types of questionnaires available include mailed questionnaires, telephonic questionnaires, hand delivered questionnaires and group-administered questionnaires (de Vos *et al.* 2005: 166). Due to the large study sample required, limited finances and time constraints, self-administered questionnaires were considered to be most cost effective and ethically sound. The questionnaire included seven broad sections which are outlined below (Appendix 1).

A number of closed-ended questions, open ended questions and Likert type matrix questions ranging from strongly agree to strongly disagree were utilized. Open ended questions allowed the participants to answer freely without a predetermined response. Closed-ended questions offered the professional nurse response options from which they could choose the one that most closely matched the appropriate answer. The Likert scales consisted of several declarative items that express a viewpoint on a topic, allowing participants to indicate the degree to which they agreed or disagreed with each statement (Polit and Beck 2008: 419; Burns and Grove 2008: 410). Questionnaires incorporating Likert scales have been successful in many studies related to spirituality and spiritual care (Ray and McGee 2006: 331; O'Shea *et al* 2011: 38; Chism and Magnan 2009: 598**;** Shore 2010: 9; McSherry and Jamieson 2010: 1758).

The following scales were used in the present study: “The Role of Religion and Spirituality in Social Work Practice” was readapted for nursing and permission to utilize the instrument was granted by Professor M. Sheridan, Assistant Professor and Research Associate at Harvard Medical School, who developed the scale. This scale was utilized in the study by Bhagwan (2002: 50) in South Africa with social workers. “The Spiritual Care Rating Scale” (SSCRS) developed and utilized by McSherry (1998); McSherry (2006); McSherry and Jamieson (2010) was also included in the questionnaire after securing permission to use same from Professor McSherry (Appendix 2). The merging of both these scales, together with the researcher’s own questions gave birth to a new survey questionnaire that was utilized specifically for this study.

The survey questionnaire consisted of seven subsections described as A, B, C, D, E. and F on the questionnaire. The following themes reflected the sub-sections of the questionnaire:

Subsection A:

In this section closed-ended questions were used to ask about demographic details such age, gender, race, marital status, religion and employment history.

Subsection B:

The views of the professional nurse with regard to the role of spirituality in nursing practice were explored using a 5 level Likert scale.

Subsection C:

A likert scale based on work of McSherry’s SSCRS on Spirituality and Spiritual Care.

Subsection D:

The role of spirituality in the lives of patients.

Subsection E:

Views regarding the use of spiritual-based activities/interventions in patient care.

Subsection F:

Views regarding spirituality and nursing education available to nurses and, whether spirituality is considered in nursing education.

The questionnaire was designed along the subsection headings used by McSherry and Jamieson (2010: 1757) and was in line with the research objectives of this

study. Attempts were made to ensure representation across all demographic and geographical areas. In order to generalize the findings, the researcher had to ensure that the questionnaire was valid and reliable. Furthermore, the advantage of adopting an adapted questionnaire is that comparisons can be made nationally and internationally. Once the questionnaire for the present study was designed, a pilot test was carried out.

3.6 PILOT STUDY

A pilot study is trial run of a small scale study to test face and content validity of the instrument that was used in a major study from the same population. It identifies feasibility and flaws or unforeseen problems (Pilot and Beck 2008: 213; Brink, van der Walt and van Rensburg 2012: 57). A review of the questionnaire by four specialists from the nursing facility was conducted prior to submitting the questionnaire to the Ethic Committee of the Durban University of Technology. The group included one nurse manager, one nurse lecturer, one operational manager and one clinical nurse facilitator. Minor modifications to the questionnaire were made.

3.7 VALIDITY AND RELIABILITY

3.7.1 Validity

The validity of an instrument determines the extent to which it actually reflects the abstract construct being examined (Burns and Grove 2008: 380). Validity can be classified as content, face and construct validity. Content validity refers to whether the instrument measures the concept we assume it is, while an instrument has face validity when it at a superficial level looks as though it is measuring what it purports to measure (Polit and Beck 2008: 57; Brink, van der Walt and van Rensburg 2012: 168). Construct validity refers to the degree to which an instrument measures a theoretical construct. This ensures that the instrument accurately measure what it is supposed to measure, given the context in which it is applied (Polit and Beck 2008: 461; Burns and Grove 2008: 380; Brink, van der Walt and van Rensburg 2012: 168). A pilot study of the questionnaire was conducted to ensure its validity. There was good face and content validit

3.7.2 Reliability

Reliability of an instrument makes reference to the consistency of empirical measures obtained in the use of the instrument such as a questionnaire and indicates the degree of random error in its measurement method (Burns and Grove 2008: 377). Brink, van der Walt and van Rensburg (2012: 171) concurred that reliability refers to the extent to which the instrument can be depended upon to deliver consistent results when repeated over time on the same participants, or if used by two different researchers. Specific statistical tests such as the Cronbach's alpha co-efficiency test have been designed to provide measures of internal consistency for questionnaires (Brink, van der Walt and van Rensburg 2012: 172). An alpha score of more than 0.70 is accepted as indicating a high level of reliability.

Reliability of "The Role of Religion and Spirituality in Social Work Practice" scale developed by Professor Sheridan and used by Bhagwan (2002: 50) was tested in three different studies using Cronbach's alpha. The scale demonstrated high internal consistency across all these studies, with alpha=0.88 (Sheridan et al, 1994 cited in Bhagwan 2002: 50), alpha=0.82 (Sheridan and Amato-von-Hemert 1999 cited in Bhagwan 2002: 50) and alpha=0.83 (Sheridan 2000b cited in Bhagwan 2002: 50).

The Spirituality and Spiritual Care Rating Scale (SSCRS) developed by McSherry and utilized by McSherry and Jamieson (2010: 1757) was the second questionnaire scale utilized. Permission was received from the researcher (Appendix 2). The SSCRS scale has demonstrated consistent levels of reliability and validity with an original Cronbach's alpha coefficient of 0.64 (McSherry and Jamieson 2010: 1757). The SSCRS has been used in over 42 different studies in 11 countries (Lovanio and Wallace 2007: 43).

A descriptive cross cultural survey of Persian nurses (n= 107) used a Persian version of the Spirituality and Spiritual Care Rating Scale (SSCRS) to assess the reliability and validity of the SSCRS scale. To assess content validity the questionnaire was given to 10 faculty members with relevant specialities. To assess face validity the questionnaire was given to 13 psychiatry nurses to identify potential problems. The instrument was found to be clear, easy and

understandable. To assess reliability of the scale, test-retest was carried out. The findings is that the instrument was valid and reliable (Khoshknab *et al.* 2010: 2939).

Similarly, Tiew, Drury and Creedy (2011: 84) conducted a convenience sample of first year student nurses (n=745) by adapting segments of the SSCRS questionnaire to measure the validity and reliability of the SSCRS scale. Results showed that the SSCRS was a valid and reliable instrument for measuring the multifaceted perspectives of spirituality and spiritual care in practice by student nurses. Data collection followed thereafter.

3.8 DATA COLLECTION PROCESS

Data collection began with a series of telephonic and e-mail correspondence between the nurse managers and researcher during early December 2012. This allowed the researcher to brief the nurse managers on the data collection process, to gain their co-operation and address relevant concerns. Arrangements were made for safe storage of questionnaires and access times for nurses to complete the questionnaires. This information was disseminated to all the operational managers via their operational managers at the hospitals identified for the study. Survey questionnaires and letters of information and consent (Appendix 3 and 4) were personally delivered to each hospital by the researcher as per a prearranged schedule. All except one hospital was amenable to assist the researcher in the distribution and collection of the survey questionnaires.

When the researcher arrived at the first hospital, the nurse manager sent a call out to all her assistant nurse managers and/or operational managers to collect questionnaires and consent forms from her office in the presence of the researcher. Completed questionnaires were returned to the nursing manager's office before five pm that day. The next three hospital's nurse managers granted permission to their operational managers to assist the researcher in distribution of questionnaires and consent forms in their departments. The researcher was allowed access into each ward, and handed over the questionnaires and consent

forms to the operational managers in person. The researcher returned later that evening, at five pm to collect completed questionnaires.

As indicated, only one hospital indicated reluctance to assist the researcher despite prior arrangements being made for same. A total of 50 questionnaires were then left with nursing management for staff to fill in if they wished to participate. A few weeks later the researcher was informed that 22 professional nurses had completed the questionnaire. These were then collected.

Throughout the data distribution and collection process there was no prior briefing as the questionnaire and consent forms included a letter of information with all the relevant information. An invitation to contact the researcher if the need arose was made. The researcher carried two labeled sealed cardboard post boxes, which were used as a drop box for nurses to place their questionnaires and consent forms in respectively. While some questionnaires were collected at the end of the same day, a follow up visit to three of the hospitals in February 2013 was needed to obtain the required number of questionnaires. After a second call for participation, return rates improved. All completed questionnaires were then locked into a steel locker. The researcher was able to secure a final total of 385 questionnaires (see Table 5). Once the required number of questionnaires was reached the researcher commenced data capturing and analysis.

Table 5: Total number of questionnaires distributed and collected per hospital

Hospital	**Professional nurses**	**Questionnaires distributed (n)**	**Questionnaires collected**
Addington	233	86	22
Greys	430	159	116
Shepstone	258	95	64
Madadeni	288	107	96
Ngwelezane	279	103	87
Total		550	385

3.9 DATA CAPTURING

Initially all questionnaires were checked for accuracy and omissions. Missing data was captured accordingly. Questionnaires were coded numerically from one to 385. Coding is the process where the information received is transformed into symbols, usually numbers (Polit and Beck 2008: 642). A coded spread sheet was created with the assistance of a professional statistician. The data was then entered onto the spread sheet using the SPSS version 20.0. The spread sheet consisted of columns that contained the question responses. Each participant corresponded with a row. Columns were created in line with the number of questions in the questionnaire. This was followed by statistical analyses and presentation of findings.

3.10 STATISTICAL ANALYSIS

Statistical analysis refers to categorising, ordering, manipulating and summarising data so that the research questions can be answered (de Vos *et al*. 2005: 218). Quantitative research data was captured and analysed by the organization and analysis of data using statistical procedures which include descriptive and inferential statistics (Brink, van der Walt and van Rensburg 2012: 178). The data for this study was reduced and analysed with the help of a professional statistician, using the statistical software SPSS version 20.0. Descriptive statistics and inferential statistics were applied to data.

3.10.1 Descriptive statistical analysis and descriptive statistical tests

Descriptive statistics describes the organizing and summarizing of quantitative data by investigating the distribution of scores on each variable and by determining whether the scores on different variables are related to each other (Lind, Marchal and Mason 2004: 06). Univariate and bivariate analysis which are most appropriate for descriptive statistics was utilized in the study. Univariate analysis measures central tendency and dispersion. The most appropriate measure of central tendency for interval data is the mean and the most appropriate measure of dispersion for interval data is the standard deviation.

Bivariate analysis concerns the measurement of two variables at a time (Lind, Marchal and Mason 2004: 06). A Cronbach alpha test and factor analysis is the most common descriptive statistical tests.

- **Cronbach's alpha**

  Cronbach's alpha scoring was applied to all sections of the questionnaire. Cronbach's alpha measures reliability. Alpha scores for all sections of the questionnaire were more than 0.70. An alpha score of more than 0.70 indicates a high level of reliability (Brink, van der Walt and van Rensburg 2012: 172). The computation of Cronbach's alpha is based on the number of items on the survey and the ratio of the average inter-item covariance to the average item variance. Under the assumption that the item variances are all equal, this ratio simplifies to the average inter-item correlation, and the result is known as the Standardized item alpha or Spearman-Brown stepped-up reliability coefficient (UCLA 2007: 24).

  If the average inter-item correlation is low, alpha will be low. If the inter-item correlations are high, then the items are measuring the same underlying construct. An increase in the number of items increases Cronbach's alpha. If you have multi-dimensional data, Cronbach's alpha will generally be low for all items. In this case, a factor analysis can be used to identify which items load highest on which dimensions, and then take the alpha of each subset of items separately **(**UCLA 2007: 24).

- **Factor analysis**

  Factor analysis was also utilized in the study to identify underlying variables or factors that explain the pattern of correlations within a set of observed variables. Factor analysis is used in data reduction to identify a small number of factors that explain most of the variance that is observed in a much larger number of manifest variables. Factor analysis can also be used to generate hypotheses or to identify variables for further analysis (UCLA 2007: 24).

3.10.2 Inferential statistical analysis and inferential statistical tests

Inferential statistics using Pearson's or Spearman's correlations at a significance level of 0.05 were also utilized. Inferential statistics uses sample data to make an inference about the population (Brink, van der Walt and van Rensburg 2012: 190). Pearson's correlation, which designates the magnitude of relations between variables, was applied to the data set which analysed the relationships between the following variables: Gender, age, educational level, spiritual beliefs, spiritual beliefs and years of experience. In-depth statistical analysis regarding spirituality and spiritual nursing care was correlated with health and well-being of patients. Sub-themes within the larger sections of the questionnaire were identified and explained. The traditional approach to reporting a result requires a statement of statistical significance.

- **Chi-square test**

  Chi-square testing was also conducted. A Chi-square test is any statistical hypothesis test in which the test statistic has a chi-square distribution when the null hypothesis is true, or any in which the probability distribution of the test statistic (assuming the null hypothesis is true) can be made to approximate a chi-square distribution as closely as desired by making the sample size large enough (Willemse 2009: 209). Such hypotheses can be tested using Chi-square tests for nominal and ordinal data, which are obtained by counting the occurrence of each observation in a category at a level of significance of 0.05 (Brink, van der Walt, and van Rensburg 2012: 180). A p-value is generated from a test statistic**.** The value 0.05 as the level of significance has become a standard in statistics. In addition thematic analysis found common themes and variations amongst participants' responses. These themes were grouped and analysed.

- **Correlation tests**

  The Pearson's correlation tests were also conducted. Correlation tests determine the connection between the actual dimensions of two or more variables. The Pearson's r- value indicates the strength of the relationship

between the variables. The closer values are to ± one, the stronger the relationship (both positive and negative). The closer the value is to zero, the weaker the relationship (Douglas, William and Robert 2004: 457; Stephens 2004: 136). In this study, we looked at two variables at a time to ascertain the connection between the different questions of the questionnaire. This identified positive correlations between two variables, or a negative correlation between two variables, or no correlation at all. Many positive correlations were noted in the study.

3.11 DATA PRESENTATION

Data was presented in the form of tables and graphs by the use of bar charts and pie charts. The various types of figures and cross tabulations used in the study are outlined below:

3.11.1 Tables and Figures

- **Graphs**

A variety of Bar charts were used in the study. These charts comprise of horizontal and vertical bars (Willemse 2009: 29). Various levels of complexity were possible. All bars were of the same width with the length corresponding to the frequency.

- **Discrete data**

Pie charts were used as divisions between participants or groups of participants. (Willemse 2009: 29). In the study, pie charts divided group of participants of the study as per questions from the questionnaire. Various levels of complexity were possible.

3.11.2 Cross tabulation

Data resulting from observations made on two different related categorical variables (bivariate) of the questionnaire were summarised using tables known as two way frequency tables or contingency tables. The word contingency is used to determine whether there is an association between the variables (Willemse 2009: 28).

3.12 ETHICAL CONSIDERATIONS

“Ethics is defined as the philosophic study of morality. It is the study of goodness, moral values and right action” (Camden 2009: 278). Research ethics refers to how we plan and justify our research topic, design our research, gain access to data, collect data, process data, store data, analyses data and finally write up our findings in a responsible and moral manner (Polit and Beck 2008: 185). The researcher began collection of data in December 2012 after complying with the requirements set out by the Institutional Research and Ethics Committee of Durban University of Technology (Ref No. 42/2012). The Institution Research Ethics committee (IREC) of The Durban University of Technology reviewed the proposal and the study obtained full ethical clearance (Appendix 5).

Permission was sought from the Hospital managers of the following provincial hospital managers: Addington, Greys, Madadeni, Ngwelezana and Port Shepstone (Appendices 6.1 to 6.5). They were asked to secure help from nurse managers to assist the researcher with distribution and collection of questionnaires. Once letters of support were received (Appendices 6.1 to 6.5), a formal request to conduct the study was forwarded and to the KwaZulu-Natal Provincial Health Research and Knowledge Management Committee (Appendix 7). Permission was received in November 2012 (Appendix 8) and data collection commenced in December 2012. This process was completed at the end of February 2013.

The anonymity of professional nurse was safeguarded as the questionnaires did not require any identifying details. A letter of information (Appendix 3) with details of the study was included as part of the questionnaire. Participants were asked to complete a consent form (Appendix 4), once they agreed to participate in the study. Participation was voluntary and participants could withdraw from the study at any time. The contact details of the researcher, the researcher’s supervisor and the universities Ethics Committee was displayed on the questionnaire and on the consent form for participants who had queries. Completed questionnaires and consent forms were posted in sealed separate boxes so that there was no way of linking a questionnaire to the participant. All completed questionnaires were locked

in a steel locker once collected. They were then retrieved for data analysis and then re-secured after analysis. It will be shredded after 15 years.

3.13 CONCLUSION

This chapter delineated the road map that the researcher used to collect and analyse the data. The research design, population and sample, a survey instrument, data collection and analysis process were discussed. The statistical software (SSPS 20.0) was introduced as the tool to analyse data. The specific tests run were as follows: Cronbach's test, Factor analysis, Chi square tests and Pearson's correlation tests. In the next chapter a summary of the data analysed using these statistical tests will be presented.

CHAPTER FOUR

FINDINGS

"Spirituality is different for everyone and there is not one way only to be a spiritual person. I learnt through experience that what is a fruitful spiritual practice for one person may not necessarily be helpful to you or someone else and that it is up to each of you to find what suits you best. In the end, spirituality is innate and cannot be imposed, though a wise teacher can assist the process. It is there at the heart of you, waiting to be accessed when you are ready."

Claire Montanaro (2008: 23)

4.1 INTRODUCTION

This chapter presents data obtained from the current study. Questionnaires were used to collect the data, which was analysed using SPSS version 20.0. The following sections presents the findings made according to the sub-themes delineated in the questionnaire. First the demographic data is presented followed by findings related spirituality and spiritual care, the role of spirituality in the lives of patients and the use of spiritual activities/interventions. Data related to spirituality in nursing education is presented at the end.

4.2 THE SAMPLE

The sample consisted of professional nurses from five public hospitals in KwaZulu-Natal. In total 500 questionnaires were distributed and 385 were returned resulting in a response rate of 77%.

4.3 DATA ANALYSIS

A range of nominal and ordinal data was used to analyse the data. These included nominal or categorical data, ordinal data, interval measurements and ratio measurements. According to Steyn *et al* (1994: 7) nominal or categorical data is a classification of responses e.g. gender. Ordinal measurement is achieved by ranking e.g. the use of a one to five rating scale from 'strongly agree' to 'strongly disagree'. Interval measurement is achieved if the differences are meaningful e.g.

temperature. Ratio measurement is the highest level, where difference and the absence of a characteristic (zero) are both meaningful e.g. distance.

SECTION A

4.4 DEMOGRAPHIC DATA

The analysis of demographic data relates to age, gender, marital status, race, ethnic orientation, number of children of the participants and years of experience.

4.4.1 Age

Table 6: Age and gender

Age (years)	Gender		Total
	Male	Female	
20 – 30	2.6% (n=15)	12.5% (n=137)	15.1% (n=152)
31 – 40	3.9% (n=11)	35.7% (n=96)	39.6% (n=107)
41 – 50	2.9% (n=3)	25.0% (n=60)	27.9% (n=63)
51 – 60	0.8% (n=1)	15.6% (n=3)	16. 4% (n=4)
> 60	0.3% (n=40)	0.8% (n=344)	1.1% (n=384)
% of total	10.4%	89.6%	100%

Table 6 reflects the age and gender composition of participants in the study. The age range for professional nurses surveyed varied between 20 and 60 years. More than 40% of the participants were between the ages of 31–40 years. Only 15.1% of the sample was younger than 30 years. The majority of participants were female (89.6%) as compared to males (10.4%). The ratio of males to females was approximately 1: 9.

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4.2 Race

Figure 1: Racial composition

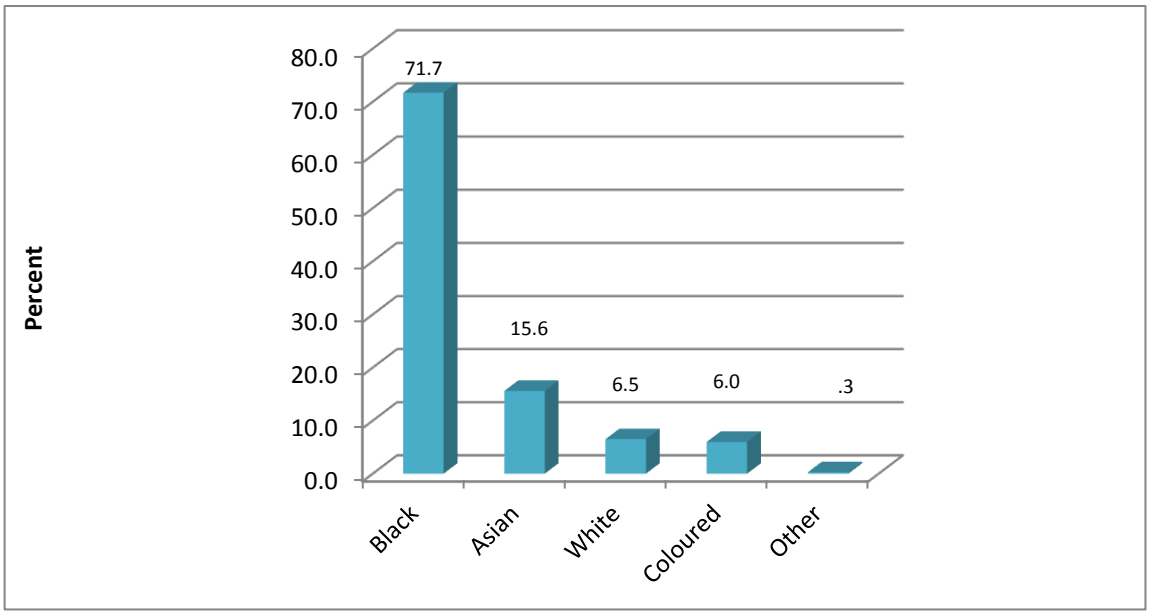


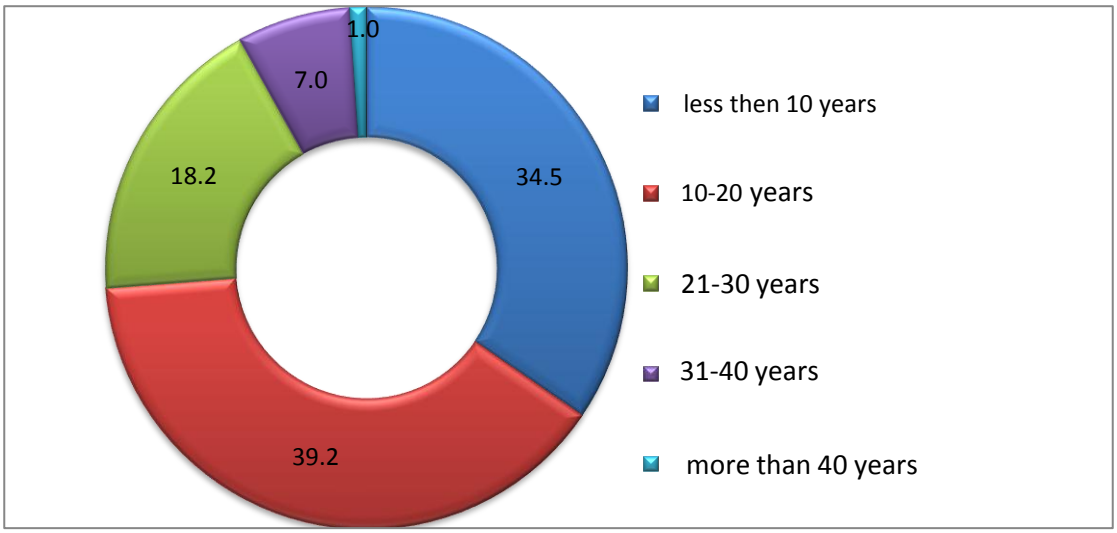
Figure 1 of the study reflects the racial composition of the sample. A majority were Black (71.7%), followed by Asians (15.6%) and an equal proportion of Whites and Coloureds (average of 6.3%). A small percentage was unspecified (0.3%).

4.4.3 Marital status and number of children

There were an equal number of single and married participants (an average of 45%) in the sample. Just a few participants were either divorced (6.5%) or widowed (3.9%). Almost 25% of the sample had just one child. Married participants had two children (17.3%) and three children (9.4%) while single participants had either two children (10.7%) and three children (0.2%). About 8% of the sample had four children. Just 1% of the sample had five children.

4.4.4 Nursing experience of participants

Figure 2: **Nursing experience of participants**



Nearly 40% of the participants reported having between 10-20 years of nursing experience. A further 18.2% had between 21-30 years of nursing experience while 7% of participants had between 31-40 years of experience. Only 34.5% of participants indicated having less than 10 years of experience (see Figure 2). The following section focuses on the personal spirituality of the sample.

4.5 NURSES PERSONAL SPIRITUAL /RELIGIOUS BELIEFS

Participants were questioned about their personal spiritual/religious affiliation, attendance at spiritual/religious services (during training and after qualifying), personal spiritual practices and nursing as part of their spiritual life/path. The subsections that follow present findings in respect of these issues.

4.5.1 Nurses personal spiritual/religious orientation and affiliation

Table 7: Spiritual orientation and religious affiliation of participants

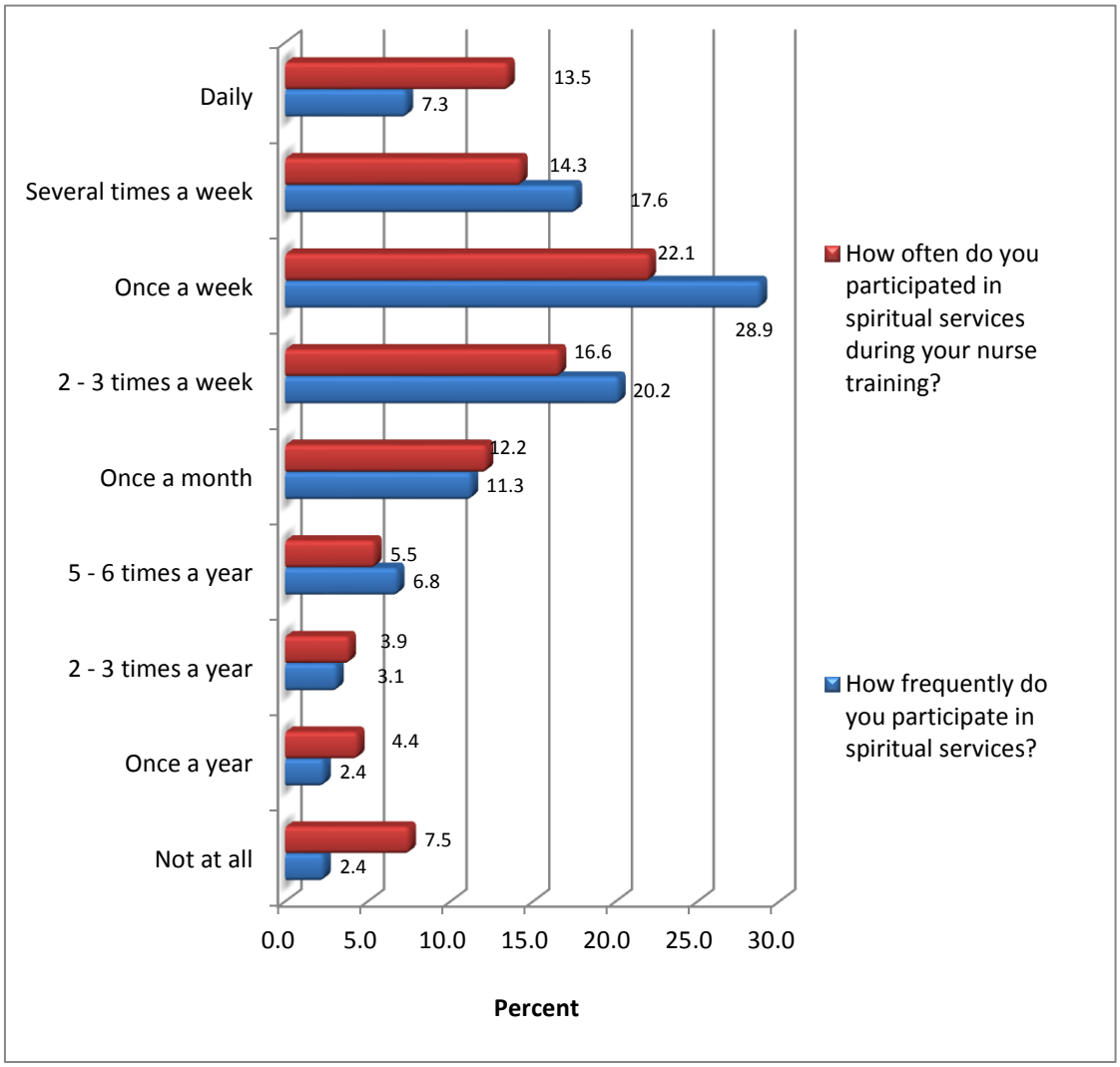
Religious affiliation or spiritual orientation	Indicate your relationship to a spiritual group					Total
	Active participation, high level of involvement	Regular participation, some involvement	Identification with religion or spiritual group, very limited or no involvement	No identification, participation or involvement with religious or spiritual group	Dislike and negative reaction to religion or spiritual tradition	
Agnostic	0% (0)	0% (0)	0% (0)	0.5% (2)	0% (0)	0.5% (2)
Atheist	0% (0)	0% (0)	0% (0)	0.3% (1)	0% (0)	0. 3% (1)
Buddhist	0% (0)	0.5% (2)	0% (0)	0% (0)	0.5% (02)	1% (4)
Christian	20.4% (78)	40.7% (156)	20.9% (80)	4.4% (17)	0.5% (02)	86.9% (333)
Hindu	1. 0% (4)	2.3% (0)	2.6% (10)	0.3% (1)	0% (0)	6.3% (24)
Traditional African	0.5% (2)	0.8% (3)	0.3% (1)	0% (0)	0% (0)	1.6% (6)
Other	0.3% (1)	1.3% (5)	1.6% (6)	0.3% (1)	0% (0)	3.4% (13)
% (Total)	22.2% (85)	45.7%(175)	25.3% (97)	5.7% (22)	1% (4)	100% (383)

A majority of the participants (86.9%) belonged to the Christian faith. One percent was Buddhist, while 6.3% reported following the Hindu faith. A small percentage indicated being Agnostic (0.5%) and 0.3% said they were Atheists. Despite the fact that a majority of the sample was Black it was surprising that only 1.6% of the participants indicated following African Traditional faith. This can be attributed to the increased number of African churches which embrace both Christian faith and tenets of African Traditional Religion (Bhagwan 2002).

Almost 68% of the sample reported active or regular participation with their spiritual group/faith, while only 25.3% identified with a spiritual group/faith but had very little or no involvement with the group/faith. Just 5.7% did not identify with a spiritual group/faith and 1% admitted dislike or negative reaction to spiritual tradition. A comparison of the frequency of attendance at spiritual services as a student nurse and current attendance at spiritual services follow.

4.5.2 Attendance at spiritual/religious services during training and after training

Figure 3: Attendance at spiritual/religious services as a student nurse and after training



As reflected in Figure 3 nearly twice as many (13.5%) reported attending spiritual services daily during their training as students, as compared to their current attendance as professional (7.3%). Nearly a third of the sample (28.9%) attended spiritual services on a weekly basis currently. This current weekly attendance (28.9%) at spiritual service is slightly higher when compared to when these participants were in training (22.1%).

4.5.3 Nurses personal spiritual practices

Almost half of the participants (49.5%) indicated that they engaged in personal spiritual practice daily. The rest of the sample indicated as follows: several times a week (18.1%), once a week (9.9%), two to three times a week (6.3%) and once a month (3.9%). About 7.9% stated that they engaged in personal spiritual activities 1-6 times per year and less than 5% indicated not engaging in any spiritual activity. When asked whether participants felt that nursing was part of their spiritual life or path, almost nine out of ten participants (89.4%) answered “yes” and the remaining 10.6% answered “no.”

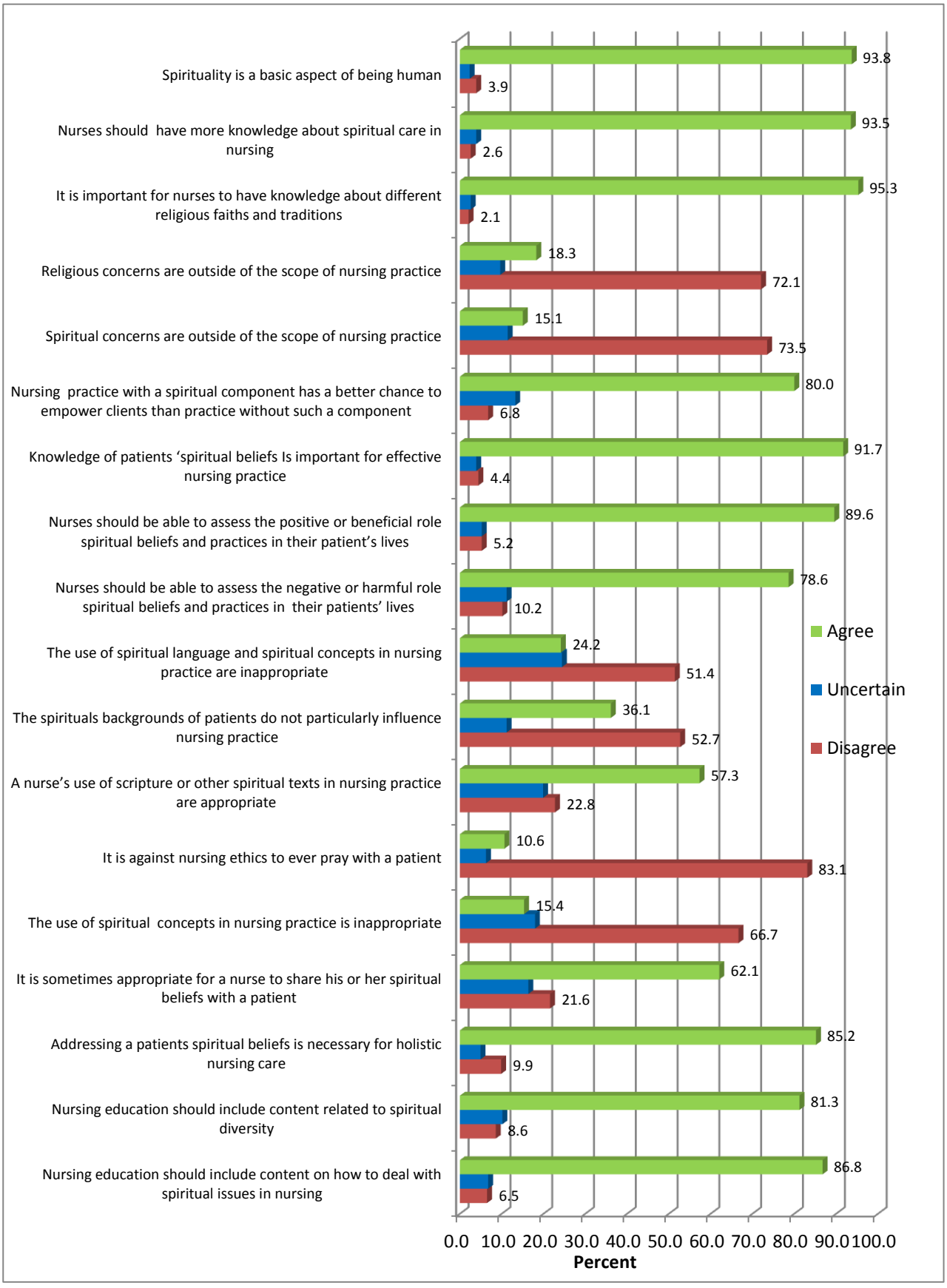
SECTION B

This section presents data in respect of the views of the nursing participants regarding the role of spirituality in nursing practice.

4.6. THE ROLE OF SPIRITUALITY IN NURSING PRACTICE

“Nurses who are called to be healers must recognize that the path of healing is a spiritual journey for both those in need of healing and those facilitating the process” (Nagai-Jacobson 2002 cited in Krampl 2007: 02). Professional nurses views on the role of spirituality and spiritual care in nursing practice was assessed using the “Role of Religion and Spirituality in Practice” (RRSP scale) (Bhagwan 2002: 178). The scale was used in studies with social workers. The scale items were adapted to be used with nurses (see Figure 4). The scale comprised of 18 items which included both positively and negatively worded statements such as “nurses should have more knowledge about spiritual care in nursing”, “the use of spiritual concepts/scriptures/language is appropriate in nursing”, “spiritual/religious concerns are outside the scope of nursing” and “assessing patients’ spiritual beliefs is necessary for holistic nursing care.”

Figure 4: The role of spirituality in nursing practice



A five point Likert scale, ranging from 1=strongly disagree to 5=strongly agree was used to measure professional nurses level of agreement with items on the scale. Negatively worded statements were reversed scored. Next, responses were added to arrive at a single score. The total score per participant was calculated. High ratings indicated a positive attitude towards spirituality and spiritual care. Responses ranged from 58 to 78 with a mean score of 62.21. This rating is similar to the high mean rating of 63.93 by Bhagwan (2002: 179) where she investigated the role of religion and spirituality with student social workers (n=332). The high mean rating in respect of the current sample reflects a positive view related to the role of religion and spirituality in nursing.

Some responses on the scale (see Figure 4) reflect strong agreement, strong disagreement or average responses to individual scale items. The first three statements indicate the highest levels of agreement (average of 95%) regarding spiritually, being a core aspect of being. An average of 72.8% participants agreed that spirituality and religion are in the scope of nursing practice.

In addition, 91.7% of participants agreed that knowledge of patients' spiritual beliefs is important for effective practice and that nursing practice with a spiritual component can empower the patient (80%). A further 89.6% of participants felt that nurses should assess the positive or beneficial role of the patients' beliefs and practices and 78.6% felt that nurses should also assess the negative role or harmful role of the patients' beliefs and practices. Praying with the patient was seen as ethically acceptable by 83.1% participants. A little more than half of the sample each believed that spiritual language can be used with patients (51.4%) and a further 52.7% believed that a patient's spiritual background does influence the profession.

SECTION C

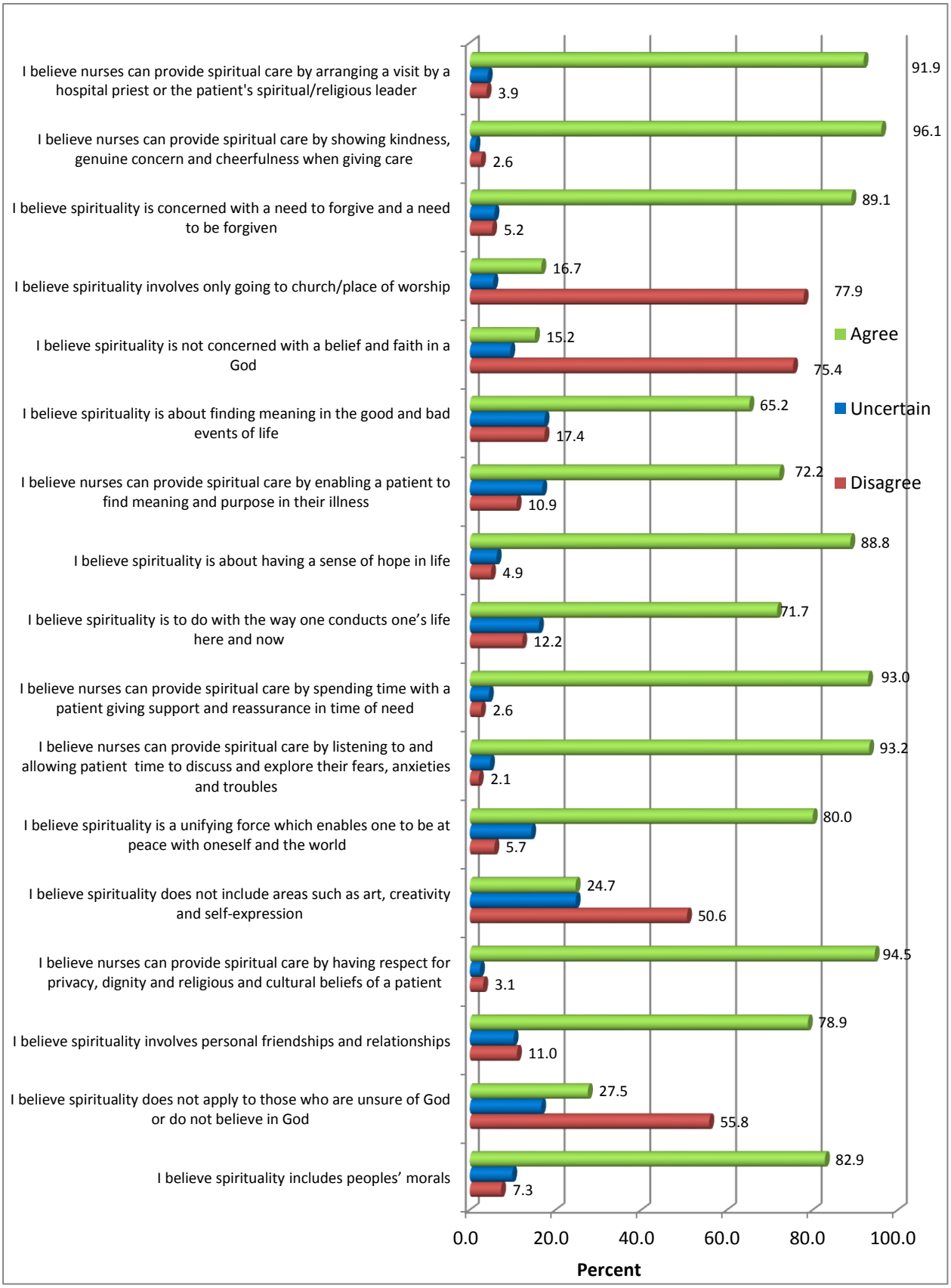
The following section deals with nurses' perceptions regarding spirituality and spiritual care.

4.7 NURSES' VIEWS ON SPIRITUALITY AND SPIRITUAL CARE IN NURSING PRACTICE

Surveys have found that over 90% of the general population believe in a higher power (Mueller, Plevak and Rummans 2001 cited in Krampl 2007: 60). Studies conducted globally show that spirituality and spiritual care is an indispensable element of nursing care (McSherry, 1998: 36; Narayanasamy and Owens, 2001: 446; Shin *et al.* 2001: 83; McSherry *et al.* 2004: 934; Sessanna *et al* 2010: 1692; Mahmoodishan *et al.* 2010: 7). Although some nurses willingly pay attention to patients' spiritual needs, there is a lack of consensus regarding nurses' interpretation of spirituality and spiritual care (Mahmoodishan *et al.* 2010: 01). Therefore, the integration of knowledge of spirituality in different cultural contexts, by nurses should be explored.

Section C of the questionnaire, an adaptation of the SSCRS questionnaire (McSherry and Jamieson 2010: 1757) comprised of a 12 point Likert scale that asked about spirituality and spiritual care in nursing practice. All but three had questions that were positively phrased. Participants were required to indicate their level of agreement from 5=strongly agree to 1=strongly disagree. The results are summarised in Figure 5 below.

Figure 5: Nurses' perceptions regarding spirituality and spiritual care

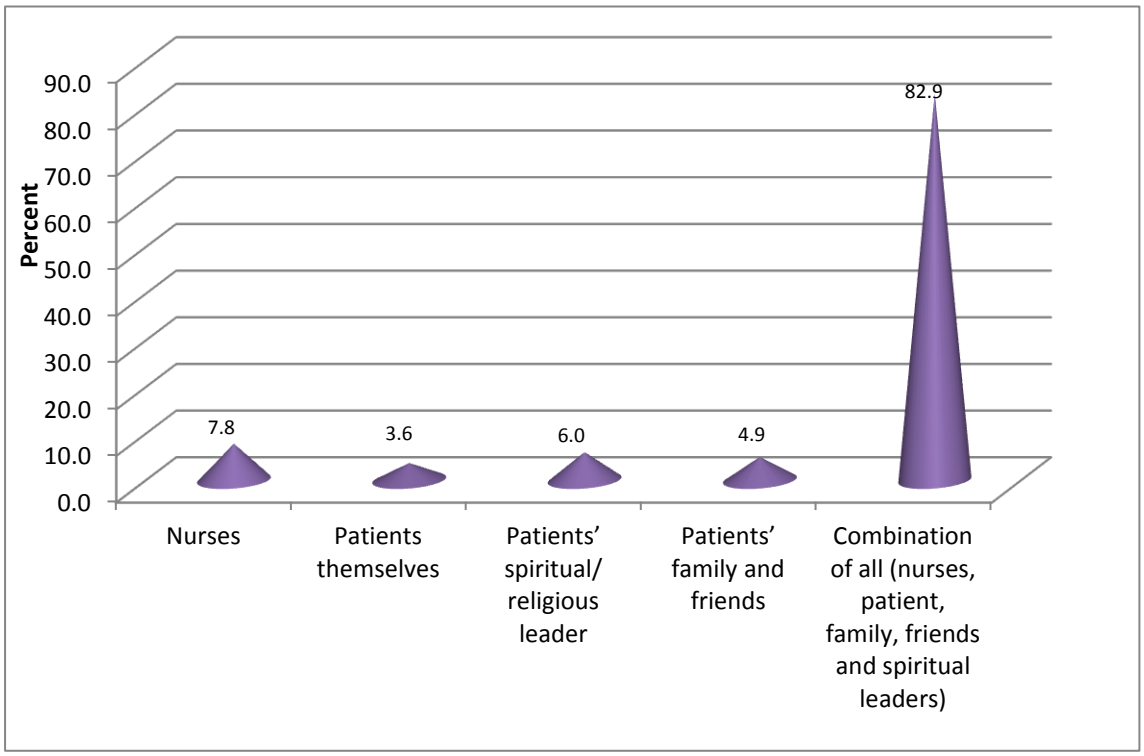


An average of 89% of the sample indicated that respect for patients' dignity, respect for privacy and religious/spiritual beliefs; kindness, support and reassurance; listening to patients' fears, showing concern, personal friendships and relationships; a sense of peace; maintaining hope, forgiveness and finding meaning and purpose in illness are elements of spirituality and spiritual care. Visits by spiritual/religious leaders, family and friends were seen to be valuable for 91.9% of participants. Almost 80% of participants agreed that going to church did not necessarily equate to being spiritual. Another 82.9% of participants felt that spirituality included peoples' morals.

4.8 SPIRITUAL CARE PROVIDERS

This section of the questionnaire asked participants to choose who they felt should provide spiritual care to patients from a list of health care providers". Figure 6 below reflects the opinions of participants as to who should provide spiritual care to patients. Multiple responses were allowed hence the total score could not be 100 percent.

Figure 6: Spiritual care providers

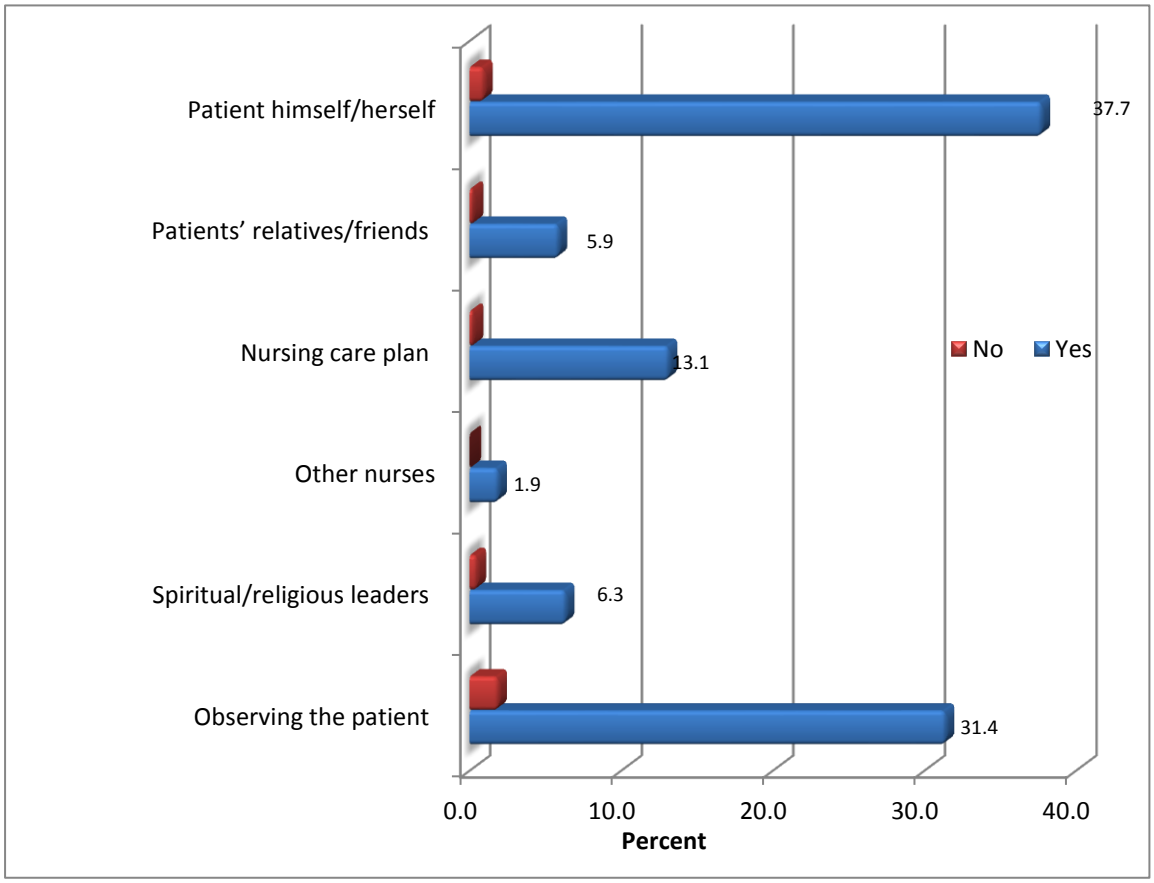


A majority of the participants (82.9%) believed that the nurse, patient's family and friends, spiritual/religious leaders and the patient themselves should be responsible for spirituality and spiritual care. Only 7.8% of participants felt nurses solely should provide spiritual care. Patient's friends and family were chosen as providers of spiritual care by 4.9% of participants and 6% of participants indicated that spiritual care should be the responsibility of the patient's spiritual/religious leader. Less than 4% of participants indicated that the patients themselves should manage their own spiritual care.

4.9 IDENTIFICATION OF PARTICIPANTS' SPIRITUAL NEEDS

Participants were also asked if they encountered patients with spiritual needs and about how they became aware of such patients' spiritual needs. Figure 7 below represents how participants became aware of a patient's spiritual needs and the mechanism that brought it to their attention.

Figure 7: Identification of patient's spiritual need



Ninety one percent of professional nurses stated that they have encountered patients with spiritual needs. These needs (see Figure 7) were verbalized by the patient (37.7%), by relatives or friends (5.9%), spiritual/religious leader (6.3%), other nurses (1.9%), and through observing the patient (31.4%) and the nursing care plan (13.1%).

4.10 MEETING PATIENTS SPIRITUAL NEEDS

Participants were asked to indicate “yes” or “no” when asked whether they were able to meet the patients’ spiritual needs. If the response was “no” they were asked to provide reasons for not meeting the patient's spiritual needs. About 71% (n=272) indicated that they were able to meet patients’ spiritual needs, while 26.5% (n=102) indicated that they were unable to do same. Reasons cited for not being able to provide spiritual care were a lack of time, shortage of staff, language barriers between the nurse and the patient and the uncertainty of how to provide spiritual care. The next section examines the role of spiritual care from the perspective of the patient.

SECTION D

In this section, data related to the salience of spirituality to patients is presented.

4.11 THE SALIENCE OF SPIRITUALITY TO PATIENTS

The section illuminates the factors that motivate patients to engage with spiritual issues. As spirituality provides an abundance of benefits, it becomes imperative for nurses to use this resource in clinical practice. By demonstrating that they are considering the spiritual dimension, as part of a holistic approach to patient care, nurses give a clear message that they are concerned with the whole person (Penman 2012: 134). A Likert scale with 12 questions (see Table 8) was used to ascertain the salience of spirituality to patients, as understood from nurses’ perception. The participant’s level of agreement in respect of the salience of spirituality to patients is rank ordered from highest to lowest.

Table 8: Salience of spirituality to patients	Agree	Uncertain	Disagree
1. All patients have their own belief in spirituality	93.5	3.1	3.4
2. As individuals grow, life experiences increases their spiritual maturity	82.3	13.0	4.7
3. Spiritual participation helps protect patients against depression	82.1	13.8	4.2
4. Patients who are abused or neglected may especially benefit from spiritual beliefs or practices	81.3	13.0	5.7
5. Religious beliefs provide guidelines for behaviours that are beneficial to patients	80.5	14.8	4.7
6. Some patients are exceptionally spiritually mature or gifted	78.7	15.8	5.5
7. Terminally ill patients search for meaning and purpose in life	69.4	18.7	11.9
8. It is not unusual for some patients to have spiritual experiences that influence their lives	67.6	19.3	13.1
9. Some patients do not have the cognitive abilities to reflect on spiritual matters	65.8	22.2	12.0
10. Some patients experience problems or anxiety due to spirituality that go unnoticed by nurse	57.9	26.5	15.6
11. Hospitalization is a time of spiritual awareness	52.3	24.5	23.2
12. As patients grow older, they lose their natural connection to spirituality	20.8	14.3	64.8

As reflected in Table 8 more than 80% agreed that patients have their own personal spiritual beliefs (93.5%), spiritual participation helps protect patients against depression (82.1%), religious beliefs provide guidelines for behaviours that are beneficial to patients (80.5%), life experiences increases their spiritual maturity (82.3%), and patients who were abused or neglected may especially benefit from spiritual beliefs or practices (81.3%).

SECTION E

Spiritual activities/interventions will be discussed in the section that follows.

4.12 SPIRITUAL INTERVENTIONS/ACTIVITIES IN PATIENT CARE

This section focuses on spiritual activities/interventions used by professional nurses. Participants were asked to rate the frequency with which they used certain spiritual activities whilst caring for patients (see Table 9). The frequency with which participants practiced these spiritual activities is ranked ordered from highest to lowest as per the categories “often” and “sometimes”.

Table 9: Use of spiritual interventions/ activities in patient care	Often	Some times	Rarely	Never
1. Encourage the patient's family to support any spiritual interest by the patient	27.0	45.0	17.5	10.5
2. Pray privately for a patient	24.8	42.6	15.9	16.7
3. Assess if the physical and social environment promotes or prevents the spiritual well-being of the patient	23.4	43.2	18.5	14.8
4. Help a patient verbalize their spiritual values	21.6	49.0	19.8	9.6
5. Assess a patient's spiritual interest	20.8	46.5	24.4	8.3
6. Recommend spiritual forgiveness, confession	20.6	36.5	20.3	22.7
7. Assist a patient to talk about their personal spiritual beliefs or practice	20.3	47.8	22.6	9.4
8. Recommend participation in a spiritual support system, program, or activity	19.7	44.4	22.6	13.2
9. Use spiritual language or concepts	18.4	40.8	21.6	19.2
10. Listen to spiritual experiences or mystical experiences, reported by patient	18.2	42.4	23.7	15.6
11. Gather information on the patient's spiritual back-ground	18.0	47.0	24.8	10.2
12. Refer a patient to others for spiritual counselling e.g., minister, priest, rabbi, Chaplin or traditional healer	17.1	46.5	21.8	14.5
13. Share your own spiritual beliefs or views	16.9	38.5	20.1	24.5
14. Pray or meditate with a patient	16.7	26.4	26.6	30.3
15. Recommend participation in volunteer social activities	15.3	42.3	24.7	17.7
16. Recommend meditation	15.1	26.6	22.1	36.2
17. Encourage patients' to consider if spiritual beliefs and practices are helpful	14.8	43.2	22.1	19.8
18. Discuss with a patient the role of a spiritual belief system in relation to a significant others	13.5	41.1	25.8	19.5
19. Help a patient consider the spiritual meaning of his/her current life situation	13.5	47.1	25.0	14.3
20. Encourage a patient to discuss spiritual ritual as a practice intervention (e.g., house blessings, remembering ancestors; celebrating life transitions; healing rituals)	12.8	31.3	22.7	33.3
21. Help a patient reflect on his/her beliefs about death	11.7	35.0	26.1	27.2
22. Recommend spiritual books or writings	11.5	32.1	31.9	24.5
23. Help a patient reflect on his/her beliefs about what happens after death?	11.4	38.4	22.1	28.1
24. Encourage or recommend spiritual expression by the patient e.g. poetry, painting, or music	10.9	25.8	25.0	38.3
25. Recommend the use of a spiritual diary or journal	9.4	30.4	26.2	34.0
26. Collaborate with outside spiritual practitioners on behalf of patient	9.4	32.2	23.9	34.5
27. Help patients' to consider if spiritual beliefs and practices are harmful	7.8	28.6	23.4	40.1
28. Participate in a patient's spiritual rituals	6.8	22.1	16.1	54.9

An average of 20% of participants stated that they “often” encourage the patient’s family to support any spiritual interest by the patient, pray privately for a patient, assess if the physical and social environment promotes or prevents the spiritual well-being of the patient, help a patient verbalize their spiritual values, assess a patient’s spiritual interest, recommend spiritual forgiveness, confession, assist a patient to talk about their personal spiritual beliefs or practice or recommend participation in a spiritual support system, programme, or activity.

More than 40% of participants indicated that they “sometimes” encourage the patient’s family to support any spiritual interest by the patient, pray privately for a patient, assess if the physical and social environment promotes or prevents the spiritual well-being of the patient, help a patient verbalize their spiritual values, assess a patient’s spiritual interest, assist a patient to talk about their personal spiritual beliefs or practice or recommend participation in a spiritual support system, programme, or activity, use spiritual language and concept, listen to spiritual or mystical experiences reported by patients, gather information on patients spiritual background, refer patients for spiritual counselling, recommend participation in volunteer social activities, encourage patients to consider if spiritual beliefs and practices are helpful, discuss with a patient the role of a spiritual system in relation to significant others and help a patient consider the spiritual meaning of his or her current life situation.

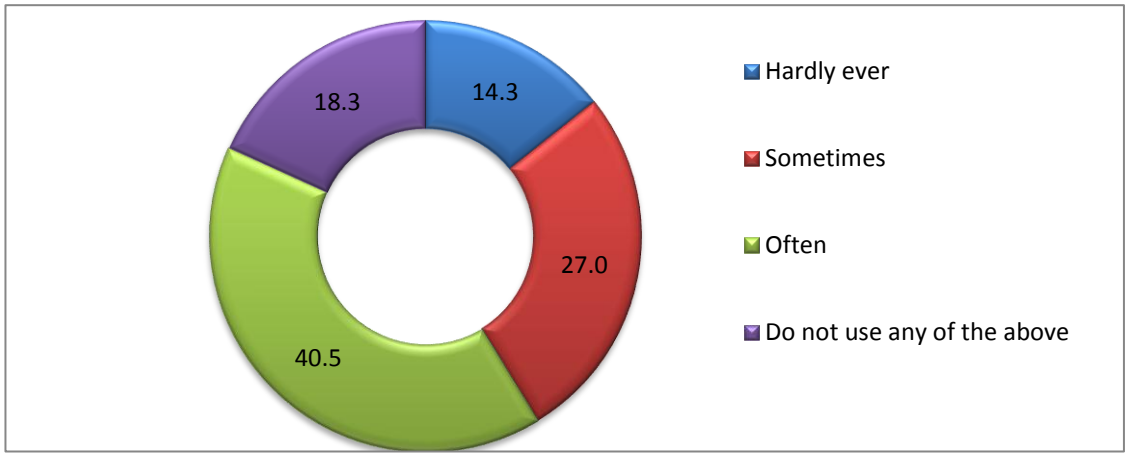
Participants were also asked if they participate in a patient’s spiritual rituals. Only 6.8% answered “often,” 22.1% indicated “sometimes while an average of 71% stated “rarely” or “never”. This was the lowest rating in this section of the questionnaire. Most of the responses were concentrated in the category “sometimes” followed by the category “often” while an average of 22.8% of participants stated that they rarely use the above mention spiritual activities in their daily practice and an average of 22.9% stated that they never use these spiritual nursing activities.

An additional open ended question was asked: “are there other spiritually-based interventions that you have personally undertaken that you consider an appropriate nursing intervention for patients?” Additional nursing interventions identified were “praying with or for the patient, reading the bible, listening to patient, referral to priests or other religious/spiritual leaders and encouraging family visits.”

4.13 UTILIZATION OF SPIRITUAL INTERVENTIONS IN PATIENT CARE

The study also investigated the spiritual interventions used, and the frequency with which they requested patient and/or family permission was also assessed. This is presented in figure 8 below.

Figure 8: Obtaining permission for spiritual interventions



Approximately 40.5% indicated that they requested permission “often” from the patient or family prior to utilizing spiritual interventions. Twenty seven percent indicated requesting permission “sometimes” while 14.3% indicated that they hardly ever requested permission. A little more than 18% indicated not using any of the above mentioned spiritual interventions. Participants were also asked the following: “should nurses help a patient develop spiritually as well as emotionally and socially?” Three-quarters (75.4%) of the sample agreed or strongly agreed that nurses should try to assist patients to develop emotionally socially and

spirituality, while 10.8% did not agree or strongly did not agreed. Almost 14% of the sample stated that they were uncertain.

SECTION F

This section presents data which indicates whether nursing education considers spirituality.

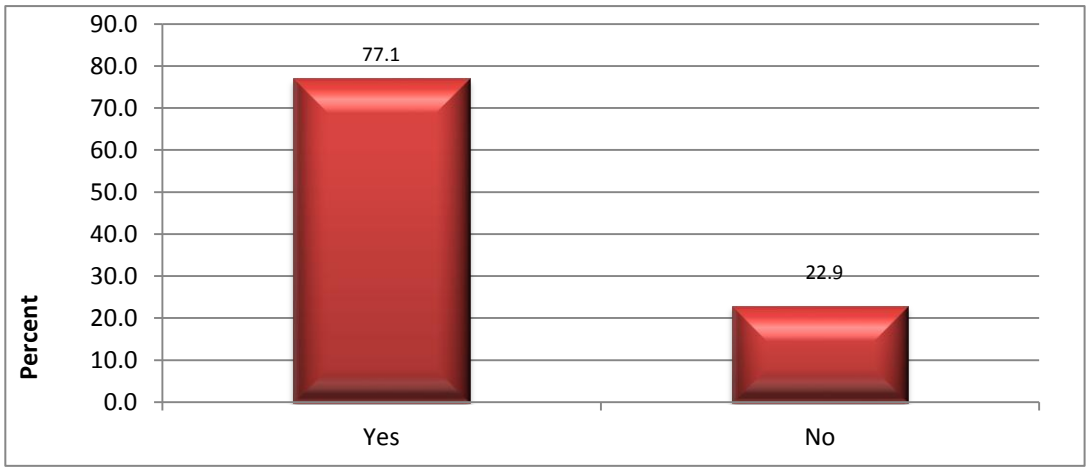
4.14 SPIRITUALITY AND NURSING EDUCATION

Data regarding whether nursing education has prepared nurses to deliver spiritually based nursing care and whether spiritual care was considered in nursing education is presented in this section.

4.14.1 Information received on spirituality and spiritual care during nurse training period

To understand the current status of spirituality in nursing education, the following questions were included in the questionnaire: “During the course of your training as a nurse did you receive any information on spirituality and spiritual care?” A yes or no response was requested. Figure 9 illustrates the responses received.’

Figure 9: Information received on spirituality and spiritual care during Training



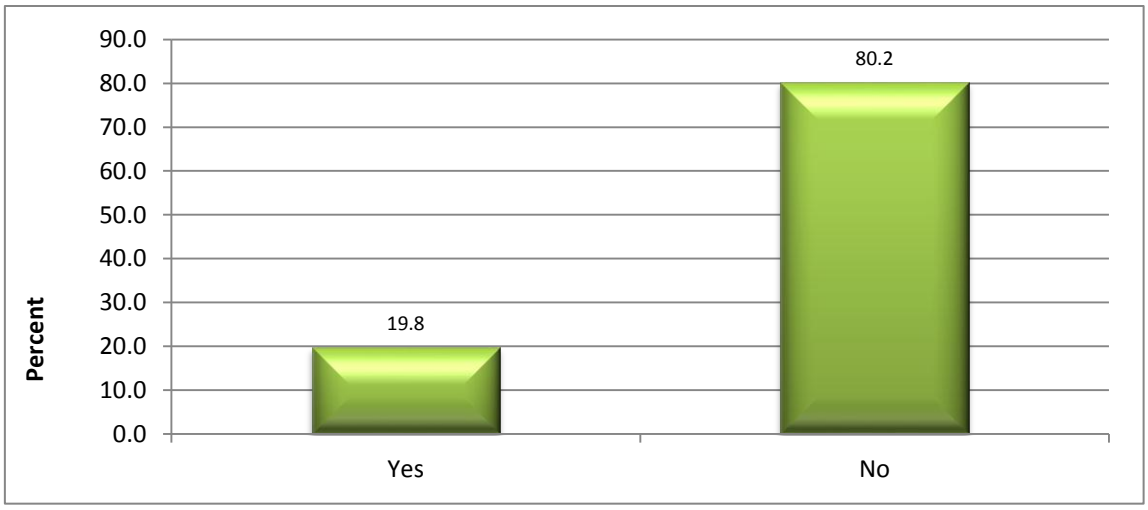
More than three-quarters (77.1%) expressed receiving some training in their student years while 22.9% expressed that they received no training at all. In order

to assess if such training was effective for those who answered yes, the next question asked “If yes, were you satisfied with the information received?” A little less than two-thirds (64.2%) reported being satisfied with the training received. About 35, 8% indicated that they were not satisfied with the information received on spirituality during training.

4.14.2 Education and training on spirituality and spiritual care

This section focuses on data related to education and training on spirituality and spiritual care.

Figure 10: Workshops or courses on spirituality and spiritual care after training



The study also investigated the extent to which nurses received training on spirituality and spiritual care after they qualified. Nearly eight out of every ten participants indicated that they had no post qualification training related to spirituality and spiritual care (80.2%). Only 19.8% indicated receiving post qualification training or attended workshops on spirituality and spiritual care. Of the 19.8% of participants who had received training on spirituality and spiritual care 65.3% believed that the training had better equipped them to handle patients’ spiritual needs. The remaining 34.7% felt that the education received was not completely effective. The next section of the study focuses on reliability and validity issues of the questionnaire and the various statistical tests that were applied to the data

4.15 RELIABILITY STATISTICS

Reliability and validity of the questionnaire was tested using the Cronbach's alpha test before other statistic testing was conducted.

4.15.1 The Cronbach's alpha test

A reliability coefficient of 0.70 or higher is considered as "acceptable" (UCLA 2007). Table 10 below reflects the Cronbach's alpha score for all sections that constituted the questionnaire in this study.

Table 10: Cronbach's alpha score

Section	Cronbach's Alpha
B	0.704
C	0.794
D	0.767
E	0.937
Overall	0.920

The reliability score for all questions was greater than the suggested value of 0. 70. This indicated a high degree of acceptable, consistent scoring for each of the different categories of the questions for this research. This justifies the integrity of the questionnaire as being reliable and valid.

4.15.2 The Chi square test

The Chi square test was performed to determine whether there was a statistically significant relationship between the variables (rows versus columns) (Burns and Grove 2008: 499; Polit and Beck 2008: 600). A significant result is "$p < 0.05$". Results revealed a large number of statistically significant relationships between the variables in the study**.**

4.15.3 Correlations tests

Bivariate Spearman's correlation was performed on the ordinal data. Positive values indicated a directly proportional relationship between the variables and a negative value indicated an inverse relationship (Burns and Grove 2008: 479; Polit and Beck 2008: 602). The study revealed many positive values hence there were numerous directly proportional relationships between the variables. Few negative values were also noted.

4.16 CONCLUSION

In this chapter, the data obtained from the study were presented. Reliability and descriptive statistics were used to describe the findings from the questionnaires completed by professional nurses. Tables, figures and graphs were used to display data on the information supplied by the respondents. Factor analysis was used to signify a number of questions with a number of hypothetical factors. PASW version 20.0 (SPSS) was used for this purpose. Tables and graphs indicate the analysis by section. Both open ended questions and closed ended questions were used to elicit more subjective information. Hypothesis testing was used to determine whether significant relationships existed between variables. The concluding chapter relates to a discussion of findings made.

CHAPTER FIVE

INTERPRETATION, DISCUSSION AND SUMMARY OF FINDINGS

5.1 INTRODUCTION

"I thank you God for

This amazing

Day: for the leaping greenly

Spirits of trees

And a blue dream of sky; and for everything

which is natural which is

infinite which is yes

(I who have died am alive

again today,

and this is the sun's

birthday; this is the birth

day of life and love and

wings; and of gay

great happening ilimitably

earth)

how should tasting

touching hearing seeing

breathing any-lifted from

the no

of all nothing- human

merely being

doubt unimaginable You?

(now the ears of my ears are

awake and

now the eyes of my eyes are opened)"

E. E. Cummings (2009).

Despite nursing's historical commitment to spiritual care and research that supports spiritually based care, many nurses are unprepared to deal with this facet of care (Lind, Sendelbach and Steen 2011: 87). A multitude of international studies support the salience of spirituality to nursing and recommend that spirituality be included as part of basic and post graduate nurse training programmes (Taylor 2007: 585; Lantz 2007: 36; Deal 2010: 852; Tjale and de Villers 2008: 04; Lubbe 2008: 65; Becker 2009: 704; McSherry and Jamieson 2010: 1758; Barlow 2011). In this chapter a discussion and interpretation of the findings are made. Recommendations for further research are also suggested.

5.2 DEMOGRAPHIC FINDINGS

5.2.1 Age

A majority of the participants were between 31-50 years (67.5%). This reflects a mature and experienced sample of professional nurses whose opinion would have been based on accumulated experience, knowledge and skill. A qualification towards registration as a professional nurse takes four to five years to achieve (SANC 2013), resulting in fewer participants (15.1%) being in the group 20-30 years as they would still be students in training. This was evident in the present sample. It is however more than the overall age distribution of professional nurses in South Africa, where most professional nurses are in the age group 30-50 years (48%) (South African Nursing Council 2013).

5.2.2 Gender

A majority of participants were female (89.6%). The ratio of males to females in this study was approximately 1:9. This is in line the demographic profile for all categories of nurses in South Africa which yields a larger ratio of female (93%) to males (7%) (SANC 2013). These findings are consistent with samples abroad where there is a strong dominance of females (McSherry and Jamieson 2010: 1758; Chism and Magnan 2009: 597; Wehmer *et al.* 2010: 04). The predominance of females runs as a thread throughout the profession as a whole. Historically nursing has been seen as a female orientated profession, with a few males joining recently. The fact that there is a presence of males reflects that there

is some interest in nursing which may change this historical gender biased in the future.

5.2.3 Race

Participants were found to be predominantly black (71.7%), followed by 15.6% Asian, 6.5% White and 6% Coloured. This reflects the overall race distribution in Kwazulu-Natal where there are 86.8% Blacks, 7.4% Asian, 4.2% Whites and 1.4% Coloureds (Census 2011). It is also reflective of the South African population which is predominantly Black (79.4%), with fewer Whites (9.2%), Coloureds (8.8%), and 2.6% Asians (Census 2011). The prevalence of Blacks concurs with current South African legislation on affirmative action which aims to correct the inequalities of apartheid, and has allowed a greater number of black citizens the opportunity to enter the nursing profession (African National Congress 2011). International samples in Europe and America differ and reflect that a majority of the nursing participants are White (McSherry and Jamieson 2010; Deal 2010; Barlow 2011).

5.2.4 Marital status and children

There was a balance of single (45%) and married (43.9%) professional nurses (average of 45%) in the sample. A majority of participants (32.5%) have two children. This is in line with the fertility rate of 2.3 children born per South African woman (Census 2011). Long hours, busy work schedules and shift work that are required by nursing may account for a small number of children per nurses' households. The cultural practice of lobola by black South Africans also makes marriage expensive and may be a reason as to why there are that many unmarried mothers in the sample. Further given that traditional ceremonies are often viewed as more binding in African culture could also be a reason for this. The HIV and AIDS pandemic which has resulted in numerous single mothers may further account for a higher number of single mothers in the current sample.

5.2.5 Years of experience

A majority of participants (65%) reported having more than 10 years of nursing experience which reflects a sample characterized by extensive years of nursing knowledge and clinical experience.

5.3 NURSES' PERSONAL SPIRITUAL/RELIGIOUS ORIENTATION

A majority of participants in this study followed a particular religious faith (95.8%). About 86.9% were Christian, 6.3% were Hindu, 1.6% followed Traditional African faith, 1% was Buddhist and 0.8% had no religion. This is in line with national Census (2011) where Christians account for 79.7% of the population followed by 1.5% Muslims, 1.3% Hindus and 0.2% Jews. An additional 15.1% had no religion, 2.3% were classified as other and 1.4% was unspecified (Census 2011). Although most black South Africans (87.9%) are Christians (Census 2011) they may however continue to practice the rituals of their Traditional African faith (Lubbe 2008: 05; du Toit and van Staden 2008: 39) as evident in African churches. International studies reflect similar findings with a high prevalence of Christian (90.5%) in the samples (Wehmer *et al* 2010: 05). Given that most participants follow a particular faith tradition may be the reason underpinning the high levels of support for religion and spirituality in nursing practice as was evidenced on the RRSP scale.

5.4 NURSES' ATTENDANCE AND PARTICIPATION IN SPIRITUAL/RELIGIOUS SERVICES

There was a high level of attendance at and participation in spiritual/religious services daily, several times a week, weekly or monthly during nurse training (78.7%). This concurs with the fact that almost the entire sample adheres to a particular faith tradition. This high level during training years may be linked to the need for personal religious and spiritual support whilst enduring the stress of studying and for their training to be successful. The attendance at and participation in spiritual/religious services daily, several times a week, weekly and monthly increased to 85.3% post training which reflect that religion and spirituality remained a constant feature in their personal life. Their high levels of continued

attendance at service concur with other data related to their support of spirituality in nursing practice.

Almost the entire sample (93.2%) identified with a spiritual group or reported active/regular participation with a spiritual group. This is in line with the fact that almost the entire sample indicated identification with a particular religious faith. Similar findings were made by Chism and Magnan (2009: 597) where 87% of American nurses indicated having a spiritual affiliation to a spiritual/religious group and 90% regarded themselves as somewhat or very spiritual. In this study, it was found that nurses' relationship to a spiritual/religious group did play a role in terms of how their knowledge of patients' spiritual beliefs for effective nursing practice was scored. This was also evident in the current sample who regarded nursing as part of following a spiritual path.

A statistically significant relationship (p-value) between "Indicate your relationship to a spiritual group" and "knowledge of patients "spiritual beliefs is important for effective nursing practice" was found at 0.001. It seems that belonging to a spiritual/religious group did play a significant role in terms of how participants scored the statements. Participants who attended spiritual/religious groups may have understood the importance of personal spirituality to both themselves and patients and probably drew on same, when assessing and providing spiritual nursing care.

A statistical significant relationship (p-value) was also found between "how frequently do you participate in spiritual/religious services?" and "I believe nurses can provide spiritual care by arranging a visit by a hospital priest or the patient's spiritual/religious leader" (0.049). This suggests that nurses may have benefited from these spiritual leaders and may also be personally comfortable arranging for spiritual/religious leaders to visit patients and thus scored it accordingly. Further the high levels of personal religiosity and spirituality in the sample probably resulted in nurses' feeling more empowered to bring spirituality into patient care and into believing the importance of linking outside spiritual leaders with the hospital environment to enhance holistic care.

Apart from fellowship and collective prayer, participants were found to participate extensively in private/personal prayer and other personal spiritual activities. This again links to the high scores found on both on the RRSP scale and the SSCRS scale utilized in this study. Given that 83.8% of the present sample reported participating in private or personal prayer daily to several times per week concurs with their high level of support for this type of intervention with patients facing illness. Studies confirm the salience of prayer to improving health and well-being in a myriad of studies abroad (Callister et al. 2004; Koenig 2009: 283; French and Narayanasamy 2011: 1198; Balboni et al. 2011: 836; Griffins 2012: 245).

5.5 THE VIEWS OF PROFESSIONAL NURSES ON SPIRITUALITY AND THE ROLE OF SPIRITUALITY AND SPIRITUAL CARE IN NURSING PRACTICE

5.5.1 Spirituality

Participants in this study viewed spirituality as having faith and belief in God (75.4%), as involving personal friendships and relationships (78.9%), enabling one to find meaning and purpose in illness (72.2%), not only going to church or a place of worship (77.9%), and participating in prayer (83.1%) for patients. Participants also agreed that spiritual/religious concerns are not outside the scope of nursing practice (average of 72.8%). These views on spirituality resonate with conceptualizations of spirituality in the literature as being the same (Penman, Oliver and Harrington 2009: 30).

Penman, Oliver and Harrington (2009: 30) examined the views and lived experiences of Australian palliative care clients (n=4) and their caregivers (n=10) using interviews. Data reflects spirituality as believing that there is God, as giving power, strength, courage, purpose and encouragement, as a commitment to religion by affiliation to a religious organisation and as relationships with others, that spiritual engagement is illustrated by maintaining relationships by being present, showing concern, giving attention and support, showing love, a sense of selflessness and feeling for others.

5.5.2 Role of spirituality and spiritual care in nursing practice

There is a high level of acceptance of spirituality and spiritual care in nursing practice as part of their nursing role. This could be attributed to their personal spirituality. It can also be supported by the fact that 88% of the participants see nursing as a calling and 89.4% consider nursing as part of their spiritual path. A statistically significant relationship (p-value) of 0.001 was found between the variables “indicate if you consider nursing to be a part of your spiritual life or path?” and “I believe nurses can provide spiritual care by spending time with a patient, giving support and reassurance in times of need.” This suggests that nurses who believed that nursing was a part of their spiritual path, would be more inclined to provide spiritually based nursing care that is embedded in respect, kindness, compassionate listening, praying for patients and referral to spiritual leaders

In addition, a statistically significant relationship (p-value) between “indicate if you consider nursing to be a part of your spiritual life or path?” and “I believe nurses can provide spiritual care by having respect for privacy, dignity and religious and cultural beliefs of a patient” was found (0.040). This suggests that nurses who view nursing as a spiritual calling would most likely score in favour of treating patients with respect, as part of spiritual care. It also supports the notion that the delivery of quality nursing care comes from a feeling of calling to the profession.

Similar findings were made by Bailey, Moran and Graham (2009: 43) who interviewed Irish nurses’ (n=22), in order to understand their experiences of delivering spiritual care. A majority of participants (77%) agreed that spiritual care was part of their role and 75% articulated that spirituality was a key attribute of nursing care. A further 55% of participants reported that making a personal connection was important for patients to be comfortable in expressing spiritual needs. Descriptions from their study which resonate with the data in the present study included: being there, being with the patient, giving hope, holding the patient’s hand or spending time with the patient. Eighty two percent of the sample described the importance of listening and 93.2% believed that spiritual care can be provided by listening and allowing patients to discuss their fears, anxieties and troubles. These findings suggest that spiritual care creates a more intimate

relationship between patients and nurses, and that nurses should have spiritual resources to provide spiritually based care and interventions.

Deal and Grassley (2012: 474), made similar findings in their study when they explored the lived experiences of giving spiritual care, by interviewing ten registered nurses in a Texas nephrology haemodialysis unit. Data reflected similar themes which included drawing close to the patient, drawing from the well of spiritual resources such as God, life experience and prayer, sensing the pain of spiritual distress of the patient and lacking resources such as time, space or energy to give spiritual care. Deal and Grassley (2012: 474) concluded that "giving spiritual care is like diving down deep where the nurse may be afraid to trespass on the patients' feelings and privacy"

Mahmoodishan *et al.* (2010: 08) reported that nurse (n=20) agreed that nurses interact with patients, families and others in a friendly manner, but nurses who are religious and prayer conscious, interact with patients in a more friendly and empathetic manner. They concluded that nurses' personal spiritual/religious orientation, nurses' participation in spiritual/religious services and perception of spirituality can directly affect how nurses behave, how they deal with their patients and how they communicate with them with regard to the provision of spiritual care. This supports data in the present study, particularly the link between personal spirituality and spiritually based nursing care.

Nurses who are more receptive of spirituality in professional care tend to listen to a patient's spiritual beliefs and show concern for their spirituality when providing care (Barlow 2011). A correlation between "nurses should help a patient develop spiritually as well as emotionally and socially" with "nurses should be able to assess the positive or beneficial role of spiritual beliefs and practices in their patient's lives" was found at a level of 238. This suggests that nurses should assess their patients' spirituality in order to facilitate spiritual growth and development, particularly when faced with a crisis. It further supports the need for spirituality based interventions and care in a nursing context. Writers such as Deal (2008: 07); Ojink (2009); Swinton and Patterson (2010: 231), Barlow (2011) affirm the role of spirituality as part of professional care.

5.6 SALIENCE OF SPIRITUALITY TO PATIENTS

The study also found that more than 80% of participants believed that spirituality was an important dimension in the lives of patients. This concurs with other studies in an international context where nurses believed that spirituality was salient to their patients as well (Carron and Cumbie 2011: 552; Helming 2009: 598). When faced with physical illness and emotional distress many patients turn to spiritual resources (Swinton and Pattison 2010: 226). A majority of the current sample concurred that patients have personal spiritual beliefs (93.5%), spirituality helps protect patients against depression (82.1%), religious beliefs provides guidelines for behaviours that were beneficial to patients (80.5%), life experiences increases their level of spiritual maturity (82.3%) and that abused or neglected patients benefit from spiritual beliefs or practices (81.3%).

Ninety one percent of the present sample and 95.5% of participant from a study by McSherry and Jamieson (2010: 1757) indicated that they had encountered patients with spiritual needs. This reflects a patient population who are spiritual even though at times these needs may not have been the primary reason for admission. These spiritual needs were identified by communicating with the patient (42.9%), relatives or friends (6.8%), spiritual/religious leader (7.5%), other patients (2.1%), observing the patient (37.1%) and the nursing care plan (15.3%). McSherry and Jamieson (2010: 1757) also found that 92.6% of nurses felt that nurses, patients, chaplains, family and friends and other health care professionals were all responsible for providing spiritual care.

These findings reinforce the need for nurses to spend time listening to the patient, their family, friends and spiritual/religious leaders in order to identify these spiritual needs. This is in response to 82.9% participants who indicated that spiritual care should be the collective responsibility of nurses, patients, family, friends and spiritual leaders. Participants (92.6%), in McSherry and Jamieson (2010) reported similar findings. Given that a majority of the sample many of whom have been in practice for that a decade, affirms that patients had spiritual needs, suggests the importance of considering spirituality as an important dimension in nursing care. Astrow et al (cited in Vachon 2008: 218), who surveyed cancer patients' (n=369)

found that 73% patients had spiritual needs and 58% felt that nurses should ask about their spiritual needs. More than 80% of participants of the present study agreed that spirituality is essential as it helps prevent depression.

Participants were also asked if they participate in patient's spiritual rituals. Only 6.8% answered "often", 22.1% indicated "sometimes while 71% stated "rarely" or "never." This finding suggests that nurses are aware of the ethical constraints around providing spiritually based care. Although private prayer may be deemed acceptable, it is unethical for the nurse to participate in the patient's spiritual rituals which is not within the realm of nursing ethics (SANC 2005: 34). The fact that the sample was aware of ethical constraints suggests an ability to ensure the maintenance of boundaries between professional care and those interventions which are not acceptable despite them having high levels of personal religiosity and spirituality.

This awareness of professionalism in the milieu of personal spirituality (both nurses and patients) was noted in other studies such as that by Carron and Cumbie 2011: 557) who indicated that 73% of nurses did not routinely provide spiritual care, but referred patients to the clergy, encouraged patients to pray privately and discussed spiritual topics with patients occasionally. Nurses, however, identified listening, touch, use of music and caring as spiritual activities (Carron and Cumbie 2011: 557). Such activities received similar support in the present study and fall within the context of professional practice.

5.7 ASSESSMENT OF PATIENTS' SPIRITUAL NEEDS

Spiritual care will not be possible without consistent spiritual assessment. In most instances it was found that spiritual assessments were done with patients (37.7%), their family and friends (5.9%), spiritual/religious leader (6.3%) and other nurses (1.9%). Common reasons cited for not providing spiritual care were a lack of knowledge related to spiritual care, staff shortage and lack of time. The issue around a lack of knowledge suggests the need to strengthen further training in this area given a patient population with strong spiritual needs. Currently South Africa is experiencing a severe shortage of nurses, with their being 31.1% vacant posts in the public health section (Denosa 2004 cited in Mellish, Oosthuizen and Paton

2010). Despite such challenges the spiritual needs of patients cannot be overlooked as part of a comprehensive approach to nursing care and to spiritual interventions that may enhance well-being and recovery.

5.8 SPIRITUAL NURSING ACTIVITIES/ INTERVENTIONS

About 80% of participants in this study indicated that nursing activities such as respect for patients' dignity, respect for privacy and religious/spiritual beliefs, kindness, support and reassurance, listening to patients' fears, showing concern, personal friendships and relationships, a sense of peace, maintaining hope, forgiveness and finding meaning and purpose in illness underpin spiritually based care. This can be linked to the high levels of acceptance on the RRSP scale regarding the role of spirituality in nursing practice and concurs with findings made by McSherry and Jamieson (2010: 1758) in the United Kingdom, where an average of 94.5% of nurses (n=4054) agreed or strongly agreed that nurses can provide spiritual care by having respect for privacy, dignity and religious and cultural beliefs of patients.

Spiritual interventions/activities identified by participants in the present study included praying with or for the patient (83.1%), spending time supporting and reassuring the patient (93%), listening to patient verbalize his fears and anxieties (93.2%), showing respect for dignity and spiritual/religious beliefs (94.5%), showing kindness and concern (96.1%), visits to spiritual/religious leaders (91.9%), offering hope (88.8%) and finding meaning in illness (72.2%). Nursing literature reflects that these are common spiritual practices in a nursing context (Carron and Cumbie 2011: 557) and are within the realm of professional, ethical care. Other interventions viz being in nature, exercise, taking walks/hikes, family and friends, reading spiritual/religious/general books, listening, touch, use of music and caring also fall within this realm and nurses should be equipped with how to integrate these activities as part of suggestions to patients to ensure health and well-being. (Monareng 2012: 02; Barlow 2008; Bailey, Moran and Graham 2009: 47).

Praying with or for the patient, spending time supporting and reassuring the patient, listening to patient verbalize his fears and anxieties, showing respect for dignity and spiritual/religious beliefs, showing kindness and concern, arranging

spiritual/religious leaders visits and offering hope are ethical interventions that are reflected in section 31(1) of the South African Nursing Act (SANC 2005: 34) and have been supported in literature related to spirituality and spiritual care (Sawatzky and Pesut 2005: 21).

These activities can form the starting basis for beginner professional nurses to begin introducing spiritually based care into nursing practice in South Africa. These interventions are being used in an international context. Ekedahl and Wengstrom (2010: 532) found that Swedish nurses' (n=15) prayed with the patient, the patient's family and also prayed silently. Ray and McGee (2006: 332) also reported that Canadian professional nurses expressed spirituality through prayer, provided support through spiritual sources such as pastors and religious leaders and provided hope as a spiritual basis to care.

Penman's (2012: 140) study identified other interventions as being present, story-telling, life review and quiet time which provided a feeling of peace, rest, confidence and breathing space in the person's suffering. Having faith, being empathic, reading the bible, forgiveness, meditation, practicing rekhi, rendering service, music and pilgrimage were identified as additional spiritual engagements that enhances health and healing. Some of these interventions were also reported by the sample in the current study. Whilst activities such as meditation, practicing rekhi and pilgrimage are not part of professional care, nurses must still respect and support patients' private beliefs and practices (SANC 2005: 34) in nursing conversation.

Bivariate Spearman's correlation was also conducted on ordinal data. A positive value of 225 indicated a directly proportional relationship for "I believe nurses can provide spiritual care by enabling a patient to find meaning and purpose in their illness" and "hospitalization is a time of spiritual awareness". This validates the belief that nurses', who see hospitalization as a time of spiritual awakening, will be more willing to encourage patients to find meaning and purpose in their illness.

The correlation value between "I believe nurses can provide spiritual care by listening to and allowing patients time to discuss and explore their fears, anxieties

and troubles" and "knowledge of patients spiritual beliefs is important for effective nursing practice" is 0.378. This implies that the more nurses listen to the patients' fears and difficulties, the deeper the insight into patients' spiritual beliefs and needs thus enhancing effective nursing practice. "I believe nurses can provide spiritual care by having respect for privacy, dignity and religious and cultural beliefs of a patient" and "I believe nurses can provide spiritual care by spending time with a patient, giving support and reassurance in time of need" scored 511, when correlated. This suggests that the more respect nurses have for their patients', the more support and time they would give to a patient.

5.9 SPIRITUALITY AND NURSING EDUCATION

Only 64.2% stated that they were somewhat satisfied with the information they received on spirituality in nursing education. The other 22.9% reported not having received information. This void in education and dissatisfaction reflects the need for education in the South African context to consider earnestly the salience of spirituality to nursing care and the need to provide education and training on interventions that are ethical and can be beneficial to patient well-being and recovery. Only about 19.8% who received post qualification information on spirituality and spiritual care which had enabled them to meet patients' spiritual needs.

5.9.1 Content to be included in training courses on spirituality and spiritual care

Data suggests that there is a need for workshops, courses, prescribed texts, seminars and teaching aids on spirituality and spiritual care. The correlation value between "nursing education should include content related to spiritual diversity" and "nurses should have more knowledge about spiritual care in nursing" was 0.253. This suggests that the more spiritual content included in the curriculum, the better the understanding of the concept of spiritual care in the field of nursing.

When "nursing education should include content on how to deal with spiritual issues in nursing" and "I believe nurses can provide spiritual care by showing kindness, genuine concern and cheerfulness when dealing with patients" was

correlated, a score of 442 emerged. This reflects the importance of being genuine and integrating kindness for spiritually based nursing care, as part of preparedness shows the value of kindness, genuine concern and cheerfulness when dealing with patients. A further correlation between “nursing education should include content related to spiritual diversity” and “It is important for nurses to have knowledge about different religious faiths and traditions” is -245 suggests the importance of information on religious and spiritual diversity and how it may intersect with issues of health and recovery as part of education. Particular attention to alternative and complementary therapies embedded in diverse cultural contents should be included.

5.9.2 Potential topics for spiritual education and teaching

The above mentioned spiritual content was reflected in the data of the present study, where support was found for topics on different religious faiths and traditions, spiritual diversity, the positive/beneficial role of spiritual beliefs and practices in the lives of patients, salience of spirituality to patients, who should be responsible for providing spiritual care?, spiritual nursing interventions, spiritual beliefs in health and illness, physical and social environments that promotes spiritual well-being and the role of spiritual healers in spiritual nursing care.

Effective and comprehensive educational programmes lay the foundation for meaningful learning (Pohl 1981: 12; Lind, Sendelbach and Steen 2011: 89). Yong et al. (2011: 280) added that training courses for nurses have been effective in preparing nurses to deliver spiritual based nursing care. It is therefore necessary for nursing education to align teaching content with information on spirituality and spiritual care.

A study by Wu and Lin (2011: 250) found that 53 (58%) Chinese student nurses received spiritual care lectures. An additional 58 (74%) of these nurses indicated receiving on-going spiritual care education after they qualified. Consequently 30% of these professional nurses felt that these courses/workshops had better enabled them to meet their patients’ spiritual needs.

In support of introducing spiritual content into nursing education Baldacchino (2011: 501) investigated the impact of spiritual training courses on three groups of

Maltese student nurses (n=93). All participants commented that the course helped update their knowledge on spiritual care. It was found to increase self-awareness of their own spirituality and affirmed their role as change agents in order to implement holistic care. In this vein Vlasblom *et al.* (2010: 790) developed and conducted a "spirituality and nursing care" training course for Dutch nurses (N=49). Prior to the training, 67% of the nurses indicated that their personal view of life resulted in easier discussion of spiritual questions and needs. After training, this percentage had increased to 90 which re-affirm that such training enhances nurses' knowledge of spirituality and spiritual care.

Following a similar trend Ledger and Bowler (2013: 22) initiated the Belief in Recovery project and Tyne and Wear Foundation Trust. The aim of the study was to develop a training course on spirituality by first surveying psychiatric nurses (n=131) spiritual training needs. The study revealed that spirituality is a key aspect of patient-centered holistic care, particularly in mental health care. Furthermore, it was found that although many patients express the importance of spirituality in their recovery nurses often neglected this area. Nurses acknowledged their role in meeting patients' spiritual needs, however they often lack confidence in this area.

This led to the development of practice guidance notes and used the FICA spiritual assessment tool (Borneman, Ferrell and Puchalski, 2010: 163). The FICA tool covers four key areas of enquiry: faith and belief, importance of faith and belief to the patient, community involvement and addressing spiritual needs in nursing care. Participants then attended the training and completed an evaluation questionnaire. The training was rated positively on every aspect. The survey was repeated in 2012 with all question areas showing improvement. This affirms that continuous knowledge related to spirituality can enhance holistic patient care, broaden nurses understanding in this area and raise nurses consciousness to the possibility of the presence of spirituality (Mcclain 2008:1; Wong, and Lee cited in Wu and Lin 2011: 250; Swinton and Pattison 2010: 226).

Training related to spirituality and spiritual care can therefore increase nurses' knowledge and skill around competent and ethical spiritually based care. The

inclusion of academic content is both deserving and timeous given the strong support for spirituality amongst the current sample and its salience to patients in the South African context.

5.10 CONCLUSION

This study was salient as it was one of the first surveys on spirituality in nursing that covered the entire Province of Kwa-Zulu Natal. More importantly as one of the first research studies on spirituality in nursing, this study not only filled a much needed gap in the South African context, but also pointed important areas for future research.

In general, the study found high levels of personal religiosity and spirituality amongst professional nurses; a trend which is evident in the overall South African population as well. This was evident in the latest Census (2011) which reported that a majority of the population are Black and follow a particular faith tradition. This high level of spirituality amongst the sample, spilled over into their nursing role with a majority of the sample agreeing that spirituality, spiritual care and interventions were a crucial part of holistic nursing. A relatively high response rate was found on the RRSP scale which confirms strong support for the role of spirituality in nursing care.

Whilst this may be attributed to the sample's high level of personal spirituality, the fact that they encountered patients who brought the spiritual dimension into the nursing context, may also have contributed to the high mean ratings on the RRSP scale. A majority of the sample concurred that patients expect spiritual care when faced with illness, psychological distress and difficulties. Prior research in conjunction with data from present study supports the fact that spiritual care helps patients cope better with illness. Spirituality and spiritual care is seen as providing a sense of direction, hope and inner peace; allowing patients to accept and cope with problems, thereby restoring their sense of wellbeing through faith.

What is important is that this was a sample with significant nursing experience which may reflect that spirituality has been a part of their nursing care for many years. Whilst this and their own personal spirituality may have led to a level of

comfort in providing spiritually based care, it must be emphasized that many are doing so despite having no formal training in spiritual care. Spirituality requires specialized knowledge and skill to discern between providing professional nursing care in a way that is ethical and meets the primary need of patient physical care and well-being. It is therefore concerning that many provide spiritual care despite a lack of professional training. Given the large number of patients being encountered who require spiritual care, it is important that nursing education meets the need to prepare nurses to provide spiritually based intervention in an ethical way which benefits and supports patient recovery.

Education should focus on nursing activities that enhance spirituality and spiritual care. Responses emerging from the data include praying for the patient, spending time with the patient, supporting and reassuring the patient, listening to the patient, showing respect for spiritual/religious beliefs, showing kindness, assisting with visits to spiritual/religious leaders, offering hope and finding meaning in illness. Nurses need to be taught to provide relational spirituality in the context of professional ethics. A majority expressed that the barriers to providing spiritual care included a lack of time, uncertainty of how to provide spiritual care, and lack of knowledge regarding diverse religious faiths. These are areas warranting attention in education.

Despite these challenges, most participants agreed that although spiritual care takes extra time, it has the potential to make a huge difference in a patients' healing, cooperation, and satisfaction. Although most participants had received some information on spiritual care during their training, most nurses felt that such training was insufficient. Most agree on the need for workshops/courses/seminars for the current group of professional nurses. In order for this to happen, it is critical that there is a paradigm shift in nursing education and practice that will enable spirituality to be seen as an important and integral part of spiritual care. Given the multitude of research studies which have documented spirituality's role in effecting healing, coping and recovery in the midst of grave illness, it is timeous that this paradigm shift occurs in South Africa.

5.11 LIMITATIONS OF THE STUDY

The current survey was conducted at multiple public hospitals across the landscape of KwaZulu-Natal. Visits to distant hospitals had to be planned in advance with time schedules that were at the convenience of the institution. Geographic distance limited the number of visits to a maximum of two visits per hospital. This puts pressure on the researcher to make maximum use of limited time. Transport and accommodation became costly.

Data collection was successful at all but one nursing institution. The researcher was unable to collect sufficient questionnaire at this particular institution. She was informed by nursing management that professional nurses at the institution were either too busy or otherwise not willing to participate in the survey. After leaving a batch of questionnaires at the institution, the researcher managed to secure only 21 completed questionnaires.

A further limitation was that a small percentage of professional nurses, who were initially willing to participate in the study, withdrew their participation after being informed that they were required to complete a consent form as part of the survey. Based on the data analyses, it was necessary to suggest recommendations.

5.12 RECOMMENDATIONS

The numerous findings of this study have implications for nursing care and nursing education. Further research related to spirituality and spiritual care is necessary as patients welcome spiritual care as identified in this study. Also, nurses need to be equipped with the relevant spiritual tools in order to offer this level of care. There is a dire need for information, training and or course work on spirituality and spiritual care for nurses. Nurses in this study agreed that education related to spirituality and spiritual care is insufficient to assist them render such care with precision and confidence. Within South Africa, our disease profile, morbidity rate and mortality rate is escalating rapidly (Department of Health 2012). Now, more than ever, the spiritual dimension of care cannot and should not be ignored.

Future studies in the field of spirituality and spiritual care would assist nurses provide competent and consistent spiritual care, resulting in patients having access to support and coping resources which would bring hope and meaning to illness and suffering. While it may be necessary to maintain a clear distinction between the concepts of spirituality and religion, both aspects of care can have a positive impact to the overall wellbeing of the patient and the nurse as well. Within a South African context, both concepts are used interchangeably where both make reference to caring for the whole person (mind, body and soul) (Lubbe 2008: 15).

While several studies abroad have identified spiritual activities and interventions for nurses, there is a need for the development of models and frameworks for spiritual care in nursing. Such models and frameworks can be developed to match our patient's disease profile. Research studies that assess the role of spirituality and spiritual care from the patient's perspective are also recommended as this would permeate into the current body of knowledge related to spirituality and spiritual care. This can help nurses understand the spiritual needs of the patients from a direct source. As current nursing education is to be absorbed into higher education in 2016 (SANC 2012) research findings in the field of spirituality and spiritual care can assist in planning of the new curriculum.

In an inclusive manner, nurses who provide spiritual care have the power to create a spiritual tapestry, through their work in myriad of forms, with patients reaping the benefits of spiritual attention as a consequence (Bailey, Moran and Graham 2009:48). It is envisaged that the findings and recommendations of this study paves the path for spirituality and spiritual care to finds it place in holistic care and nursing education.

"Let no one ever come to you without leaving better and happier. Be the living expression of God's kindness: kindness in your face, kindness in your eyes, kindness in your smile"

(Mother Teresa 1950).

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Letter of information

Questionnaire on spirituality and spiritual care amongst professional nurses in KwaZulu-Natal

Dear participant

Thank you for your willingness to consider participating in this study. I am very grateful for same.

This survey is being conducted to explore spiritual care amongst professional nurses in Kwa-Zulu Natal. The survey first asks about the spiritual beliefs of nurses and then about the role of spirituality in nursing practice and nursing education. It includes the use of spiritually-based intervention. If you wish to comment on any question, please feel free to use the space in the margins. Your comments will be read and taken into account. You will need an average of 15 minutes to complete the questionnaire.

This survey uses a questionnaire that has been adapted from the instruments used by McSherry (2011) and Bhagwan (2002).Permission has been obtained from both researchers to utilize and adapt segments of their questionnaire for this study. Included in the questionnaire is a definition on spirituality to enable you to understand the term more clearly. Data will be collected from professional nurses who are working in provincial hospitals within KwaZulu-Natal. Ultimately it is hoped that the findings will enable the researcher to make recommendations to guide nursing education in relation to spirituality and spiritual care.

This project has been reviewed by the faculty of Health Science Research and Higher Degrees Committee and has received ethical clearance from Durban University of Technology Institutional Research Ethics Committee.

Participation in the study is totally voluntary and you may withdraw from the study whenever you wish. Consent to participate is required and you will have to complete the attached consent form to indicate the same. All information received is confidential and your anonymity is guaranteed as your identifying details are not required. Kindly answer all questions. Should you have any queries kindly contact me at the number provided below or alternatively you can email me.

Kindly complete the consent form provided.

Thank you for your time and participation.

Sincerely

Sandhya Chandramohan.
Contact details: 0338973523/0333915379
Cell: 0837915379 or (email) sandhyachandramohan@yahoo.com

Supervisor: Dr. Raisuyah Bhagwan
Contact details: 0313732197 or (email) bhagwanr@dut.ac.za

The Institutional Research Ethics administrator (telephone) 031 373 2900.

Complaints can be reported to the DVC: TIP, Prof F. Otieno on 031 373 2382 or dvctip@dut.ac.za.

PART A

The first section includes questions on demographic and various personal and professional background variables. Please indicate the appropriate response.

1. Please indicate your age?

- ❑ 20 – 30
- ❑ 31 – 40
- ❑ 41 - 50
- ❑ 51 – 60
- ❑ Over 60

2. Please indicate your gender.

- ❑ Male
- ❑ Female

3. Please indicate your ethnic group.

- ❑ Black
- ❑ Asian
- ❑ White
- ❑ Colored
- ❑ Other (specify: _____

4. Please indicate your marital status.

- ❑ Single
- ❑ Married or domestic partner
- ❑ Divorced / Separated
- ❑ Widowed

5. Please indicate how many children you have?

_____ children

6. Please indicate how frequently you participate in spiritual services (e.g. attending church, temple, worship group or other activity)?

- ❑ daily
- ❑ several times a week
- ❑ once a week
- ❑ 2-3 times a month
- ❑ once a month
- ❑ 5-6 times a year
- ❑ 2-3 times a year
- ❑ once a year
- ❑ not at all

7. Please indicate how often you participated in spiritual services during your nurse training. e.g. attending church, temple, worship groups or situations of communal activities.

- ❑ daily
- ❑ several times a week
- ❑ once a week
- ❑ 2-3 times a month
- ❑ once a month
- ❑ 5-6 times a year
- ❑ 2-3 times a year
- ❑ once a year
- ❑ not at all

8. Please indicate your religious affiliation or spiritual orientation?

- ❑ Agnostic
- ❑ Atheist
- ❑ Buddhist
- ❑ Christian:
- ❑ Hindu
- ❑ Jewish
- ❑ Muslim
- ❑ Traditional African
- ❑ Other (specify: _____

9. Please indicate your relationship to a spiritual group.

- ❑ active participation, high level of involvement
- ❑ regular participation, some involvement
- ❑ identification with religion or spiritual group, very limited or no involvement
- ❑ no identification, participation or involvement with religious or spiritual group
- ❑ dislike and negative reaction to religion or spiritual tradition

10. Please indicate if you consider nursing to be a part of your spiritual life or path?

- ❑ No
- ❑ Yes

11. Please indicate how often you participate in private or personal spiritual practices e.g., meditation, prayer, rituals, reading scriptures etc. ❑ daily ❑ several times a week ❑ once a week ❑ 2-3 times a month ❑ once a month ❑ 5-6 times a year ❑ 2-3 times a year ❑ once a year ❑ not at all 12. Please indicate how long you have been in nursing practice? ❑ Less than 10 years ❑10 – 20 ❑ 21 -30 ❑ 31 – 40 ❑More than 40 years	

To aid you in responding to the following questions, respective definitions of spirituality and religion are provided.

- Spirituality is defined as “the search for meaning, purpose, and connection with self, others, the universe, and ultimate reality, however one understands it. This may or may not be expressed through religious forms or institutions.”

- Religion is defined as "an organized structured set of beliefs and practices shared by a community related to spirituality.”

- When both spirituality and religion are referred to in one question, answer if either applies, or consider spirituality as inclusive of both religious and non-religious perspectives.

PART B

The role of spirituality in nursing practice

The following questions ask your views about the role of spirituality in nursing practice.
Please rate your level of agreement or disagreement with each statement by circling the one number that best reflects your opinion on the 5-point scale

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
1.Spirituality is a basic aspect of being human.	1	2	3	4	5
2. Nurses should have more knowledge about spiritual care in nursing	1	2	3	4	5
3.It is important for nurses to have knowledge about different religious faiths and traditions.	1	2	3	4	5
4. Religious concerns are outside of the scope of nursing practice.	1	2	3	4	5
5. Spiritual concerns are outside of the scope of nursing practice.	1	2	3	4	5
6.Nursing practice with a spiritual component has a better chance to empower clients than practice without such a component.	1	2	3	4	5
7. Knowledge of patients 'spiritual beliefs Is important for effective nursing practice.	1	2	3	4	5
8. Nurses should be able to assess the positive or beneficial role of spiritual beliefs and practices in their patient's lives	1	2	3	4	5
9. Nurses should be able to assess the negative or harmful role of spiritual beliefs and practices in their patients' lives.	1	2	3	4	5
10. The use of spiritual language and spiritual concepts in nursing practice are inappropriate.	1	2	3	4	5
11. The spirituals backgrounds of patients do not particularly influence nursing practice.	1	2	3	4	5
12. A nurse's use of scripture or other spiritual texts in nursing practice are appropriate.	1	2	3	4	5
13. It is against nursing ethics to ever pray with a patient.	1	2	3	4	5
14. The use of spiritual concepts in nursing practice is inappropriate.	1	2	3	4	5
15. It is sometimes appropriate for a nurse to share his or her spiritual beliefs with a patient.	1	2	3	4	5
16. Addressing a patients spiritual beliefs is necessary for holistic nursing care.	1	2	3	4	5
17. Nursing education should include content related to spiritual diversity.	1	2	3	4	5
18. Nursing education should include content on how to deal with spiritual issues in nursing	1	2	3	4	5

Part C

Spirituality and spiritual care

For each question please circle one answer which best reflects the extent to which you agree or disagree with each statement.

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
1. I believe nurses can provide spiritual care by arranging a visit by a hospital priest or the patient's spiritual/religious leader.	1	2	3	4	5
2. I believe nurses can provide spiritual care by showing kindness, genuine concern and cheerfulness when giving care.	1	2	3	4	5
3. I believe spirituality is concerned with a need to forgive and a need to be forgiven.	1	2	3	4	5
4. I believe spirituality involves only going to church/place of worship.	1	2	3	4	5
5. I believe spirituality is not concerned with a belief and faith in ~~a~~ God.	1	2	3	4	5
6. I believe spirituality is about finding meaning in the good and bad events of life.	1	2	3	4	5
7. I believe nurses can provide spiritual care by enabling a patient to find meaning and purpose in their illness.	1	2	3	4	5
8. I believe spirituality is about having a sense of hope in life.	1	2	3	4	5
9. I believe spirituality is to do with the way one conducts one's life here and now.	1	2	3	4	5
10. I believe nurses can provide spiritual care by spending time with a patient giving support and reassurance in time of need.	1	2	3	4	5
11. I believe nurses can provide spiritual care by listening to and allowing patient time to discuss and explore their fears, anxieties and troubles.	1	2	3	4	5
12. I believe spirituality is a unifying force which enables one to be at peace with oneself and the world.	1	2	3	4	5
13. I believe spirituality does not include areas such as art, creativity and self-expression.	1	2	3	4	5
14. I believe nurses can provide spiritual care by having respect for privacy, dignity and religious and cultural beliefs of a patient.	1	2	3	4	5
15. I believe spirituality involves personal friendships and relationships.	1	2	3	4	5
16. I believe spirituality does not apply to those who are unsure of God or do not believe in God.	1	2	3	4	5
17. I believe spirituality includes peoples' morals.	1	2	3	4	5

Who do you feel should be responsible for providing spiritual care?

- ☐ Nurses
- ☐ Patients themselves
- ☐ Patients' spiritual/ religious leader
- ☐ Patients' family and friends
- ☐ Combination of all: (nurses, patient, family, friends and spiritual leaders)

Other (please specify) ……..

2. In your nursing care have you ever encountered a patient(s) with a spiritual need(s)?

- ☐ Yes
- ☐ No

3. If then how did you become aware of this need(s)?

- ☐ Patient himself/herself
- ☐ Patients' relatives/friends
- ☐ Nursing care plan
- ☐ Other nurses
- ☐ Spiritual/religious leaders
- ☐ Observing the patient

Other ……

4. Do you feel that you are usually able to meet your patient's spiritual needs?

- ☐ Yes
- ☐ No

(If No please specify).....

PART D

The role of spirituality in the lives of patients

Listed below are several beliefs about Patients' spiritual capacity and the role of spirituality in their lives. Please rate your level of agreement or disagreement with each statement by circling the one number that best reflects your opinion on the 5-point scale.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. Hospitalization is a time of spiritual awareness.	1	2	3	4	5
2 All patients have their own belief in spirituality.	1	2	3	4	5
3. Some patients do not have the mental abilities to reflect on spiritual matters.	1	2	3	4	5
4. Terminally ill patients search for meaning and purpose in life.	1	2	3	4	5
5. Spiritual participation helps protect the patient against depression.	1	2	3	4	5
6. It is not unusual for some patients to have spiritual experiences that influences their lives.	1	2	3	4	5
7 As patients grow older, they lose their natural connection to spirituality.	1	2	3	4	5
8. Some patients are exceptionally spiritually mature or gifted.	1	2	3	4	5
9. Some patients experience problems or anxiety due to spirituality that go unnoticed by nurse.	1	2	3	4	5
10.Religious beliefs provide guidelines for behaviors that are beneficial to patients.	1	2	3	4	5
11. As individuals grow, life experiences increases their spiritual maturity.	1	2	3	4	5
12. Patients who are abused or neglected may especially benefit from spiritual beliefs or practices.	1	2	3	4	5

PART E

Use of spiritual activities in patient care.

Please indicate the frequency of which you practice the following in your daily nursing care. Circle one most correct response for each question.

1. Gather information on the patient's spiritual back-ground.	Never	Rarely	Sometimes	Often
2. Assess a patient's spiritual interest.	Never	Rarely	Sometimes	Often
3. Recommend spiritual books or writings.	Never	Rarely	Sometimes	Often
4. Pray privately for a patient.	Never	Rarely	Sometimes	Often
5. Pray or meditate with a patient.	Never	Rarely	Sometimes	Often
6. Recommend meditation.	Never	Rarely	Sometimes	Often
7. Use spiritual language or concepts	Never	Rarely	Sometimes	Often
8. Help a patient verbalize their spiritual values.	Never	Rarely	Sometimes	Often
9. Recommend participation in a spiritual support system, program, or activity.	Never	Rarely	Sometimes	Often
10. Recommend participation in volunteer social activities.	Never	Rarely	Sometimes	Often
11. Refer a patient to others for spiritual counseling. e.g., minister, priest, rabbi, Chaplin or traditional healer.	Never	Rarely	Sometimes	Often
12. Recommend the use of a spiritual diary or journal.	Never	Rarely	Sometimes	Often
13. Recommend spiritual forgiveness, confession.	Never	Rarely	Sometimes	Often
14. Discuss with a patient the role of a spiritual belief system in relation to a significant others.	Never	Rarely	Sometimes	Often
15. Assist a patient to talk about their personal spiritual beliefs or practice.	Never	Rarely	Sometimes	Often

16. Help a patient consider the spiritual meaning of his/her current life situation.	Never	Rarely	Sometimes	Often
17. Help a patient reflect on his/her beliefs about what happens after death?	Never	Rarely	Sometimes	Often
18. Help a patient reflect on his/her beliefs about death.	Never	Rarely	Sometimes	Often
19. Encourage a patient to discuss spiritual ritual as a practice intervention. (e.g., house blessings, remembering ancestors; celebrating life transitions; healing rituals).	Never	Rarely	Sometimes	Often
20. Participate in a patient's spiritual rituals.	Never	Rarely	Sometimes	Often
21. Encourage patients' to consider if spiritual beliefs and practices are helpful.	Never	Rarely	Sometimes	Often
22. Help patients' to consider if spiritual beliefs and practices are harmful.	Never	Rarely	Sometimes	Often
23. Share your own spiritual beliefs or views.	Never	Rarely	Sometimes	Often
24. Collaborate with outside spiritual practitioners on behalf of patient.	Never	Rarely	Sometimes	Often
25. Encourage or recommend spiritual expression by the patient e.g. poetry, painting, or music.	Never	Rarely	Sometimes	Often
26. Listen to spiritual experiences or mystical experiences, reported by patient.	Never	Rarely	Sometimes	Often
27. Encourage the patient's family to support any spiritual interest by the patient.	Never	Rarely	Sometimes	Often
28. Assess if the physical and social Environment promotes or prevents the spiritual well-being of the patient.	Never	Rarely	Sometimes	Often

29. Are there other spiritually-based interventions that you have personally done that you consider appropriate nursing intervention for patients?

No ❑
Yes ❑ ➔ (If yes) what are these interventions/ activities?

_____

30. When you provide any of these interventions listed above how often do you obtain family permission?

❑Always ❑Sometimes ❑Hardly Ever ❑Do not use any of the above Interventions /activities?

31. Nurses should help a patient develop spiritually as well as emotionally and socially.

❑Strongly Disagree ❑Disagree ❑Neutral ❑Agree ❑Strongly Agree

PART F

Spirituality and Nursing Education

1. During the course of your nurse training did you receive any information on spiritualty and spiritual care?

- ☐ Yes
- ☐ No

2. If yes, where you satisfied with the information received.

- ☐ Yes
- ☐ No

3. Indicate your level of satisfaction with the information received.

- ☐ Very satisfied
- ☐ Satisfied
- ☐ Neutral
- ☐ Dissatisfied
- ☐ Very dissatisfied

4. Since qualifying as a nurse have you been on any training courses or workshops which covered spiritual care?

- ☐ Yes
- ☐ No

5. If yes do you feel this has better enabled you to better meet your patient's spiritual needs?

- ☐ Yes
- ☐ No

Thank you

Centre For

Practice and Service Improvement

STAFFORDSHIRE UNIVERSITY

Centre for Practice and Service Improvement
Staffordshire University
Blackheath Lane
Stafford
ST18 0AD

Email: wilf.mcsherry@staffs.ac.uk
Direct line: 01785 353630
Fax: 01785 353731

11 April 2012

Dear Sandhya Chandramohan,

Re: SSCRS Permission

Thank you for the interest you have shown in my research and the Spirituality and Spiritual Care Rating Scale (SSCRS). I hereby give you authorisation and permission to reproduce or use the scale in your research. There is no fee for using the scale or the questionnaire; however I would appreciate if you could forward me a copy of your research findings and report when completed.

I enclose a copy of the questionnaire in which the SSCRS can be found. If you require any further information, please contact me.

The scale was developed as part of descriptive study. If you want to obtain a copy of my original thesis - you should be able to receive through Inter Library Loan the title is - A Descriptive Survey of Nurses' perceptions of Spirituality and Spiritual Care Unpublished Master of Philosophy Thesis, The University of Hull, England.

A summary of how the SSCRS was constructed was published in the International Journal of Nursing Studies 2002:

> McSherry W., Draper P, Kendrick D (2002) Construct Validity of a Rating Scale Designed to Assess Spirituality and Spiritual Care *International Journal of Nursing Studies* 39 (7) 723 - 734

May I take this opportunity to wish you all the best with your studies. If I can be of any assistance in the future then do not hesitate to contact me again.

Yours sincerely,

Professor Wilfred McSherry

Professor in Dignity of Care for Older People
Centre for Practice and Service Improvement

Appendix 3

LETTER OF INFORMATION

Title of the Research Study:

Spirituality and spiritual care amongst professional nurses at public hospitals in KwaZulu-Natal.

Principal Investigator/s/researcher: Sandhya Chandramohan (B Cur degree)

Co-Investigator/s/supervisor**:** Dr Raisuyah Bhagwan (PHD)

Brief Introduction and Purpose of the Study:

Research related to spirituality has grown in the Western context, with many studies that have documented the importance of spirituality to health and wellbeing in relation to a range of issues such as HIV/AIDS, cancer and heart disease (Koenig 2001). In South Africa research in this field is sparse hence prompting the need for this study. The purpose of this study is to explore professional nurse's views on the role of spirituality in nursing, the importance of spiritual care to nursing practice and whether spirituality is currently considered in education.

Outline of the Procedures:

Data will be collected using survey questionnaires.The questionnaires and consent forms will be issued to nurse managers of each hospital in person by the researcher. The nurse managers will be asked to distribute the questionnaires and consent forms to all professional nurses in their departments once permission from the Department of health and hospital managers have been obtained. Permission will also be requested to allow nurse managers to distribute and collect questionnaires. A meeting between the nurse manager and researcher will be scheduled prior to distribution of questionnaires to brief the nurse manager on the data collection process, to gain their co-operation and address any other concerns. This will include safe storage of the boxes and access times for nurses to post questionnaires therein. Each nurse manager will be issued with two labeled sealed cardboard post box into which the professional nurses will be able to slot in their completed questionnaires and consent forms separately. Participants will be allowed to take the questionnaires home to complete at leisure. Participants will be informed of an average time limit of 15 minutes that will be needed to complete the questionnaire. There will be no direct contact with participants and no prior briefing will be necessary as the questionnaire and consent form will be include all relevant information. A letter of information that explains the purpose of the study will also be included in the questionnaire. This aims at recruiting professional nurses for the survey. Participation is voluntary and participants will be free to withdraw from the study at any stage with no repercussions. After a month the researcher will collect the boxes to ascertain response rates. Should it be insufficient then a further call will be put out and the same procedure utilized to secure further questionnaires.

Inclusion criteria

1. All professional nurses at selected regional/tertiary provincial training hospitals. These hospitals are accredited with the South African nursing Council to provide practical nurse training for the comprehensive nursing diploma programme.
2. Professional nurses who are willing to participate in the study.

Exclusion criteria

1. Professional nurses employed at private hospitals as they are not accredited by the South African Nursing Council to provide practical training in the 4 year comprehensive nursing diploma programme. They may not be able to comment on the course effectively.
2. Enrolled and auxiliary nurses due to their limited training and practice.
3. Student and pupil nurses as their training would be incomplete.
4. Campus professional nurses as they are not working in the clinical practical field and have limited contact with patients.

Risks or Discomforts to the Participant: There are no foreseen risks or discomfort to the participants.

Benefits:

Participant: None

Researcher: Presentation of research paper and publication of journal articles on spirituality and spiritual care.

Reason/s why the Participant May Be Withdrawn from the Study:

Participation is voluntary and participants may withdraw at any stage with no penalty.

Remuneration: The participant will not receive any remuneration.

Costs of the Study: The participant will not be expected to cover any costs.

Confidentiality:

Participant confidentiality will be assured as participants will not be required to write their names or personal details details on the questionnaire. There will be a separate consent form that will be posted in a separate box. Completed questionnaires will be locked in a steel locker and will ultimately be shredded after 15 years thus maintaining total confidentiality.

Research-related Injury:

The study is non-evasive hence there should be no research related injury.

Persons to Contact in the Event of Any Problems or Queries:

Researcher: Sandhya Chandramohan (telephone) 0338973523 or (email) sandhyachandramohan@yahoo.com

Supervisor: Raisyuah Bhagwan (telephone) 0313732197or (email) bhagwanr@dut.ac.za

The Institutional Research Ethics administrator (telephone) 031 373 2900. Complaints can be reported to the DVC: TIP, Prof F. Otieno on 031 373 2382 o

Appendix 4

CONSENT

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Sandhya Chandramohan about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: 041/12.
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

_____	_____	_____	_____
Full Name of Participant	Date	Time	Signature / Right Thumbprint

I, Sandhya Chandramohan herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

Sandhya Chandramohan	_____	_____
Full Name of Researcher	Date	Signature
_____	_____	_____
Full Name of Witness (If applicable)	Date	Signature

Please note the following:

If anyone makes a mistake completing this document e.g. wrong date or spelling mistake a new document has to be completed.

DURBAN UNIVERSITY of TECHNOLOGY

INSTITUTIONAL RESEARCH ETHICS COMMITTEE (IREC)

11 October 2012

IREC Reference Number: **REC 47/12**

Mrs S C Chandramohan
35 Vedic Crescent
Darjeeling Heights
Pietermaritzburg
3201

Dear Mrs Chandramohan

Spirituality and spiritual care amongst professional nurses at public hospitals in KwaZulu-Natal

I am pleased to inform you that Full Approval has been granted to your proposal REC 47/12.

The Proposal has been allocated the following Ethical Clearance number IREC 041/12. Please use this number in all communication with this office.

Approval has been granted for a period of one year, before the expiry of which you are required to apply for safety monitoring and annual recertification. Please use the Safety Monitoring and Annual Recertification Report form which can be found in the Standard Operating Procedures [SOP's] of the IREC. This form must be submitted to the IREC at least 3 months before the ethics approval for the study expires.

Any adverse events [serious or minor] which occur in connection with this study and/or which may alter its ethical consideration must be reported to the IREC according to the IREC SOP's. In addition, you will be responsible to ensure gatekeeper permission.

Please note that any deviations from the approved proposal require the approval of the IREC as outlined in the IREC SOP's.

Yours Sincerely

[redacted]

Dr D F Naude
Chairperson: IREC

Appendix 6.1

35 Vedic Crescent
Darjeeling heights
Pietermaritzburg, 3201
10/09/2012

The Hospital Manager: Dr E.R. Masilela
Addington Hospital
P O Box 977
Durban, 4000

Re: Request to survey professional nurses at the following provincial hospitals in KwaZulu-Natal: Addington Hospital, Greys Hospital, Madadeni Hospital, Ngwelenzana Hospital and Port Shepstone Hospital.

Dear Sir /Madam

I am a lecturer in Nursing Education at Greys Campus, Pietermaritzburg, pursuing the following degree: Master of Technology in Nursing at the Durban University of Technology.

The purpose of this current study is to explore nursing practitioners' views on the role of spirituality in nursing, the salience of spiritual care to nursing practice and whether spirituality is currently considered in education. To this end a quantitative research design, will be utilized to survey the views of professional nurses at select public hospitals in KwaZulu-Natal through a process of multiphase random sampling.

I kindly request permission to use your hospitals in order to access the views of professional nurses. I require a letter of support from you in accordance to our Provincial Department of health. I have already obtained provisional ethical clearance from Durban University of Technology. Kindly find attached a copy of my proposal, questionnaire, letter of information and consent for your information.

My intention is to survey 86 professional nurses at your hospital using questionnaires. Professional nurse will be invited to volunteer to take part in my survey. There will be no physical or emotional risks involved. Information will be confidential. No benefits will be given for their participation. They may withdraw from the survey whenever they want to, with no penalties. If you have any questions or concerns, kindly contact either me, my supervisor or the Institutional Ethics administrator on the telephone numbers below.

Thank you for your consideration of this matter and I look forward to hearing from you at your earliest convenience.

Yours sincerely
Sandhya Chandramohan.
Student No.21240208
Contact details: 033 8973523 (work), 033 3915379 (home), 0837915379 (Cell) or
sandhyachandramohan@yahoo.com (email).

Supervisor: Dr. Raisuyah Bhagwan
Contact details: 0313732197 or bhagwanr@dut.ac.za (email).

The Institution Research Ethics administrator: 031 373 2900.
Complaints can be reported to the DVC: TIP, Prof. Otieno on 031 373 2382 or dvctip@dut.ac.za.

health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Postal Address: Private Bag X54318 Durban 4000
ss: 83 Jan Smuts Highway, Mayville, Durban 4001
Tel.031 2405308: Fax. 031 2405500
Email. nan.hoosain@kznhealth gov.za
www.kznhealth.gov.za

Enquiries: Ms Jabu Hlazo
Tel: 031 240 5303
Date: 24 October 2012

Attention: Sandhya Chandramohan: E-mail sandhyachandramohan@yahoo.com

REQUEST TO CONDUCT RESEARCH:

Spirituality and spiritual care amongst professional nurses at public hospitals in KwaZulu-Natal.

Support is hereby granted to conduct research on the above topic.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regard to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health
3. Please ensure that this office is informed before you commence your research.
4. The District Office will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the District Office.

[redacted]

pp District Manager
eThekwini
Telephone: 031 2405303
Fax : 031 2405500
Email: jabulisiwe.hlazo@kznhealth.gov.za

Appendix 6.2

35 Vedic Crescent
Darjeeling heights
Pietermaritzburg, 3201
10/09/2012

The Hospital Manager: Dr K. Bilenge
Greys Hospital
Private Bag X9001
Pietermaritzburg, 3201

Re: Request to survey professional nurses at the following provincial hospitals in KwaZulu-Natal: Addington Hospital, Greys Hospital, Madadeni Hospital, Ngwelenzana Hospital and Port Shepstone Hospital.

Dear Sir /Madam

I am a lecturer in Nursing Education at Greys Campus, Pietermaritzburg, pursuing the following degree: Master of Technology in Nursing at the Durban University of Technology.

The purpose of this current study is to explore nursing practitioners' views on the role of spirituality in nursing, the salience of spiritual care to nursing practice and whether spirituality is currently considered in education. To this end a quantitative research design, will be utilized to survey the views of professional nurses at select public hospitals in KwaZulu-Natal through a process of multiphase random sampling.

I kindly request permission to use your hospitals in order to access the views of professional nurses. I require a letter of support from you in accordance to our Provincial Department of health. I have already obtained provisional ethical clearance from Durban University of Technology. Kindly find attached a copy of my proposal, questionnaire, letter of information and consent for your information.

My intention is to survey 176 professional nurses at each hospital using questionnaires. Professional nurse will be invited to volunteer to take part in my survey. There will be no physical or emotional risks involved. Information will be confidential. No benefits will be given for their participation. They may withdraw from the survey whenever they want to, with no penalties. If you have any questions or concerns, kindly contact either me, my supervisor or the Institutional Ethics administrator on the telephone numbers below.

Thank you for your consideration of this matter and I look forward to hearing from you at your earliest convenience.

Yours sincerely
Sandhya Chandramohan.
Student No.21240208
Contact details: 033 8973523 (work), 033 3915379 (home), 0837915379 (Cell) or
sandhyachandramohan@yahoo.com (email).

Supervisor: Dr. Raisuyah Bhagwan
Contact details: 0313732197 or bhagwanr@dut.ac.za (email).

The Institution Research Ethics administrator: 031 373 2900.
Complaints can be reported to the DVC: TIP, Prof. Otieno on 031 373 2382 or dvctip@dut.ac.za.

health

Department:
Health
PROVINCE OF KWAZULU-NATAL

GREY'S HOSPITAL
OFFICE OF THE CHIEF EXECUTIVE OFFICER
Private Bag X9001, Pietermaritzburg, 3200
Town Bush Road, Chase Valley, Pietermaritzburg
Tel.: 033 897 3321, Fax.: 033 3422 324
Email.: sandy.sivrathan@kznhealth.gov.za
www.kznhealth.gov.za

Reference: Research
Enquiries : Dr K B Bilenge
Telephone : (033) 897 3321

27 September 2012

Sandhya Chandramohan

Per email : sandhyachandramohan@yahoo.com

Dear Ms Chandramohan,

RE : PERMISSION TO CONDUCT SURVEY AT GREY'S HOSPITAL

I have pleasure in informing you that permission has been granted to you by the Hospital CEO to conduct a survey with professional nurses at Grey's Hospital. .

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. **This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.**
3. Please ensure this office is informed before you commence your research.
4. The Hospital will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the Hospital CEO.

Regards,

[redacted]

DR K. B. BILENGE
ACTING CHIEF EXECUTIVE OFFICER
GREYS HOSPITAL

Appendix 6.3

35 Vedic Crescent
Darjeeling heights
Pietermaritzburg, 3201
10/09/2012

The Hospital Manager: Mr T.A. Mtshali
Madadeni Hospital
Private Bag 6642
Newcastle

Re: Request to survey professional nurses at the following provincial hospitals in KwaZulu-Natal: Addington Hospital, Greys Hospital, Madadeni Hospital, Ngwelenzana Hospital and Port Shepstone Hospital.

Dear Sir /Madam

I am a lecturer in Nursing Education at Greys Campus, Pietermaritzburg, pursuing the following degree: Master of Technology in Nursing at the Durban University of Technology.

The purpose of this current study is to explore nursing practitioners' views on the role of spirituality in nursing, the salience of spiritual care to nursing practice and whether spirituality is currently considered in education. To this end a quantitative research design, will be utilized to survey the views of professional nurses at select public hospitals in KwaZulu-Natal through a process of multiphase random sampling.

I kindly request permission to use your hospitals in order to access the views of professional nurses. I require a letter of support from you in accordance to our Provincial Department of health. I have already obtained provisional ethical clearance from Durban University of Technology. Kindly find attached a copy of my proposal, questionnaire, letter of information and consent for your information.

My intention is to survey 107 professional nurses at each hospital using questionnaires. Professional nurse will be invited to volunteer to take part in my survey. There will be no physical or emotional risks involved. Information will be confidential. No benefits will be given for their participation. They may withdraw from the survey whenever they want to, with no penalties. If you have any questions or concerns, kindly contact either me, my supervisor or the Institutional Ethics administrator on the telephone numbers below.

Thank you for your consideration of this matter and I look forward to hearing from you at your earliest convenience.

Yours sincerely
Sandhya Chandramohan.
Student No.21240208
Contact details: 033 8973523 (work), 033 3915379 (home), 0837915379 (Cell) or
sandhyachandramohan@yahoo.com (email).

Supervisor: Dr. Raisuyah Bhagwan
Contact details: 0313732197 or bhagwanr@dut.ac.za (email).

The Institution Research Ethics administrator: 031 373 2900.
Complaints can be reported to the DVC: TIP, Prof. Otieno on 031 373 2382 or dvctip@dut.ac.za.

health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Tel:034 –3288137
Fax:034 –3291595
Email:Happy.Khanyi@kznhealth.gov.za
www.kznhealth.gov.za

TO	:	**Chandramohan Sandhya 21240218**
		Durban University of Technology
FROM	:	**MRS HSL KHANYI**
		MADADENI PROVINCIAL HOSPITAL
DATE	:	**2012-10-09**
RE	:	**Research study spirituality and spiritual care amongst nurses at public hospitals**
INDEX	:	
Enquiries	:	**HSL Khanyi, DMN**

Attention: Mrs. Chandramohan

Your application to conduct a 'research on spirituality and amongst professional nurses at public hospital ' is supported.

Wishing you all the best in your studies.

THE HOSPITAL MANAGER
DEPARTMENT OF HEALTH
MADADENI HOSPITAL
ACCOUNT
2012 -10- 25
PRIVATE BAG X6642
NEWCASTLE, 2940

[redacted]

CEO
Mr TA Mtshali
Madadeneni Hospital

Appendix 6.4

35 Vedic Crescent
Darjeeling heights
Pietermaritzburg, 3201
10/09/2012

The Hospital Manager: Dr T.T. Khanyile
Ngwelezana Hospital
Private Bag X20021
Empangeni, 3880

Re: Request to survey professional nurses at the following provincial hospitals in KwaZulu-Natal: Addington Hospital, Greys Hospital, Madadeni Hospital, Ngwelenzana Hospital and Port Shepstone Hospital.

Dear Sir /Madam

I am a lecturer in Nursing Education at Greys Campus, Pietermaritzburg, pursuing the following degree: Master of Technology in Nursing at the Durban University of Technology.

The purpose of this current study is to explore nursing practitioners' views on the role of spirituality in nursing, the salience of spiritual care to nursing practice and whether spirituality is currently considered in education. To this end a quantitative research design, will be utilized to survey the views of professional nurses at select public hospitals in KwaZulu-Natal through a process of multiphase random sampling.

I kindly request permission to use your hospitals in order to access the views of professional nurses. I require a letter of support from you in accordance to our Provincial Department of health. I have already obtained provisional ethical clearance from Durban University of Technology. Kindly find attached a copy of my proposal, questionnaire, letter of information and consent for your information.

My intention is to survey 103 professional nurses at each hospital using questionnaires. Professional nurse will be invited to volunteer to take part in my survey. There will be no physical or emotional risks involved. Information will be confidential. No benefits will be given for their participation. They may withdraw from the survey whenever they want to, with no penalties. If you have any questions or concerns, kindly contact either me, my supervisor or the Institutional Ethics administrator on the telephone numbers below.

Thank you for your consideration of this matter and I look forward to hearing from you at your earliest convenience.

Yours sincerely
Sandhya Chandramohan.
Student No.21240208
Contact details: 033 8973523 (work), 033 3915379 (home), 0837915379 (Cell) or
sandhyachandramohan@yahoo.com (email).

Supervisor: Dr. Raisuyah Bhagwan
Contact details: 0313732197 or bhagwanr@dut.ac.za (email).

The Institution Research Ethics administrator: 031 373 2900.
Complaints can be reported to the DVC: TIP, Prof. Otieno on 031 373 2382 or dvctip@dut.ac.za.

MEMORANDUM

No2 Lood Avenue, Cnr Chrome & Crescent Avenue Empangeni Rail
Private Bag X 20034, Empangeni, 3880
Tel.: 035 7870631/3/4/5/6/7/8/9, Fax: 035 7870644/0865176012
Email: Secretary.UthunguluDistrictOffice@kznhealth.gov.za
www.kznhealth.co.za

HEALTH
KwaZulu-Natal

OFFICE OF THE DISTRICT MANAGER

Enquiries: MM ZUNGU

TO	:	PRINCIPAL INVESTIGATOR/S/RESEARCHER: SANDHYA CHANDRAMOHAN (B Cur DEGREE) CO-INVESTIGATOR/S/SUPERVISOR DR. RAISUYAH BHAGWAN (PHD)
EMAIL	:	Sandhya.Chandramohan@kznhealth.gov.za
FROM	:	DISTRICT MANAGER
DATE	:	19 October 2012
SUBJECT	:	SPIRITUALITY AND SPIRITUAL CARE AMONGST PROFESSIONAL NURSES AT PUBLIC HOSPITALS IN KWAZULU-NATAL

I have pleasure in informing you that permission has been granted to you by the District Office to conduct research on **"Spirituality and Spiritual Care Amongst Professional Nurses at Public Hospitals in KwaZulu-Natal"**

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. The District Office will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the District Office.

Thanking you

[redacted]

MR MM ZUNGU
DISTRICT MANAGER
UTHUNGULU

NB: KINDLY RETURN ALL DOCUMENTATION WHEN REPLYING!!

Appendix 6.5

35 Vedic Crescent
Darjeeling heights
Pietermaritzburg, 3201
10/09/2012

The Hospital Manager: Mr G.B.C Khawula
Port Shepstone Hospital
Private Bag X5706
Port Shepstone

Re: Request to survey professional nurses at the following provincial hospitals in KwaZulu-Natal: Addington Hospital, Greys Hospital, Madadeni Hospital, Ngwelenzana Hospital and Port Shepstone Hospital.

Dear Sir /Madam

I am a lecturer in Nursing Education at Greys Campus, Pietermaritzburg, pursuing the following degree: Master of Technology in Nursing at the Durban University of Technology.

The purpose of this current study is to explore nursing practitioners' views on the role of spirituality in nursing, the salience of spiritual care to nursing practice and whether spirituality is currently considered in education. To this end a quantitative research design, will be utilized to survey the views of professional nurses at select public hospitals in KwaZulu-Natal through a process of multiphase random sampling.

I kindly request permission to use your hospitals in order to access the views of professional nurses. I require a letter of support from you in accordance to our Provincial Department of health. I have already obtained provisional ethical clearance from Durban University of Technology. Kindly find attached a copy of my proposal, questionnaire, letter of information and consent for your information.

My intention is to survey 95 professional nurses at each hospital using questionnaires. Professional nurse will be invited to volunteer to take part in my survey. There will be no physical or emotional risks involved. Information will be confidential. No benefits will be given for their participation. They may withdraw from the survey whenever they want to, with no penalties. If you have any questions or concerns, kindly contact either me, my supervisor or the Institutional Ethics administrator on the telephone numbers below.

Thank you for your consideration of this matter and I look forward to hearing from you at your earliest convenience.

Yours sincerely
Sandhya Chandramohan.
Student No.21240208
Contact details: 033 8973523 (work), 033 3915379 (home), 0837915379 (Cell) or
sandhyachandramohan@yahoo.com (email).

Supervisor: Dr. Raisuyah Bhagwan
Contact details: 0313732197 or bhagwanr@dut.ac.za (email).

The Institution Research Ethics administrator: 031 373 2900.
Complaints can be reported to the DVC: TIP, Prof. Otieno on 031 373 2382 or dvctip@dut.ac.za.

health

Department:
Health
PROVINCE OF KWAZULU-NATAL

PORT SHEPSTONE REGIONAL HOSPITAL
Private Bag X5706, PORT SHEPSTONE 4240
11 Bazley Street, PORT SHEPSTONE 4240
TEL: 039 688 6208
FAX: 039 682 1514
melinda.cranzi@kznhealth.gov.za
www.kznhealth.gov.za

Reference: 2/7
Enquiries: Mr. GBC Khawula
Telephone: (039) 688 6208

15th October 2012

Chairperson: Research Committee
KZN Department of Health
Private Bag 9051
PIETERMARITZBURG
3200

RE: PERMISSION TO SURVEY PROFESSIONAL NURSES : SPIRITUALITY AND SPIRITUAL CARE AMONGST PROFESSIONAL NURSES AT PUBLIC HOSPITALS IN KWA-ZULU-NATAL

OBJECT

To grant permission for Mrs. Sandhya Chandramohan to do a survey on spirituality and spiritual care amongst Professional Nurses at Public Hospitals in KwaZulu-Natal.

SUPPORTING DOCUMENTS

Appended hereto is documentation received from the Durban University of Technology.

OFFER OF SUPPORT

This office wishes to inform the Committee that the proposed survey to be conducted by Mrs. Chandramohan is wholly supported. There are no financial implications.

RECOMMEDATION

In view of Mrs. Chandramohan request I recommend the necessary authority be granted by the Research Committee for Mrs. Chandramohan to continue with her research.

Submitted for your attention and further action.

Yours sincerely

[redacted]

MR GBC KHAWULA
CHIEF EXECUTIVE OFFICER

PORT SHEPSTONE HOSPITAL
BAZLEY STREET
P/BAG X[illegible] SHEPSTONE 4240
2012 -10- 16
HOSPITAL MANAGER'S OFFICE

Appendix 7

35 Vedic Crescent
Darjeeling heights
Pietermaritzburg, 3201

10/09/2012

The Interim Chairperson
The Provincial Health Research and Knowledge Management Committee
Department of Health, KwaZulu-Natal
Private Bag X9051
Natalia
Pietermaritzburg
3201

Re: Request to survey professional nurses at the following provincial nurse training hospitals in KwaZulu-Natal: Addington hospital, Greys hospital, Madadeni hospital, Ngwelezana hospital and Port Shepstone hospital.

Dear Sir/Madam

I am a lecturer at Greys Nursing Campus, Pietermaritzburg pursuing the following degree: Master of Technology in Nursing at the Durban University of Technology.

My topic is Spirituality and spiritual care amongst professional nurses at public hospitals in KwaZulu-Natal.The purpose of this current study is therefore to explore nursing practitioners' views on the role of spirituality in nursing, the salience of spiritual care to nursing practice and whether spirituality is currently considered in education. To this end a quantitative research design, will be utilized to survey the views of professional nurses at select public hospitals accredited with the South African Nursing Council for practical nurse training in the comprehensive nursing Diploma through a process of multiphase random sampling.

I request permission to use the above-mentioned provincial nurse training hospitals in order to access the views of 550 registered nurses. The hospital management of these hospitals has provisionally agreed (see letters of support- Appendices 6.1 to 6.2) pending your approval. I have obtained ethical clearance from Durban University of Technology No 47/12. Please find attached a copy of my proposal, research questionnaire, letter of information, consent form and the ethical approval letter for your information.

Professional nurse from the above mentioned hospitals will be invited to volunteer to take part in the survey. There will be no physical or emotional risks involved. Information will be confidential. The nursing Service Managers will be asked to assist with the distribution and collection of questionnaires. No benefits will be given for their participation. They may withdraw from the study when ever they want to, with no penalties.

If you have any questions or concerns, kindly contact either me or my supervisor on the telephone numbers below.

Thank you for your consideration of this matter and I look forward to hearing from you at your earliest convenience.

Yours sincerely
Sandhya Chandramohan.
Student No.21240208
Contact details: 0338973523 (work), 033 3915379 (home), 0837915379 (cell) and
sandhyachandramohn@yahoo.com (email).
Supervisor: Dr. Raisuyah Bhagwan
Contact details: 0313732197

The Institutional Research Ethics administrator: 031 373 2900.
Complaints can be reported to the DVC: TIP, Prof F. Otieno on 031 373 2382 or dvc@dut.ac.za

health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Health Research & Knowledge Management sub-component
10 – 103 Natalia Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg
3200
Tel.: 033 – 3953189
Fax.: 033 – 394 3782
Email.: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference : HRKM 158/12
Enquiries : Mr X Xaba
Tel : 033 – 395 2805

Dear Mrs S. Chandramohan

Subject: Approval of a Research Proposal

1. The research proposal titled **'Spirituality and spiritual care amongst professional nurses at public hospitals in KwaZulu Natal'** was reviewed by the KwaZulu-Natal Department of Health.

   The proposal is hereby **approved** for research to be undertaken at Madadeni, Grey's, Addington, RK Khan, Port Shepstone and Ngwelezana Hospital.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified facility before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

[redacted]

Dr E Lutge
Chairperson, Health Research Committee
Date: 05/11/2012

DURBAN UNIVERSITY of TECHNOLOGY

STATISTICIAN DECLARATION FOR CONSULTATION:

I, Deepak Singh have read Sandhya Chandramohan's Masters proposal (student no: 21240218) and given her appropriate recommendations in terms of sample size and type of sampling method.

Signed..... **Date** 19 April 2012