SPIRITUAL CARE IN AUSTRALIAN GENERAL PRACTICE NURSING: AN INTERPRETIVE DESCRIPTIVE STUDY

by

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CONTENTS

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ABBREVIATIONS

ABS	Australian Bureau of Statistics
AHPRA	Australian Health Practitioner Regulation Agency
ANMF	Australian Nursing and Midwifery Federation
APNA	Australian Primary Health Nurse Association
CINAHL	Cumulative Index of Nursing and Allied Health Literature
GP	General Practitioner
GPMP & TCA	General Practitioner Management Plan & Team Care Arrangement, also called 'care plan'.
NMBA	Nursing and Midwifery Board of Australia
PN	Practice Nurse
PRISMA	Preferred Reporting Items for Systematic reviews and Meta-Analyses
RACGP	Royal Australian College of General Practitioners
SBREC	Social and Behavioural Research Ethics Committee
SNAP	Smoking, Nutrition, Alcohol consumption, Physical Activity

ABSTRACT

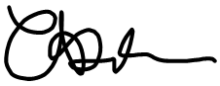
The subject of spiritual caring in nursing has attracted increasing interest over the past 20-30 years. Research on the topic has taken place predominantly in the acute or palliative care sectors. Studies of nurses who work in General Practice (known as Practice Nurses) are not evident. Using an Interpretive Descriptive study design, data was collected from nurses working in General Practices within Australia, to gain an understanding about how they view spirituality and spiritual care and contains descriptions about their spiritual care experiences. Four themes were elicited from the findings: 1. The individualised importance of spiritualty and spiritual care. 2. Spiritual care as an aspect of person-centred care. 3. Person-centred spiritual care practice. 4. Barriers and enablers to addressing spiritual needs. Participants identified that Practice Nurses require better education about spirituality and how to address spiritual needs; as well as the capacity and tools to be able to incorporate spiritual care into clinical practice. They also identified that in order to facilitate spiritual care, documentation templates used in General Practice should include prompts to address spiritual and/or religious needs.

DECLARATION

I certify that this thesis:

1. does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university; and

2. to the best of my knowledge and belief, does not contain any material previously published or written by another person except where due reference is made in the text.

Signed 

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Embarking on a Masters in nursing degree began with Divine inspiration and as a memorial to my late mother and father who had great faith in me as a nurse and encouraged all my endeavours.

Staying the course has only been possible with the support of husband, supervisors, family and work colleagues; as well being convicted of the Divine calling to complete it.

A big thankyou to my two amazing, encouraging and patient supervisors Claire Verrall and Dr Dean Whitehead

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CHAPTER 1

INTRODUCTION

1.1 Overview

The Australian General Practice setting provides the context for this study which explores the understanding Practice Nurses have about spirituality and spiritual care, and their experiences of integrating spiritual care into their practice. This chapter provides a contextual background to the topic, identifies potential gaps in the literature and introduces the study's significance, aims and objectives. Definitions of terms used in the study are also explored. Briefly however, Practice Nurse (PN) is the term given to a nurse registered with the Australian Health Practitioner Regulation Agency (AHPRA) and working in a General Practice. The literature indicates that the diverse settings in which nurses work influence the extent to which spiritual care is practiced. This diversity is introduced here and explored further in chapter two with an overall focus on the General Practice environment. This chapter will conclude with a brief outline of the remaining chapters.

1.2 Background

Many authors have documented the importance of spiritual health to overall health and well-being as indicated by Puchalski, Vitillo, Hull, and Reller (2014). Much has been written about the role of spirituality in health and healing: the historical context, the diminishing view of the role of spiritual health in general well-being during the scientific era of the 18th and 19th centuries and the reignited interest in the topic over the last five or six decades (Ross, 2010). Incorporating spiritual care into nursing practice happens inconsistently across the globe and is yet to be supported by universal evidence-based nursing practice guidelines. The development of such guidelines has been hindered due to a lack of universal agreement about spirituality and spiritual care definitions; attributed mainly to the subjective and individual nature of both; as well as the diversity of meaning and significance of spirituality and spiritual care within different cultures (Egan et al., 2011; Rushton, 2014). The way spirituality is described seems to depend on the lens through which people view it; from a fundamentalist religiosity to a more philosophical existentialist view about the values of hope and meaning (Polzer Casarez & Engebretson, 2012; Tacey, 2020). Swinton (2010) describes the multi-faceted character of spirituality which includes what he identifies as generic, biological and religious approaches, whilst Narayanasamy (2010) offers a succinct

definition: *'spirituality is the essence of our being and one that gives meaning and purpose to our existence' (p. 37*). Descriptors commonly used in other definitions are *essence, meaning and purpose.* A broad, culturally inclusive definition of spirituality which has thus been chosen to inform this study, was devised at the 2013 International Consensus Conference on improving the Spiritual Dimension of Whole Person Care:

> *'Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices.' (Puchalski et al., 2014 p. 646)*

In a culturally diverse country such as Australia, it is reasonable to expect that *beliefs, values traditions and practices* will be equally diverse (Hilbers, Haynes, & Kivikko, 2010). According to the Australian Bureau of Statistics (ABS), 29.7% of the Australian population in 2019 was born overseas, with every country in the world represented. England, China and India are the top three countries of origin (Australian Bureau of Statistics, 2019). Practice Nurses in Australia thus encounter patients with diverse cultural and socio-economic backgrounds, as well as diverse spiritualities and/or religious affiliations.

The spiritual dimension of care is identified by many authors as being an aspect of holistic or person-centre care. Holistic care is defined as: *'care that incorporates the whole of a person, that is, physical, psychological, emotional, and spiritual dimensions.'* (Farlex Inc, 2012). In Australia, the Nursing and Midwifery Board of Australia (NMBA) nursing standards for practice use the term 'person-centred practice' described as:

> *'collaborative and respectful partnership built on mutual trust and understanding through good communication. Each person is treated as an individual with the aim of respecting people's ownership of their health information, rights and preferences while protecting their dignity and empowering choice. Person-centred practice recognises the role of family and community with respect to cultural and religious diversity.'* (AHPRA, 2016, p. 6).

The practice standards for nurses in General Practice are an addition to the NMBA standards for all nurses and provide a framework for PNs to understand and adhere to the core principles of primary health care, local population health and needs, and the impact of the social determinants of health (Australian Nursing and Midwifery Federation, 2014). McMurray and Clendon (2015) identify the social determinants as: *'biology, genetic*

characteristics; healthy child development; social support networks; education, literacy; employment and working conditions; social environments; physical environments; health practices, coping skills; health services, resources; gender, culture' (p. 10). Practice Nurses therefore, need to be mindful of all influences that may be impacting a person's health and well-being, including spirituality. The nursing practice standards, which allude to addressing spiritual needs, fall short of providing any guidelines about how a nurse might spiritually care for a patient. It is clear in the literature that addressing spiritual needs is as important as addressing physical, emotional, environmental, social and mental health needs (Harrington, 2016; Minton, Isaacson, Varilek, Stadick, & O' Connell-Persaud, 2018). What is also evident in the literature is that the spiritual dimension of care is the least practiced (Ross & McSherry, 2010).

General Practitioners with whom PNs work are often guided by The Royal Australian College of General Practitioners (RACGP) which has guidelines briefly indicating the importance of spiritual well-being in the aged and palliative care sectors (RACGP, 2008). For nurses in Australia there is currently no spiritual care practice guideline, unless they work in aged or palliative care; and limited studies in general on the topic of spiritual care in Australian nursing practice (Cooper, Chang, Sheehan, & Johnson, 2013). It is unknown how PNs address the spiritual needs of patients. This was the impetus for this study which explores what PNs in Australia think about spirituality, their understanding of spiritual care, whether spiritual care is part of their practice and what enables or prevents them from providing it.

1.3 Significance of the study

The topic of spiritual care in nursing has gained increasing interest over the last four decades (Cockell & McSherry, 2012), but research findings indicate that spiritual care is not yet universally practiced by nurses. Furthermore, there is a paucity of studies in primary care settings; specifically, General Practice. Understanding what spirituality and spiritual care mean for nurses working in General Practice and how providing such care might be incorporated into their practice of person-centred care will add to the growing body of knowledge of the topic of spiritual care in nursing. Through the application of a qualitative methodology, rich, descriptive data will be compiled from the self-described experiences of PNs, adding unique detail to the profile of spiritual care in nursing in Australia. The purpose of this study therefore, is to explore how nurses working in General Practices in Australia

incorporate spiritual care into their work. The following are definitions of terms that give context to this study.

1.4 Definition of terms

1.4.1 Spirituality and Religion

The definition quoted previously by Puchalski et al. (2014) encapsulates the commonly used terms of meaning, purpose, inner strength, belief and connectedness. In a study by Harrington and colleagues which explored spirituality in older persons in Australian care facilities, connectedness emerged as a common theme (Harrington, Williamson, & Goodwin-Smith, 2018). This is a departure from the findings of Harrington's seminal study which revealed the majority of nurses (n=20, made up of nurses from South Australian acute and palliative care settings) believed spirituality was closely related to religion (Harrington, 1993). Religion and spirituality are variously considered in the literature as either separate entities or interchangeable terms. Religion is often described in terms of doctrines, rituals, structure, and rules (Bouma, 2009; Swinton, 2010). Tacey (2020) notes that the true meaning of religion as being reconnection to the sacred or numinous, has been somewhat lost. Polzer Casarez and Engebretson (2012) note the interchangeability of 'spirituality' and 'religion' often seen in the literature. They go on to show that the two terms, though related, are different. The spirit is essentially the life of a person whereas religion is about belief systems and related rituals. Koenig (2012) uses the terms interchangeably, as does the recently published Handbook of Spirituality, Religion and Mental Health (*Rosmarin, D., & Koenig, H,* 2020). However, whilst Koenig's definitions of the two terms are quite similar, the Handbook notes them as two different constructs. The contributors have chosen to use the terms interchangeably as a concession to public opinion. This is somewhat interesting in light of what Suchanek (2006-2019) notes about non-religious atheists believing humans are spiritual beings.

Spiritual distress is a term frequently seen in the literature. (Aghadiuno, 2010; Narayanasamy, 2010). Described by the North American Nursing Diagnosis Association, the signs of spiritual distress include feelings of worthlessness, resentment, and hopelessness, fear, anger and existential questions about life, suffering and death (McSherry, 2010). Similar descriptors are found in the DSM-IV, the Diagnostic and Statistical Manual of Mental Disorders, under the category 'religious or spiritual problem' (Aghadiuno, 2010) .

1.4.2 Spiritual care

Definitions of spiritual care have been as many and varied as definitions of spirituality. Baldacchino (2006) suggests spiritual care is *being* rather than doing. It is found in how nurses interact with patients and in how nurses use themselves in nurse-patient relationships. In a collection of stories from nurses compiled by Lally and Costello (2013), the view that nursing has a strong spiritual dimension within its very nature, is common among the contributors and concurs with Baldacchino's (2006) view that spiritual care is inherent in nursing care. Spiritual care can encompass a range of activities from sitting quietly, being present with a person, actively listening to the patient's story, through to prayer, referral to a pastoral care worker or reading passages of Scripture (Anandarajah & Hight, 2001; Puchalski, 2001).

Battey (2009) suggests that plans of care to address spiritual needs of patients should be based on the patient's own definition of spirituality, rather than any religious or philosophical definition. She goes on to suggest that nurses can give spiritual care by addressing the aspects of beliefs, values, meanings, goals and relationships, which may be affecting the health and well-being of the patient. This sensitive and respectful approach is echoed by McSherry (2010) and Narayanasamy (2010). Such an approach would appropriately meet the previously described NMBA nursing standards for person-centred care (AHPRA, 2016). McSherry (2010) suggests spiritual care involves the *'interaction of one human being with another within a caring relationship and therapeutic environment' (p. 61).*

Spiritual care responds to spiritual needs, identified by Narayanasamy (2010) as including *'being connected, being respected, being appreciated, having the opportunity to love and be loved, being known and accepted, being compassionate, giving, sharing, and being productive and successful and hopeful.' (p. 38)*. Identifying needs involves making an assessment. Govier (2000) and McSherry (2010) cite the work of Ruth Stoll who in 1979 pioneered a tool for nurses to make spiritual assessments. The tool she designed, involved asking questions relating to four areas: 1. Concept of God or deity; 2. Sources of hope and strength; 3. Religious practices; 4. Relationship between spiritual beliefs and health. Govier (2000) and McSherry & Ross (2002) note that Stoll's approach mostly suited those with religious affiliations. McSherry (2010) identifies that Stoll's tool provided a template for later

spiritual care assessment tools, which sought to be less metaphysical in approach and more existential; focussing more on a person's source of strength and hope.

Spiritual care is written into healthcare policies and/or nursing guidelines in some countries including New Zealand (Egan et al., 2011) , United Kingdom (McSherry & Ross, 2002), Malta (Baldacchino, 2006), The Netherlands (Groot et al., 2017) and United States of America (Battey, 2009). In Australia spiritual care guidelines are currently provided for the aged care sector and endorsed by Palliative Care Australia (Meaningful Ageing Australia, 2016,; Palliative Care Australia & Meaningful Ageing Australia, 2017). The Aged Care guidelines cite McSherry when describing the balance between the art and science of spiritual care. The art is found in qualities such as sensitivity, meaningful connection, warmth and empathy. The science is found in the more clinical and technical aspects that can be measured, as in outcomes, indicators, evidence and work in progress (Meaningful Ageing Australia, 2016, p. 6).

1.4.3 Australian spirituality

Whilst it is not the chief purpose of this study to analyse Australian spirituality, it is the view of the author that it impacts spiritual care giving in health care in this country. Giving some definition to Australian spirituality sets it apart from its British, and American counterparts (Bouma, 2009). Australia has a diverse multi-cultural population and as a result a diverse spirituality with every country in the world represented in the population (Australian Bureau of Statistics, 2019). Additionally, the Australian Aborigines have the world's oldest continuing culture, rich in spiritual connections to the land (Tacey, 2020, pp.82-86). Unlike New Zealand where Maori influence pervades all aspects of life and culture (Egan et al., 2011), the Australian constitution does not yet recognise its First Peoples; a situation awaiting a referendum in order to be remedied (Australian Human Rights Commission, n.d.).

The arrival of the First Fleet in Botany Bay in 1788 included 1100 convicts. The new colony was designated a penal colony for convicts between 1788 and 1868 (National Museum Australia, 2020). The spiritual well-being of the transported convicts was barely an afterthought (Frame, 2009) in an era when science had more credibility than the Church (Tacey, 2020). This compares to the USA which Frame (2009) notes, anchors its spirituality in the arrival of the Pilgrim Fathers who were fleeing religious persecution. Religion, which can be seen as a subset of spirituality (Donesky, Sprague, & Joseph, 2020), is declining in priority

for Australians with an increase in people selecting ''no religion'' in the five-yearly census up to 30% in 2016 (Australian Bureau of Statistics, 2018). This was similar to the findings of the 2019 Australian Community Survey run by National Church Life Survey research, which found 35% of Australians identified as neither religious nor spiritual (Powell, 2019). In 2017 the number was slightly less at 32% (McCrindle, 2017). These statistics may have a bearing on the importance PNs place on spiritual care in their work, as well as the importance of spiritual health to patients.

1.4.4 General Practice and Practice Nurse (PN)

General Practices in Australia are mostly run as private fee-for-service businesses and range from small single doctor practices to large corporately owned, multi-site super-clinics. Fees received by General Practitioners (GPs) may be solely through rebates paid by the Australian government's Medicare Benefit Schedule or with an additional gap payment remitted by the patient (Department of Health, 2019). According to Heywood and Laurence (2018) 63% of General Practices in Australia in 2012 employed nurses. They note that PNs, are major contributors to primary health care services. More recent figures indicate that this has increased to 91% in 2018, with approximately 6300 general practices in Australia employing, on average, 3.3 nurses per practice (The Royal College of General Practitioners, 2018).

Person-centred care, promoting health, educating people about their lifestyle choices and the effect on health are tenets of primary health care which is an area of focus in Australian health reform, The National Chronic Disease Strategy, and Australia's long term health plan (Adrian, 2009; Department of Health, 2019; National Health Priority Action Council (NHPAC), 2005). The base aim of these plans is to ease the financial burden on the healthcare budget by reducing hospitalisations. General Practice, which is most often the first point of contact for many people when ill, has been transitioning from a predominantly traditional medical model of fixing or curing to a primary health care model, which includes activities such as chronic disease risk assessments and addressing chronic disease through self-management and integrated care (Adrian, 2009). This integrated care can include a number of allied health professionals, but as the author has experienced, does not include a spiritual care professional such as a pastoral care worker, chaplain, or other spiritual or religious leader. Practice Nurses play a pivotal

role in chronic disease management, and promoting health and well-being within General Practice (Australian Medicare Local Alliance, 2012). The scope of practice for nurses working in General Practice varies, depending on the skill set of the nurse, the needs of the practice population and what practice management allows. McInnes, Peters, Bonney, and Halcomb (2017) found in their study of the PN role that there is a shortfall among GP understanding of the PN's scope of practice. It may be possible that providing spiritual care, which currently attracts no remuneration, is a low priority in an income generating business.

1.5 Aim and objectives

The aim of the study is to explore PNs' experiences of spiritual caring in the Australian General Practice setting. To achieve this, volunteer participant PNs will be asked to describe their understanding of spirituality and their experiences of providing spiritual care. Interpretive Descriptive strategies will be employed to examine the findings and interpret them alongside what is known about spirituality and spiritual caring.

1.5.1 Personal justification

Personal interest in the topic began in 2012 during study for a Diploma of Ministry, when subject readings highlighted Australian statistics on the declining interest in religion in Australia. Concurrent study of the increasing burden of chronic disease in Australia evoked reflections about whether there might be a spiritual poverty among Australians which lessens their inner strength and resilience, making them more vulnerable to chronic illness. The author's experience working as a PN in a small suburban General Practice clinic, brought about a desire to see the inclusion of spiritual needs with the other 'SNAP' lifestyle choices: Smoking, Nutrition, Alcohol, Physical activity (The Royal College of General Practitioners, 2015). The author was able to add 'psychosocial and spiritual needs' to the workplace template used for chronic disease management planning, otherwise known as a GP Management Plan & Team Care Arrangement or care plan (an extract is shown in Figure 1, p. 16). This section, as with others in the care plan, is customised to meet the patient's goals and needs. These experiences led to the research question about what experiences PNs in Australia have had in providing spiritual care.

Figure 1 - Extract of a GP Management Plan & Team Care Arrangement template

Patient's Name: <<Patient Demographics: Full Name>>

GP MANAGEMENT PLAN & TEAM CARE ARRANGEMENT			
Patient problems / needs / relevant conditions	**Goals - changes to be achieved**	**Required treatments and services including patient actions, health education**	**Arrangements for treatments/services (when, who, contact details)**
5. Other			
psychosocial & spiritual health	1. Maintain a sense of wellbeing & ability to face challenges 2. Find meaning & purpose in life 3. Mental well-being	•Weekly engage in activity which feeds your soul •Get regular fresh air & sunshine •Use relaxation & meditation techniques to manage stress •Do something to help others - volunteer •Practice an attitude of gratitude, •Cultivate a healthy thought life; Laugh everyday •read, listen to or watch inspirational material •Mental Health plan •Psychology referral	self, GP psychologist:

Adapted 1/12/11 by Christine Schreiber from template by Monash Division of General Practice, March 2006; edited 19/1/19

1.6 Chapter Summary & Thesis Chapter Overview

This chapter has introduced the topic of spiritual care in Australian General Practice nursing. Background and definitions have revealed the importance of spiritual care to overall health and well-being, it's place as an aspect of person-centred care, and the differences of General Practice nursing and Australian spirituality which may mean findings from studies in other settings are not transferable.

In chapter 2, a review of the literature will be described and appraised. Chapter 3 will explain why Interpretive Description is the chosen methodology. The methods of recruitment, data collection and data analysis will be explained. Research integrity, trustworthiness and ethical issues are also discussed. The findings will be described in chapter 4, followed by a discussion of the findings, study limitations, recommendation for practice and thesis conclusion in chapter 5.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

In order to explore the experiences of PNs in providing spiritual care, it is necessary to draw on the findings of published studies which have investigated spiritual caring in nursing. Common perspectives in the literature include: the contexts in which nurses work – locality and/or field of nursing (Van Leeuwen & Schep-Akkerman, 2015), the understandings and perceptions nurses have of spirituality and spiritual care (McSherry & Jamieson, 2011), and the barriers and enablers to providing spiritual care (Jones, Dorsett, Briggs & Simpson, 2018).

This chapter outlines the search criteria and data bases used and examines the findings of twenty-two articles chosen for their relevance to the research question. A Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) flow diagram illustrates the process used to source these articles. Each article is listed by author and date on a literature review summary table which is included in the appendices [Appendix 1]. Summarised on the table are each study's purpose, methodology, setting and sample, main findings, plus relevance and implications for practice. Four key themes emerged from the appraised studies and will be discussed further in this chapter. The chapter concludes with a review of the research question, an identification of the gaps within the literature and an introduction to chapter three: Methodology and Methods.

2.2 Background

Florence Nightingale considered caring for the spiritual needs of patients as important because to care holistically for a person is to care for body, mind and soul (Minton, Isaacson, Varilek, Stadick, & O' Connell-Persaud, 2018). As scientific discovery became the principle influence on health care practice, providing spiritual care was seen as less important (Ross, 2010). However, interest in spiritual care in nursing has become more prominent over the past thirty years. For example, in a review of the literature, Ross (2006) found 45 original studies published in English between 1983 and October 2005. This compares to the *143* original studies found in a literature review by Cockell and McSherry (2012) of studies published between 2006 and 2010 using the same databases and search terms as those used by Ross. Researchers have commonly explored nurses' perceptions of spirituality and

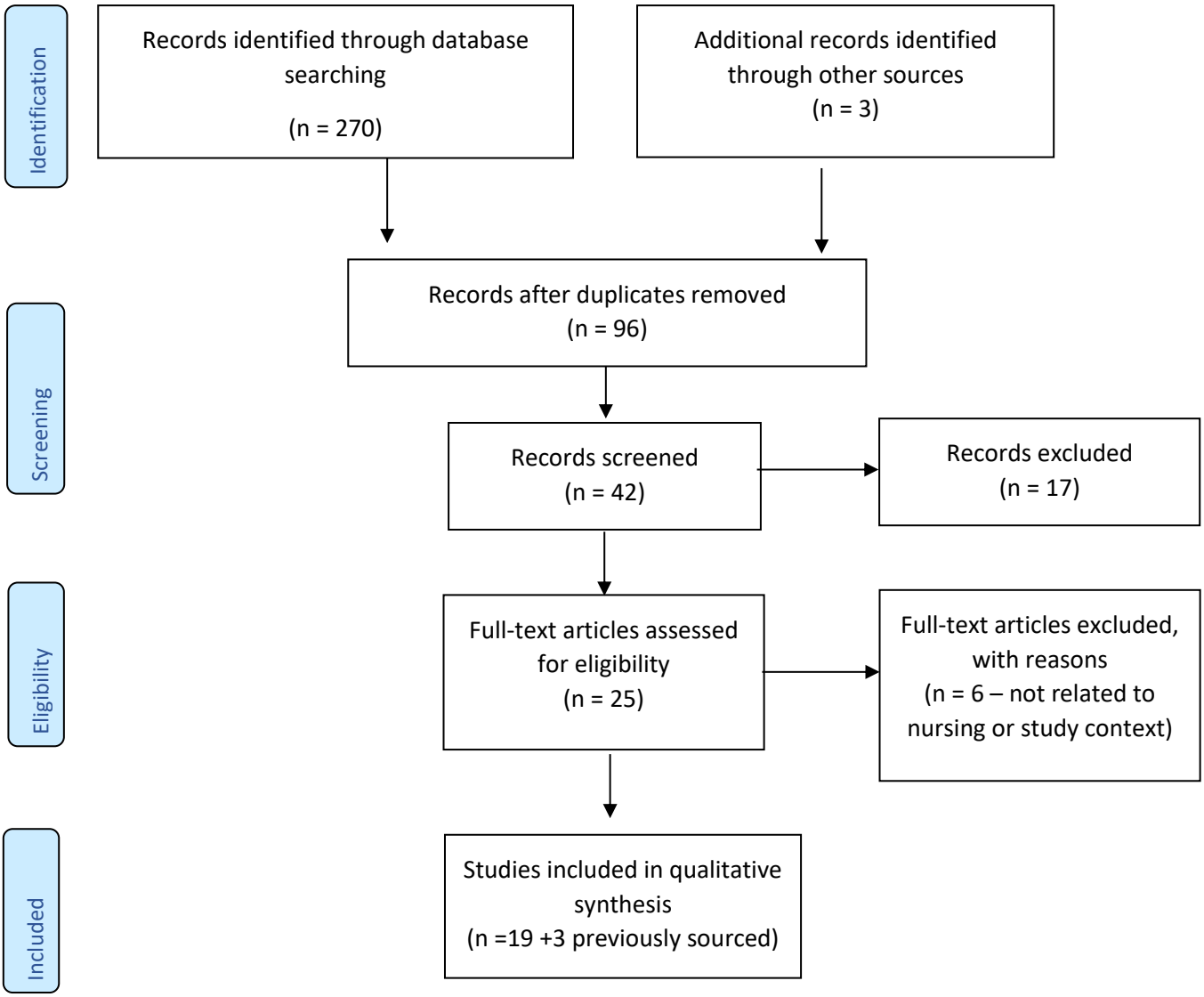
spiritual care (McSherry and Jamieson, 2011), the competencies required (Van Leeuwen and Cusveller, 2004), the barriers and facilitators of providing such care (Austin, Macleod, Siddall, McSherry, and Egan, 2016), and the influence of the settings in which nurses work (Ronaldson, 2012). Spiritual care in nursing is included in codes of practice in countries such as Malta, United Kingdom, United States, The Netherlands, Norway and is included in the International code of ethics (McSherry & Ross, 2002; Ross, 2006), but does not necessarily become part of organisational policy or individual practice (Tiew & Drury, 2012). Of interest to this study are findings from published studies related to spiritual care in a variety of cultural and workplace settings. This is based on an assumption that spiritual care practice differs between cultural contexts and that spiritual care in the often studied acute or palliative care sectors is not necessarily the experience in other contexts; Australian General Practice in particular.

2.3 The literature search

For this study two databases - The Cumulative Index of Nursing and Allied Health Literature (CINAHL) and Proquest - were chosen because of their focus on nursing, health and social sciences and ease of use. Search words and filters were used to reflect the inclusion and exclusion criteria (Table 1, p. 20). Included were primary studies published in English between 2009 and 2020 which contained the search words in close proximity to each other in the abstract. Articles which did not include the majority of words were immediately excluded. To align the literature search with this study's aim of exploring experiences of Practice Nurses in spiritual caring, the word combinations applied to the search filters were 'spiritual care' AND 'practice nurse'. However, 'Practice Nurse' proved problematic as the title of Practice Nurse was found to not have universal meaning. The majority of results highlighted nurse/nursing and practice as separate constructs. Despite this, nine articles were extracted from a potential seventy-two, as they had relevance to other aspects of this study. 'Practice Nurse' was changed to 'primary health care' AND 'nurs*' which yielded six studies in CINAHL and over a hundred studies in Proquest. To fit with this study's aim it was deemed necessary to include the search words 'spiritual care' AND 'nurse experiences', which yielded a total of 270 between the two databases. From these searches, 16 out of 51 studies were chosen by title and abstract from CINAHL. Seventeen were extracted from the first 60 of 219 on Proquest. Based on advice from a university librarian, it was found that

after reviewing the first 60 titles and abstracts, studies had little relevance, containing only one to two search words such as 'nurse' or 'care'. After removing duplicates and one incomplete article there were 25 articles. A full review of these resulted in the removal of six articles which did not meet sufficient inclusion criteria. The addition of three studies previously collected by the author yielded a total of 22 as illustrated in Figure 2 below.

Figure 2 PRISMA Flow Diagram



From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). *P*referred *R*eporting *I*tems for *S*ystematic Reviews and *M*eta-*A*nalyses: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

For more information, visit www.prisma-statement.org.

Article relevance to this study was based on whether the study presented the nurse perspective and involved a unique setting or a cultural perspective, because no studies were found to be within the Australian General Practice setting. These inclusion criteria, shown in table 1, were chosen on the basis that experiences of spiritual care may be influenced by different cultural and workplace settings.

As each article was read, dot-point notes were taken and then summarised on a literature review summary table (Appendix 1). Further readings of the articles were required to analyse the studies for research quality and relevance to the research question. Synthesis of the studies involved searching for common themes or key topics.

Table 1 - Inclusion and exclusion criteria

INCLUDED	EXCLUDED
Published 2009-2020 (date range chosen to incorporate a 2009 publication of a study in the primary care setting)	Outside date range
English language	Language other than English
Primary studies	Literature reviews, opinion pieces
Nurse perspectives	Perspectives of patients, other health care professionals
Unique work place and/or cultural setting	All but a select few from the acute or palliative care sectors
All search words contained within title or abstract and closely connected	Abstracts not containing the search word combinations

2.3 Findings

Of the twenty-two reviewed studies, fourteen were qualitative, (Carron & Cumbie, 2011; Deal & Grassley, 2012; Dhamani, Paul, & Olson, 2011; Egan et al., 2017; Elliott, Wattis, Chirema, & Brooks, 2020; Giske & Cone, 2015; Keall, Clayton, & Butow, 2014; McSherry & Jamieson, 2013; Ormsby, Harrington, & Borbasi, 2017; Ronaldson, Hayes, Aggar, Green, & Carey, 2017; Tanyi, McKenzie, & Chapek, 2009; Tirgari, Iranmanesh, Ali Cheraghi, & Arefi, 2013; Walker & Waterworth, 2017; Wong & Yau, 2010), six quantitative (Atarhim, Lee, & Copnell, 2019; Bakir, Samancioglu, & Kilic, 2017; Chan, 2010; Herlianita, Yen, Ching-Huey, Fetzer, & Lin, 2018; Kaddourah, Abu-Shaheen, & Al-Tannir, 2018; Ronaldson, Hayes, Aggar, Green, & Carey, 2012) and two used mixed methods (Cone & Giske, 2017; Smyth & Allen, 2011). The studies had a variety of aims, provided a broad variety of cultural perspectives, as well as being from various nursing contexts. The countries/locations represented, with

the number of studies in brackets, were Australia (5), USA (3), Hong Kong (2), New Zealand (2), Norway (2), UK (2), Indonesia (1), Iran (1), Malaysia (1), Saudi Arabia (1), Tanzania (1), and Turkey (1). Hospitals were the setting for eight of the studies (Bakir et al., 2017; Chan, 2010; Dhamani et al., 2011; Herlianita et al., 2018; Kaddourah et al., 2018; Smyth & Allen, 2011; Tirgari et al., 2013; Wong & Yau, 2010), five studied experiences of nurses from a mixture of settings (Cone & Giske, 2017; Deal & Grassley, 2012; Egan et al., 2017; Giske & Cone, 2015; McSherry & Jamieson, 2013) , four from Palliative care (Keall, Clayton, & Butow, 2014; Ronaldson et al., 2012, 2017; Walker & Waterworth, 2017), two from primary or community care (Carron & Cumbie, 2011; Tanyi et al., 2009), and one each from military (Ormsby et al., 2017) and mental health (Elliott et al., 2020) and one not specified (Atarhim et al., 2019). The search results highlight the lack of available information on spiritual care in Australian General Practice nursing.

2.4 Critical Appraisal

The process of critical appraisal of literature requires articles to be found, described and analysed for their quality, what they contribute to nursing practice, and their relevance to the study topic (Whitehead, 2020). As each article is read, a checklist of ten questions as described by the Critical Appraisal Skills Program (CASP UK, 2018) prompts the reader to consider: the clarity of stated aims, the appropriateness of the study design, recruitment strategies and data collection, recognition of researcher bias, consideration of ethical issues, rigor in data analysis, clearly stated findings, and the value of the research.

Study quality was considered satisfactory with aims, ethics, study design, data collection, analysis and findings clearly stated in all of the articles; each making a valuable contribution to the topic of spiritual care in nursing. Researcher bias was discussed in Carron and Cumbie (2011); Deal and Grassley (2012); Smyth and Allen (2011); Elliott et al. (2020); Tanyi et al. (2009) and implied in Tirgari et al. (2013). A number of the study authors acknowledged sample size and context as limitations, identifying that the sample may not have been representative of the broader nursing population. Response rates from the potential population for studies using surveys were reported as low, such as McSherry and Jamieson (2013). In the case of qualitative studies, data saturation was achieved after a small number (Carron & Cumbie, 2011). Keall et al. (2014) and Egan et al. (2017) identified that their

samples of voluntary participants were possibly not representative as nurses may have responded because of a particular interest in the spiritual care topic.

The studies were synthesised into four key themes: 1) Spiritual care and spirituality are not universally understood or practiced by nurses; 2) The impact of ethnic and workplace culture; 3) Challenges in assessing and documenting spiritual care; and 4) the barriers and enablers to providing spiritual care.

2.4.1 Spirituality and spiritual care are not universally understood or practiced by nurses

Nurse perceptions about spirituality and spiritual care were the topic of half the studies. Authors identified the importance of spiritual health and care, but the lack of universal understanding was demonstrated in the broad mixture of opinions nurses possess a about spirituality, spiritual care and whether it is something they should be concerned about. For some nurses spiritual caring was assumed, believing nursing as a vocation to have a strong spiritual dimension as found by McSherry and Jamieson (2013) and Egan et al (2017).

This echoes an earlier study by Baldacchino (2006) of Maltese nurses responding to spiritual distress in patients who had suffered a myocardial infarction. Conversely, in the same studies by Egan et al. (2017) and McSherry and Jamieson (2013) named above, some nurses had difficulty seeing spiritual care as part of their role. Some participants in Egan & colleague's study (Egan et al., 2017) believed instead, that training nurses to give guidance to patients to find appropriate help and resources would be more beneficial. The studies from an Islamic perspective (Atarhim et al., 2019; Bakir et al., 2017; Herlianita et al., 2018; Kaddourah et al., 2018; Tirgari et al., 2013), indicate that spirituality is presumed in those cultures.

On another note, Walker and Waterworth (2017) comment that certain cultures [unnamed] believe that their spirit is unprotected when disclosing spiritual matters. With such diverse views on spirituality and spiritual care, it is not surprising that developing an evidence-based nursing guideline for spiritual care is yet to occur. McSherry and Jamieson (2013) posit that, although nursing has endeavoured with minimal success to develop a language and concepts to give relevance to spiritual care in the nursing context, there is a lack of critical analysis of the concept of spirituality in nursing. This, they observe, has resulted in a vast

array of descriptions, definitions and attempts to reintroduce into nursing the spiritual dimension of care that was part of nursing's historical practice.

In addition to no universal definitions, a number of authors identified that there is yet to be a common universal language for spiritual care which may be a contributing factor to spirituality and spiritual care not being universally understood. They saw the need for the development of a clear and common language for spiritual needs and care (Egan et al., 2017; Giske & Cone, 2015; Ronaldson et al., 2012; Smyth & Allen, 2011; Walker & Waterworth, 2017).

Although they did not elaborate on their reasons, Giske and Cone (2015) in particular, believed nurses should additionally have a good understanding of different religions and faith traditions, iterating thoughts earlier penned by McSherry and Ross (2002). For participants in the Riyadh study by Kaddourah et al. (2018), an understanding of the sociocultural context of different religions was valuable to avoiding embarrassment. Understanding specifics about religions was not considered necessary for nurses in a 1983 study by Martin, Burrows & Pomilio, cited by Deal and Grassley (2012), which viewed allowing the patient to talk and actively listening to the patient as more important.

Giske and Cone (2015) introduced the concept of spiritual literacy, which they describe as involving concepts such as presence, compassion, connectedness, hope, kindness, listening, and meaning. Nursing practice which encompasses these concepts as part of being culturally sensitive, and holistically treating each patient as a unique individual as required by the Nursing and Midwifery Board of Australia (AHPRA, 2016), indicates that more than a basic understanding of religions is not necessary.

One aspect of spiritual care in which there does seem to be universal understanding is 'connection'. Connection is a concept which relates to the needs of individuals to have healthy connections for spiritual well-being – whether with people, things or places - and to the connections made by nurses with patients when caring for them. Connection was seen as a theme in the reviewed literature (Chan, 2010; Deal & Grassley, 2012; Herlianita et al., 2018; Walker & Waterworth, 2017), as well as the afore mentioned study by Harrington et al. (2018). Egan et al. (2017) had similar findings in their study of nurses' perceptions of spirituality and spiritual care in New Zealand, seen particularly in the Maori concept of

'whakawhanaungatunga' – 'connection between two human beings at the start of a journey of change and enlightenment' (p. 7 of 20). In offering definitions of spirituality, participants in Egan's study used words such as *essence, belief, love, meaning, and purpose.* They described spiritual care as practicing *compassion, tolerance, peacefulness, positive intention, respect, and kindness*. In the studies of Muslim nurses by Herlianita et al. (2018) and Tirgari et al. (2013) participants used similar descriptors for spiritual care.

Viktor Frankl (2006) is well known for his work on the importance of finding meaning to one's ability to cope with adversity in particular. Illness, be it acute, chronic or terminal, can evoke an existential crisis for patients. Questions arise such as 'Why me?' 'Why is this happening?' (Deal & Grassley, 2012; Tanyi et al., 2009). Thus, meaning and purpose are terms commonly found in the literature when describing spirituality, which is generally seen as an integral part of the whole person. This indicates spiritual care is part of holistically caring for a person (Carron & Cumbie, 2011; Dhamani et al., 2011). It would seem therefore, that while there is yet to be a universal language for spirituality and spiritual care as discussed in the literature, there are many commonly used terms including *essence, meaning, purpose, hope, respect, trust, dignity, kindness, and peace*. The conclusion could then be made, that spirituality can be accepted as a significant and individual dimension of a person which can be expressed in many ways. To spiritually care for a person means to listen to and observe the things that are said and done; including understanding and recognising spiritual distress; then to respond accordingly with respect and compassion, irrespective of similar or different beliefs between nurse and patient. The concept of recognising spiritual distress will be discussed further in 2.4.3.

2.4.2 The impact of ethnic and workplace culture

In this section on cultural influences, it will be seen that spirituality is integral in some cultures. Chan (2010) cited a number of different authors with varying definitions of spirituality and noted the impact of culture on those definitions. Chan concluded that spirituality is more about how individuals make or find meaning in their lives, rather than having a specific meaning.

One notable cultural influence is the Islamic view that spirituality and religion are not seen as mutually exclusive, as discussed by Atarhim et al. (2019); Bakir et al. (2017); Herlianita et al. (2018); Kaddourah et al. (2018) and Tirgari et al. (2013). Each of these studies described

spirituality as embedded in religion; there is no distinction between the two. Furthermore, participants in the Atarhim et al (2019) study believed spiritual care was only useful to people with religious affiliation. The specific influence of the culture of the respective Islamic countries was not significantly noted. The exception was Iran (Tirgari et al., 2013) where there are other cultural influences including magic and mysticism. In Tirgari and colleague's study spiritual care was seen as meeting the patient as a unique being. Nurses described a tension existing between truth telling and the cultural code of preserving hope; people don't want to know if they are dying (Tirgari et al., 2013). Wong and Yau (2010) also found views on death and dying were influenced by culture. They commented that it is a characteristic of Chinese people to avoid facing death, so are unlikely to have existential conversations about the meaning of life. Cultural mores also featured in the study by Dhamani et al. (2011) who found African beliefs about witchcraft, devils and traditional healers impacted patients' spiritual health and well-being.

In a multicultural country such as Australia, it can be a challenge for nurses to have cultural sensitivity and awareness of a diverse range of beliefs and values (AHPRA, 2016). Practice Nurses meet people from many different lands, with a variety of beliefs and values. Findings in the studies by Atarhim et al. (2019); Chan (2010); Dhamani et al. (2011), indicated that nurses are uncertain when it comes to providing spiritual care to people with different beliefs. To consider also, is the possibility that discussing spiritual matters is a cultural taboo (Cone & Giske, 2017; Egan et al., 2017; Walker & Waterworth, 2017).

The workplace context also indicated a cultural influence. The impact of workplace culture was seen most notably in Australian military nurses in Ormsby et al. (2017), Australian palliative care nurses in Keall et al. (2014); Ronaldson et al. (2012) and Smyth and Allen (2011), in differences between the palliative or acute care settings (Ronaldson et al., 2012; Walker & Waterworth, 2017; Wong & Yau, 2010) and in mental health care (Elliott et al., 2020). Each of these contexts have policies and unit managers that may or may not address spiritual care or consider its importance; and as Elliott et al. (2020) found, the culture of relationships between colleagues also impacted on the provision of spiritual care.

Carron and Cumbie (2011) and Tanyi et al. (2009) presented the primary care perspective, which although American, demonstrated the significance of the practitioner/patient relationship which has the opportunity to develop over time in primary care settings. The

impact on spiritual care of the nurse/patient relationship was also seen in Deal and Grassley (2012)'s study with renal dialysis nurses and Walker and Waterworth (2017)'s study of New Zealand palliative care nurses. Relationships were also a significant feature of the study of military nurses on deployment by Ormsby et al. (2017), where comrades became family. Australian PNs have a similar opportunity to develop long standing relationships with patients (Walker, Patterson, Wong, & Young, 2010) which may facilitate opportunities for conversations about existential matters. The significance of practitioner/patient relationships in General Practice with respect to pastoral care and better patient outcomes, was explored in a study by Cocksedge and May (2005).

Addressing spiritual needs is common practice in palliative care as indicated by Keall et al. (2014), Ronaldson et al. (2012), Ronaldson et al. (2017) and Walker and Waterworth (2017), but their findings indicated that nurses did not always feel adept to fulfill the expectation to provide spiritual care. Reasons for this are explored further in section 2.4.4.

2.4.3 Challenges in assessing and documenting spiritual care

The lack of a common language to describe spiritual matters as mentioned above, means it is difficult to assess and document spiritual care of a patient, as found by Walker and Waterworth (2017). Documentation was considered important to continuity of care but study participants described difficulties deciding what to record. Nurses want to be able to record enough to facilitate continuity of care without disclosing too much of what may have been told to them in confidence (Deal & Grassley, 2012; Keall et al., 2014). In their (2002) position paper, McSherry & Ross (2002) iterated the dilemmas involved in assessing spiritual needs and documenting spiritual care: when, how and what to assess something as diverse and personal as spirituality, whilst maintaining ethical respect. They warned against assessment approaches that may meet audit requirements, but could easily become mechanistic; another 'tick-box' task. This issue was identified by Chan (2010), Egan et al. (2017) and Elliott et al. (2020) who found that ticking boxes on an admission form may meet requirements for organisational spiritual care, but it does not mean that nurses have taken any action.

McSherry and Ross (2002) explored some of the types of assessment and associated tools, such as using direct questioning, and a spiritual distress indicators assessment. Spiritual assessment was discussed by a number of authors. Cone and Giske (2017) identified the

need for clear direction on what, when and how to assess; who does the assessing; what care is given as a result and how it is recorded. Participants in the study by Keall et al. (2014) provided a range of questions that they had used in their practice to assess their patients for spiritual needs. The appropriate care was given, provided either by the nurse, family, friends or a spiritual carer such as a chaplain. Tanyi et al. (2009) found that practitioners would be alerted to spiritual need when patients asked existential questions such as, "'Why me?'' ''Why is this happening?'' ''What have I done?'' The participants reported the importance of including spiritual needs in their dictations for the patient notes. However, it was noted that organisational policy and funding constraints were barriers to meeting spiritual needs and documenting the same.

Spiritual distress as described by Aghadiuno (2010) may seem an obvious thing to assess; but as Walker and Waterworth (2017) found in their study of palliative care nurses, it is not always easy to identify. It can vary in intensity and severity and may be misinterpreted as pain or agitation, which results in medicating rather than providing spiritual care. Similarly, in mental health, spiritual distress can often be confused with psychotic or neurotic symptoms (Elliott et al., 2020). This indicates that education around identifying and differentiating spiritual distress is an important part of nursing practice. Limited knowledge about spirituality and spiritual needs has been identified as one of the barriers to providing spiritual care.

2.4.4 Barriers and enablers to providing spiritual care

Fourteen of the twenty-two studies described barriers and enablers to the provision of spiritual care (Bakir et al., 2017; Chan, 2010; Cone & Giske, 2017; Deal & Grassley, 2012; Dhamani et al., 2011; Elliott et al., 2020; Giske & Cone, 2015; Keall et al., 2014; McSherry & Jamieson, 2013; Ronaldson et al., 2012, 2017; Smyth & Allen, 2011; Tanyi et al., 2009; Walker & Waterworth, 2017) .The number one barrier commonly reported by researchers is lack of time, often linked to lack of staff. The barrier which closely follows is lack of knowledge or training. Often linked to lack of time is workload and energy. Fatigue or lack of energy, attributed to heavy workloads, was seen as a hindrance to providing spiritual care in the studies by Herlianita et al. (2018) and Deal and Grassley (2012). Tanyi et al. (2009) also identified that spiritually caring for patients takes energy.

Positive self-awareness about personal spirituality or personal religiosity have been found to be enablers to providing spiritual care (Cone & Giske, 2017; Ronaldson et al., 2012). However, as Dhamani et al. (2011) found, this can at times be a barrier when caring for someone with different beliefs. Opportunities increase when trust has developed between nurse and patient (Keall et al., 2014; Smyth & Allen, 2011). The nurse-patient relationship was also identified as a significant enabler in a number of the studies including: Carron and Cumbie (2011), Deal and Grassley (2012) Ormsby et al. (2017) and Giske and Cone (2015).

Comfort or lack thereof with addressing spiritual matters was an issue found by Elliott et al. (2020); Ormsby et al. (2017) as well as emerging from the literature as found by Tanyi et al. (2009). Related to the comfort issue is the fear of imposing, offending or 'messing things up' (Atarhim et al., 2019; Elliott et al., 2020; Giske & Cone, 2015). Nurses are wary of being seen to impose their own viewpoint if they encourage a patient towards addressing spiritual matters (Atarhim et al., 2019). The views of participants in the Egan et al. (2017) study which recommended educating nurses to be able to guide patients to seek their own spiritual resources, rather than necessarily being the spiritual care giver, are somewhat supported in an article by Donesky et al. (2020) about spiritual care being a collaboration between nurses and chaplains. Spiritual care is described as having different levels. Primary level care is that provided by nurses through empathy, presence and support; characterised in activities such as active listening, therapeutic touch, and kindness. Chaplains, pastors, imams and other spiritual leaders offer specialty spiritual care (Donesky et al., 2020). Whilst some nurses may be at ease with praying, reading Scriptures or other sacred practices, it is fair and reasonable to not expect this to be the standard. Instead, training nurses to be spiritually literate, to be sensitive to the possibility that a patient may be experiencing spiritual distress and to be able to raise the topic would be more appropriate to the person-centred model of care.

Other barriers to spiritual care relate to institutional policy and the priority given to spiritual care. Wong and Yau (2010) found spiritual care had low priority compared to acute physical need, as it was not seen as life threatening. They also found that spiritual care was categorised as a complementary therapy. Participants in the study by Tanyi et al. (2009) also alluded to the low priority given to spiritual needs as there was no financial benefit to the practice employers.

2.6 Summary

This chapter has described studies found in the literature which have investigated spirituality and spiritual care in nursing and had the most relevance to the research aim. The studies were from a variety of countries and nursing fields offering slightly different perspectives on spirituality and spiritual caring. However, there were concepts common to some if not all. In sum, these concepts relate to the importance of spiritual health, understandings of spirituality and spiritual care, cultural influences, documentation difficulties, and the barriers and enablers to providing spiritual care.

There were no Australian studies found which considered the topic from the PN perspective. Qualitative research methods are the most effective to explore spirituality and spiritual care due to the subjective quality of them. Whilst quantitative studies have been undertaken (Austin et al., 2016; McSherry & Jamieson, 2011; van Leeuwen & Schep-Akkerman, 2015); at some point qualitative data are also collected, because matters of the human soul/spirit are difficult to measure. As discussed in the next chapter a qualitative descriptive method was chosen for the study.

CHAPTER 3

METHODOLOGY and METHODS

3.1 Introduction

As alluded to in the previous chapter, qualitative study methods are appropriate for the exploration of spiritual care experiences of PNs in Australia. The rationale for applying an Interpretive Descriptive research approach is put forward in this chapter, followed by details of the research method and design; including ethics, sample and setting, data collection, data analysis and trustworthiness.

3.2 Methodology

Qualitative research collects data about lived experiences; both individual and shared. The methodology described and named 'Interpretive Description' by Thorne and colleagues (Thorne, 2016; Thorne, Kirkham, & Macdonald-emes, 1997), was developed by and for nurse researchers. It offers a robust methodology which, following a critical appraisal of current knowledge of the phenomenon to be studied, gathers descriptive data about the subjective experience of a population from a variety of data sources. It then interprets the data based on what is already known and considers the implications for practice (Thompson Burdine, Thorne, & Sandhu, 2021). The aim is to inform practice through description, rather than form a theory (Teodoro et al., 2018; Whitehead & Disler, 2020).

Before its inception, nurse researchers were relying on the more theory based methodologies from other disciplines such as phenomenology from philosophy, ethnography from anthropology and grounded theory from sociology (Thorne et al., 1997). However, as Sandelowski (2000, 2010) notes, nurse researchers often produced studies which were more of a qualitative descriptive nature, rather than fitting with the theoretical frameworks of the traditional methodologies which were being claimed as the research design.

Sandelowski (2000, 2010), and Neergaard, Olesen, Andersen, and Sondergaard (2009) describe Qualitative Description as a viable research approach and are often cited in the literature. Like Qualitative Description, Interpretive Description, although newly named, is not a new design as such, but provides a flexible framework which incorporates various aspects of other qualitative research designs, so that nurse researchers are not constrained

and restricted to the epistemological and ontological underpinnings of more traditional methodologies. Interpretive Description elaborates on Qualitative Description by looking for meanings and explanations and asking, ''What is happening here?" ''What can be learned about this?'' (Hunt, 2009; Thorne, 2016; Thorne, Kirkham, & O'Flynn-Magee, 2004). An Interpretive Descriptive approach also makes use of the foreknowledge of the researcher as a platform on which to build a study (Hunt, 2009). This is helpful to this study, as it is prior learning as described in 1.5.1 which led to the development of the research proposal for this study. The aim to not only understand experiences of providing spiritual care in General Practice nursing, but to also inform nursing practice towards the development of a practice guideline and spiritual health assessment tool, makes an Interpretive Descriptive approach the most appropriate methodology to adopt for this study.

3.3 Ethics

All studies carry a potential element of risk. The amount of risk to participants in this study was deemed low; identified as the potential to evoke an emotional response from participants as they convey their experiences of spiritual care. Accordingly, a low-risk ethics application was submitted to the Social and Behavioural Research Ethics Committee (SBREC). A participant information package and interview tools were developed and submitted for approval. The information package included a letter of introduction, an information sheet and an interview consent form [Appendices 2a, b and c]. The interview tools included a sheet of questions and a sheet for recording the coded name, demographic information and space for supplementary field notes taken during or immediately after each interview. These are included in Appendices 4a, b and c.

Maintaining an ethical study once formal SBREC approval to commence was granted (Appendix 3) included ensuring the privacy and confidentiality of participants, maintaining the security of stored data in password protected files, avoiding coercion to participate, and demonstrating trustworthiness throughout the study. It was made clear to participants that they could choose to not answer questions or withdraw from the study at any time. Contact details of counselling services were made available should they be required.

3.4 Sample and Setting

A purposive sampling approach is used when a particular group of people are needed for data collection (Polit & Beck, 2017, p. 493); which, in this study, were PNs. Various methods

were employed to invite volunteer participants, including email, social media posts, and nursing network forums. However, obtaining recruits took a lot longer than anticipated and was compounded by the Government-imposed restrictions to prevent the spread of the SARS-CoV2 virus known as COVID-19 and the concurrent roll out of seasonal flu vaccines which began in late March 2020. It can be safely assumed that participating in a research project was not a high priority for PNs in 2020; based on the findings in the study by Halcomb et al. (2020) of the impact of the COVID 19 pandemic on primary healthcare nurses (which includes PNs), that the major concerns of participants were keeping their jobs and having enough Personal Protective Equipment whilst maintaining quality primary healthcare services under lockdown-type restrictions.

One strategy used to recruit eligible volunteer PN participants was an internet search of General Practices which claimed a person-centred or holistic approach to care which includes addressing spiritual or religious needs (AHPRA, 2016, p. 6). Once suitable General Practices were identified, participant packages were sent to Practice Managers via email with a request that the information be forwarded to the PN(s). There was either no response or an expressed disinterest to participate. The reasons for this are unknown, but a study by Cooper and Brown (2017) found that possible reasons for poor response rates in research by nurses and midwives, are lack of understanding about research or being too busy. Another potential reason is that General Practices are income generating businesses as described in chapter 1.4.4; and therefore, unlikely to be interested in activities that do not make money.

Another recruitment strategy involved an item in a weekly online newsletter published by the Australian Primary Health Nurse Association (APNA) which reaches more than 24,000 subscribers (J. Andrewartha, personal communication, April 9, 2021). Two nurses expressed interest but chose not to participate, despite a friendly reminder. To enhance potential participation, the option was provided to complete a written response to the questions devised for interview use. This complies with an Interpretive Descriptive study design which allows varied data sources and proved to have greater appeal for PNs. The written responses included demographic information, but no name, in order to maintain confidentiality. Participants could opt to provide an email address if they were interested in receiving a copy of the findings. After twelve months of recruitment, additionally using

nurse network and social media connections reaching approximately 6500 primary health nurses, of which 74% are Practice Nurses (APNA, 2020), to extend invitations to participate, a total of eight responses were obtained which is considered sufficient for an Interpretive Descriptive study (Thorne, 2016, p. 103). Six participants opted to provide a written response. Two telephone interviews were conducted. The interviewees provided written consent and were reminded that they could refrain from answering any questions or withdraw from the study at any time. Obtaining any further participants was considered unlikely by March 2021 as General Practices were preparing for the roll out of COVID 19 vaccines, as well as the annual influenza vaccination program (Department of Health, 2021a, 2021b).

To better understand why recruiting nurses for research can be a challenge, a search was made of the literature; finding one study by a group of Australian researchers (Luck, Ng Chok, & Wilkes, 2017) who themselves, finding little in the literature about the topic, examined their recruitment strategies for six of their own studies. Not unlike the effect of COVID 19 on this study, Luck et al. (2017) found that current events, be they global, political or workforce issues also had an impact on the studies they examined. They found that nurses were often too absorbed in their current situation to respond. The authors in the Luck et al (2017) study discovered that a range of strategies are usually needed to increase sample size as they experienced response rates as low as 5% up to 73%, depending on the strategy used. Approaching prospective participants in person proved to have the greatest success, but raised questions around ethical boundaries and avoiding coercion. Leaving hard copies of their survey in a ward with a collection box or advertising by flyers yielded the least response. They also found that nurses who were interested in the topic were more likely to respond. Another possible influence on the slow rate of progress to obtain volunteers for this study, could be the number and regularity of surveys nurses are asked to complete as experienced by participants in the study by Cooper & Brown (2017).

3.5 Data collection

As already noted, six participants returned written responses with varying degrees of detail. There were two telephone interviews, each lasting 15 and 30 minutes respectively. The interviews were recorded with a digital voice recorder and later transcribed verbatim by the author. The collected data was printed to facilitate close scrutiny, comparing, making notes,

highlighting, and looking for key words and phrases, in order to identify common thoughts or ideas as well as unique ideas.

An aspect of data collection in an Interpretive Descriptive methodology is building on previously collected data to guide subsequent data gathering. This was the experience in this study where the available data was in the early stages of analysis when the second semi-structured interview took place; allowing for additional questions. Secondary data sources can also add to an Interpretive Descriptive study. Hunt (2009) describes how secondary data sources in the form of narrative articles in medical journals, published essays and online blogs added further detail to his primary data in his Interpretive Descriptive study on the moral experiences of health professionals in humanitarian work. Therefore, an invitation was given to a closed Facebook group of South Australian GP nurses to offer their thoughts on spirituality, spiritual care in practice nursing and the place of spiritual care in a person-centred model of care. Unfortunately, after two weeks, there were no responses from any of the 471 members.

Interpretive Descriptive research designs aim for data saturation where it is possible and appropriate. That is, data is collected until no new data is obtained (Polit & Beck, 2017, p. 497). However, saturation was difficult to achieve in this study, due to the diverse, and at times unique, views on spirituality and spiritual care described by the eight participants. The degree of detail varied between each written response and the interviews. The two interviewees expressed a vested interest in the topic of spirituality and spiritual care and gave detailed, yet individual answers. The variety of responses from all participants, necessitated the Interpretive Descriptive technique of looking closely at the data as well as withdrawing to see the bigger picture. Repeated listening to the interview recordings as well as reading the transcripts enhanced understanding as voice tone, volume and expression added to the overall narrative.

3.6 Data analysis

Due to the uniqueness of the results, there is no right or wrong way to approach the data analysis of qualitative studies (Saldaña, 2016). Neville and Whitehead (2020) note that qualitative researchers choose the analysis method which best fits the methodology and the data collected. Whichever analytical process is chosen, in most qualitative approaches inductive reasoning is applied, often resulting in contextual generalisations from specific

observations (Polit & Beck, 2017, p. 731). One of the hall-marks of qualitative descriptive studies is staying close to the data. For this study the written responses and interview transcriptions were printed and read through several times to allow immersion in the data as Thorne (2016) describes. Key points were highlighted and notes made. Thorne warns against being too hasty about coding, a process described by Saldaña (2016) as a means to sort qualitative data into concepts described by a single word or phrase. Applying codes too soon, may put too rigid a structure on the analytic process and may result in an incomplete picture or representation of the relevant data (Thorne, 2016). Therefore, the data in this study was read and re-read over and over, before applying a line-by-line coding approach. Sections of data were copied verbatim on to a table and a numbering system was used to match code words and phrases to the data. Noting words or ideas common to each piece of datum is part of a process with a broad application described by Braun and Clarke (2006, 2014) as 'thematic analysis'. Once described, these themes or patterns are interpreted; meaning the significance of the themes, their broader meanings and implications are conceptualised. Interpretive Description adopts an iterative process which repeatedly returns to the data to note key elements seen with each reading. This involves stepping back from the data periodically to see the bigger picture, as well as staying close (Hunt, 2009). These analytic memos are reviewed and questioned, with a gradual movement towards grouping and connecting the elements. Thorne sees data analysis as a …*'move beyond thematic analysis and into the more creative and interpretive realms of figuring out options for depicting patterns and meanings*.' (Thorne, 2016 p. 169). There is a balance between *'letting your thinking go completely wild'* (Thorne, 2016, p.166) and staying with in disciplinary boundaries.

The ontological nature of this study exploring experiences of spiritual care provision by PNs means an In Vivo coding method, which uses the direct language of the participants, is the most appropriate (Saldaña, 2016). The small number of participants and consequent data proved a challenge to develop themes, rather than simplifying the process as anticipated. A table was created as described above. In applying codes it was important not to lose the more unique ideas in favour of those which were more prevalent; therefore, Braun and Clarke (2006) suggest a miscellaneous theme for ideas which do not fit anywhere else. Thus,

unique but relevant responses from participants are presented under 'Further Findings'. This, and four themes are presented in chapter four.

3.6 Trustworthiness

When trustworthiness of a study is maintained, readers of research papers should see a logical progression of activity and discussion with clear links to the research question. The researcher will demonstrate honesty and transparency in the collection of data, data analysis and discussion of the findings, especially if the findings are not what was expected or refute the research aim (Polit & Beck, 2017; Thorne, 2016). It is important to keep in focus throughout writing, the *purpose, process and context* of the study. Thorne (2016) writes, *'…the key to quality will inevitably be found within the internal logic that aligns those three elements into a coherent and convincing account' (p. 239).*

Researcher bias is an issue that qualitative researchers need to be aware of and is often seen as necessary to eliminate (Thompson Burdine et al., 2021). However, in the case of Interpretive Descriptive study designs, the views of the researcher are acknowledged for potential influence on the data analysis and findings. Reflections were noted during data collection and analysis in this study to help identify thoughts and feelings that might add insight to data analysis and findings (Hunt, 2009; Thompson Burdine et al., 2021). Furthermore, the researcher plays an active role in the identifying and selecting of themes in the data, which affects a degree of subjectivity (Braun & Clarke, 2006).

There are a variety of ways to show that a study is trustworthy (Neville & Whitehead, 2020). Lincoln & Guba are often cited for their work on criteria to ensure research trustworthiness. These are namely: credibility, dependability, confirmability, and transferability (Polit & Beck, 2017, pp. 559-560). Thorne (2016, pp. 236-238) describes a set of criteria listed below, which are appropriate for Interpretive Descriptive studies, and which this study could meet more effectively.

3.5.1 Moral defensibility

This involves clearly stating why and how information is collected and how it will be used. The findings are of little use if there is no clear purpose to them. This study about spiritual care may not have a great deal of impact in the broad context of General Practice nursing. However, if nurses (participants and readers) can be given pause to be more mindful that

patients may have spiritual needs as well as physical, emotional and mental, the goal of moral defensibility is reached.

3.5.2 Disciplinary relevance

Demonstrating disciplinary relevance is not dissimilar to the above. There needs to be a clear relationship between the research and the disciplinary knowledge to be advanced. A desired outcome of this study is to add to the growing body of knowledge about spiritual care in nursing generally as well General Practice nursing in particular.

3.5.3 Pragmatic obligation

The lines between truth and opinion can be blurred. Pragmatic obligation means presenting the findings *''as if''* they might be put into practice. Readers of research findings will have varying views and responses to the data; with some taking them on board into practice. Therefore, this study's findings will aim to yield a *'constructed truth'* to inform practice, rather than merely presenting facts; so that any findings that are adopted in practice will not have any adverse effects.

3.5.4 Contextual awareness

This study is looking at nurses' experiences, which are individual and personal. Each experience may or may not reflect those of others in the study. Furthermore, each experience may or may not have relevance to nurses in other areas such as acute care or residential aged care. Social thought tends to evolve and change over time (Thorne, 2016, chapter 7). Thoughts voiced in this study may not have the same relevance in years to come, therefore the findings of this study must be considered in the context of General Practice in the second decade of the twenty-first century and not generalised to other nursing contexts and time periods. Although, it is likely that there will be some similarities to the findings of other studies of spiritual care in nursing practice.

3.5.5 Probable truth

This study, as any qualitative study, presents the views of a limited number of individuals. As our Australian population grows and changes, the importance placed on certain values and beliefs will also likely change. The findings in this study may find relevance for some people but not all, and in this current generation, but not the next. To consider also, is the degree of importance given to spirituality and spiritual needs by nurses and patients. Whilst this

author and others presented in chapter 2 may consider spiritual care important, it is possible that, in keeping with ABS census figures as highlighted in chapter one (Australian Bureau of Statistics, 2018), a third of nurses will not think it is important; especially in the General Practice context where activities which don't generate income are often a low priority.

3.6 Summary

A qualitative research design was deemed best for this study. Interpretive Description, which was designed by nurses for nurses allows for a flexible framework to work with. It follows the lines of naturalistic enquiry as do the more established methodologies such as phenomenology, ethnography and grounded theory; and is well suited to the applied sciences which are very much involved with the experiences of people. After a long period of recruitment, data from a total of eight participants was collected and analysed. The findings are the topic of the next chapter.

CHAPTER 4

FINDINGS

4.1 Introduction

In this chapter the findings from the analysis of the data from eight participating PNs are presented. Responses reflected the diverse range of views nurses in general possess about spirituality and spiritual care. After adopting the Interpretive Description strategy of looking closely at the data as well as pulling back to see the overall picture, and asking 'Why is this here?', 'What does this mean?'; key phrases from the data helped to formulate the four themes: 1. The individualised importance of spiritualty and spiritual care. 2. Spiritual care as an aspect of person-centred care. 3. Person-centred spiritual care practice. 4. Barriers and enablers to addressing spiritual needs. Additional findings that did not fit into a theme are also presented. Each theme is discussed separately, commencing with a synopsis of the key points within each theme; using as much as possible the language used by the participants, to maintain trustworthiness. Direct or verbatim quotes as presented by the participants are used to illustrate and enhance meaning. Firstly, the nature and demographics of the participants are described.

4.2 The Participants

All eight participants were female. Two were in the 26-35 years age range; four were in the 46-55 years age range; and two were 56 years or over. Their years of experience as a PN varied from 2 months to 12 years (mean = 7.3 years) and as registered nurses from 5 years to 37 years (mean = 24.75 years). The General Practices in which the PNs worked were mostly in urban locations with one rural, and had more than ten GPs with four to six PNs. One participant was located in New South Wales and the remainder in South Australia. Half of the participants had received no formal spiritual care training. Three nurses reported limited training about spiritual care, provided during undergraduate study. Two nurses elaborated about their spiritual care training, stating that it was mostly about showing respect and understanding for people's beliefs. One nurse had received informal training through working as a volunteer pastoral care worker. Participants, in this chapter, are identified by number rather than initials to reduce incidental identification and ensure anonymity. Written responses were a mixture of brief sentences and richly descriptive paragraphs. The PNs presented a variety of views on spirituality and spiritual care generally,

but at the same time were in agreement about the personal and individual nature of both. They also that agreed that a person-centred approach to care was needed; which included addressing patients' spiritual needs if these were perceived important to them. These commonly expressed views generated the first theme.

4.3 Theme 1 – The individualised importance of spiritualty and spiritual care

Participant views on spirituality and spiritual care were indicative of the individual nature of spirituality and their spiritual care experiences. It was opined by three of the participants that spirituality was perhaps not always important to patients. Asking patients about what *is* important to them, as well as listening to them and planning care accordingly were significant in the responses given by the Practice Nurses.

Participants described spirituality as something that is personal and individual and means different things to different people; but commonly relates to beliefs, values and practices. Participants believed that spirituality can be about belief in a higher being and/or be expressed through religion or culture, with associated beliefs and perceptions about life, death and the afterlife. Spirituality can offer a sense of purpose in life, and influence how one manages health issues.

> *'Spirituality is a broad concept with many perspectives. It is generally defined as having a link to a concept which is bigger than oneself, and is often linked to the meaning of life, and/or life after death. It is often related to culture, and also religion.'(ID06)*
>
> *'Spirituality is the belief of an individual in higher being(s), their associated purpose in life and their belief of afterlife.' (ID04)*
>
> *'Spirituality is individual and relates to one's own beliefs.' (ID07)*
>
> *'Spirituality is different for different people. Some people it's a belief in a God or being active in a religion. Some people it's about peoples experiences that help them to get in touch with themselves through yoga or meditation.' (ID01)*
>
> *'…spirituality means different things to different people and in my…practice as a mental health nurse…people will often want to delineate themselves between spirituality and religiousness, they'll often say ''I'm not religious but I'm spiritual''…so*

I think the way I would define spirituality is a personal experience as opposed to a religious tradition.' (ID08)

Two nurses described how their views were influenced by personal growth and nursing experience. *'…I've become increasingly aware that spirituality is not just all about religion…' (ID05)* ID08 described becoming *'more universal in my expression of faith…see the connections and commonalities between faiths.'*

In presenting their definitions of spiritual care, participants described it as care that meets spiritual and emotional needs, not just physical. They explained that spiritual care is care that demonstrates sensitivity and openness, and focuses on the needs of the whole person and the person's family. Spiritual care was also described as acknowledging patients' religious and cultural beliefs in an understanding, respectful, and supportive manner; being compassionate and non-judgemental, as well as seeking to find out how a person's spiritualty or religion provides comfort or benefit. Spiritual care, as described by one participant, considers how spirituality, culture and religion intersect with health care contexts (ID08).

'Spiritual care is care that meets spiritual & emotional needs as opposed to physical.' (ID01)

'Recognising other people's religious & cultural beliefs…incorporating persons beliefs into care and education I am providing.' (ID03)

'…find out how they use their spirituality or their religion and how it comforts them, how it benefits them…' (ID08)

'Spiritual care involves caring for our clients, and their whole family, bearing in mind any spiritual needs they have, understanding their needs and supporting them, respecting and acknowledging them.' (ID04)

'Spiritual care focuses on the need of the whole person & family.' (ID02)

'Care that supports the patient's own spiritual needs.' (ID07)

4.4 Theme 2 –Spiritual care as an aspect of person-centred care

Practice Nurses are guided in their practice, as explained in chapter one, by NMBA nursing standards and standards for nurses in General Practice which include person-centred care; an approach inclusive of respect for values and beliefs (AHPRA, 2016; Australian Nursing and Midwifery Federation, 2014). Participants were asked to share their thoughts about person-centred care and whether it included spiritual needs. Person-centred care is *'care the patient wants' (ID01),* it involves patients, '*listens to them'* and *'gives patients a safe place to talk' (ID01).* Person-centred care

> *'is care which is targeted to an individual's needs, taking into account their individual spiritual, physical, and emotional needs, whilst respecting their culture, beliefs and values.' (ID04)*

Person-centred care is about seeing the patient as the expert and considering people's needs from their perspective. It considers their situation when recommending goals and strategies, and may or may not include spiritual care.

> *'…person-centred care is holistic care that focuses on culture, spiritual health as well as physical and mental health.' (ID02)*

> *'Person centred care puts a person at the centre of the care given. It means gaining an understanding of patients' values and beliefs, particularly about their health and well-being, and designs nursing care which takes these into account. It takes into account the context in which the patient finds themselves...I do not always enquire specifically about spiritual values; however, I always try to find out what is important to my patients, and try to give care which takes this into account.' (ID06)*

> *'…spirituality…can be sensitive for some people more than others and I think that spirituality does not necessarily have to be part of a person's care per se particularly if the person is not particularly spiritual…spiritual health is certainly important in person-centred care but basically it just depends on the level of spirituality and spiritual practices that the person practises…making sure that we don't necessarily assume that everyone [pause] spirituality is as much about the person if that makes sense.' (ID05)*

Participants viewed spiritual care as an aspect of person-centred care, but recognised that it was not widely included and that patients determine its importance.

> *'Spiritual care should be patient led, and may depend on the importance the patient places on the value of spirituality in their own lives. It involves respect for a person's spiritual beliefs even if they differ from the practitioner's own. Spiritual values are perhaps one of the least actively included aspects of holistic care, however nursing care which comes from a place of deep respect for individuals will likely always take into account person's spiritual values.' (ID06)*

> *'Spiritual care can often be overlooked when planning primary healthcare, as it is often 'easier' to focus on the more obvious physical and emotional needs of the person. Additionally, many people do not feel comfortable discussing their spiritual needs in the context of a health care setting.' (ID04)*

> *'[Spiritual care] could be quite key to health and recovery, but it depends on the kind of nursing you're doing, I guess.' (ID08)*

> *'[the place of spiritual health as an aspect of person-centred care] very important as increases/improves working relationship, trust and show respecting the entire person.' (ID03)*

> *'…working in General Practice…we see a lot of people from all walks of…I've felt that spirituality is all about being open…to… patients' and families' values and beliefs and perceptions about life about managing health and about death as well. So, [um] yeah I think spirituality is very much a personal journey and demands a lot of sensitivity and openness from us as practitioners.' (ID05)*

The person-centred approach also guided the PNs in the plans of care they created with the patients, which brought about the third theme.

4.5 Theme 3 – Person-centred spiritual care practice.

The PNs described a predominantly existential approach to spiritual care as they helped patients deal with the stressors of their health condition and its impact on their lives. These conversations usually took place during the preparation of a 'care plan'. A care plan, which was briefly described in chapter one, is the common term given to a GP Management Plan

and Team Care Arrangement which are Medicare refundable items designed to help people manage their chronic conditions. Access to Medicare funded allied health services is provided in the plan (Services Australia, 2021a).

> *'I have to admit that I don't often discuss religion spiritual [sic] needs unless the patient brings it up or if they come up with discussing this when I am doing a care plan…I do discuss with people ways to reduce stress to assist with their emotional needs if anything.' (ID01)*

Only one participant made any reference to prayer or Scriptures.

> *'…whatever faith a person presents with…I don't have any conflict within myself about you know talking to people about most aspects of spiritual and religious faith that might give people an aspect of comfort. I can pray with one person from a Christian tradition and another person I can sit with and [cough] and hear their thoughts um on you know the Quran…' (ID08)*

The participants who identified that they had experienced providing spiritual care noted that it was often patient initiated. Only one participant (ID07) had not had any experience of providing spiritual care but expressed confidence to do so if the need arose. Ways to care for spiritual needs were many and varied and included setting mutual goals that were important to the patient and discussing how plans of care might conflict with religious practices. Participants' descriptions of person-centred spiritual care also included suggesting other resources, listening to stories, finding out what gives patients comfort and having discussions about hope and belief during health assessments. Health assessments are Medicare refundable items which are applicable to target groups including refugees, Aboriginal & Torres Strait Islanders, people aged 40-49 years at risk of Type 2 Diabetes and other age groups such as people aged 45-49 years old and people aged 75 years or older. The assessments look at the physical, psychological and social aspects of a person's health (Services Australia, 2021b)

> *'Previously I have had discussions with clients around the doctrines of their faith when it impacts on food intake and fasting (i.e., for diabetics) as in Ramadan and Orthodox Jews fasting, trying to plan care with respect to beliefs' (ID04)*

'…Spiritual beliefs also occasionally impact issues such as vaccine hesitancy, or dietary recommendations' (ID06)

'…if I do the…geriatric depression scale in the health assessment and I start asking some of the questions around their perceptions of feeling hopeless or helpless and then they start talking about oh um I feel like there is so much to live to live for I feel like I'm thankful that I'm still around thanks to God or thanks to whichever they believe in…' (ID05)

''letting patients tell me what they need and what's important to them and their family' (ID02)

'I always encourage patients to let me know if care recommended causes any conflict re spiritual beliefs… [spiritual care involves] *personalised goal setting' (ID03)*

ID04 suggested that a spiritual care question could be included in care planning;

'Do you have any spiritual beliefs or needs that may impact your health plan?'

The participant PNs expressed interest in caring for the spiritual needs of patients but identified challenges and barriers to doing so; this is the premise of theme four.

4.6 Theme 4 – Barriers and enablers to addressing spiritual needs

4.6.1 Time

Time was seen as both a barrier and an enabler. As a barrier, participants expressed time pressures due to expectations of practice management about what the nurses should achieve in the allocated time, whether a brief encounter for tasks such as a flu vaccine or a longer encounter for the completion of care plans or assessments. As an enabler, there were opportunities for repeat encounters over periods of years during periodic medication or vaccine administration, when care plans were reviewed, or health assessments repeated, allowing for the development of a trusting relationship.

'Barriers would be time – need to focus of the specifics on clients' chronic disease i.e., diabetes & healthy diet/exercise – only get 45 mins for care plans or 1 hour for health checks GPs probably don't see this as a priority in the care of patients' (ID01)

'Time pressure is a huge barrier, as is perceived lack of knowledge/confidence discussing spiritual matters. Time (if there is enough) can be an enabler, but most

importantly an ongoing relationship with clients that builds over time and several different encounters' (ID04)

'I guess time can be a barrier & it may require multiple appointments to discuss spiritual needs.' (ID02)

'…so, I feel like a barrier would be the time and an enabler would be I guess family support' (ID05)

4.6.2 Other barriers

Other barriers described by participants included a lack of knowledge and a lack of confidence when there is disparity of beliefs. They also described environmental barriers such as patients feeling discomfort discussing spiritual needs in a health care setting; and the perceived low priority that would be given to spiritual needs by management due to the business model on which practices operate. Nurses identified that at times there is a discrepancy between patient beliefs and evidence-based practice; as well as the level of importance of spiritual matters given by patients.

'Western society does not always place much importance on spirituality. Specific spiritual care is not generally included in templates such as for health assessments' (ID06)

'Conflicting beliefs with evidence-based care' (ID03)

4.6.3 Other enablers

Other enablers which participants described included: ongoing relationships with patients which build trust and confidence; having an attitude of non-judgement; having compassion; having self-awareness of one's own beliefs – which may also be a barrier when beliefs clash; the life situation of the patient e.g., palliative care.

Family support was an enabler identified by one participant who had observed that patients would seek confirmation about the existential effects of a life event from a family member present. Whilst one participant saw existing assessment tools as prompting responses about perceptions of health and end of life, others saw a need to have assessment tools or care planning templates which include explicit questions about spirituality and how it impacts a patients' health and well-being. ID07 indicated that spirituality was not routinely identified

when exploring individual needs. This was attributed to the type of consultations such as *'immunisations, wound care'*; but could perhaps also be due to the lack of spirituality/spiritual care assessment tools.

> *'…enablers I would say an attitude of non-judgement…an attitude of awareness about your own inherent biases that may come with any religious faith that you might have been brought up with…I think if you're aware of the fact that your own faith tradition might cause you have your own personal beliefs which…might impact your ability to provide healthcare...we need to understand our own culture like what does it mean to be white…privilege and that kind of stuff. So, if you don't see it you can't deal with it.' (ID08)*

4.7 Further findings

Two participants gave extended responses which are worth presenting but do not fit into the themes. The first relates to formal spiritual care training. The second relates to connection as a spiritual need.

As mentioned previously, the participants had received little or no formal training about how to address the spiritual needs of patients. ID08 had obtained informal training during her time as a pastoral care volunteer under the supervision of a hospital chaplain, which gave her confidence and skills to address spiritual needs of patients. ID04 explained the need for training to address cultural and spiritual beliefs:

> *'I guess my concern is that in an era of evidence-based nursing, education about spirituality and its impact on a person's health is not taught, addressed or understood. It's fine to have standards in place that outline the need to understand and respect a person's culture, spirituality and belief but little or no time is given to training in these beliefs.' (ID04)*

As ID08 had qualifications in mental health, and was interviewed when data analysis was underway, she was asked about whether she had seen any relationship between the decline in religious (as ABS figures indicate) activity and the rise in mental health. Her reply is worth noting as it relates to the aspect of connection identified elsewhere as a spiritual need:

'…I think if you go back to what are fundamental human needs…spirituality/traditional religion fits in there like a human need because it connects us to other people gives us a sense of meaning and purpose and you know it is important. I think my own opinion based on yeah on anecdotal evidence doing the work I do is that what the rise in presentations in mental health have got more to do with [um] separateness you know and people being lonely and isolated and anxious and not feeling like they have anyone to talk to that understands them so that's why I feel like you can really talk to anyone about any subject if you come at it from that perspective of compassionate non-judgement [mm] and so I'm really I'm a strong advocate of that…I can see it working so well' (ID08)

4.8 Summary

This chapter has presented the findings contained within the study data which can be summarised by four themes: 1. The individualised importance of spiritualty and spiritual care. 2. Spiritual care as an aspect of person-centred care. 3. Persson-centred spiritual care practice. 4. Barriers and enablers to addressing spiritual needs. In chapter five these findings are interpreted and discussed in the context of the existing literature as reviewed in chapter two.

CHAPTER 5

DISCUSSION, LIMITATIONS, RECOMMENDATIONS for PRACTICE and SUMMARY

5.1 Introduction

In this chapter the findings from chapter four are interpreted, compared and contrasted with the findings from the reviewed literature presented in chapter two. Study limitations are identified. Recommendations and implications for nursing practice and research are examined and explored. An overall summary concludes the chapter and thesis.

5.2 Overview of the findings

There were similarities and differences between the findings in this study and the literature. Similarities included the aspect of person-centred care including spiritual care, with some differences among all studies about what spiritual care involves. The barriers and enablers of spiritual care provision were also common to this study and the literature. The main difference is the setting.

The General Practice workplace setting of the study participants differed from the majority of the reviewed studies and substantiates the theme from the literature that workplace culture has an impact on spiritual caring; along with the culture of the country in which a nurse works. For example; in a previously cited study by Baldacchino (2006), nurses working in the mostly Catholic Church run hospitals in Malta were culturally inclined to incorporate some element of spiritual caring into their work. Spiritual caring was also part of nursing practice in the studies from Islamic countries, where spirituality and religion are intrinsically linked (Atarhim et al., 2019; Bakir et al., 2017; Herlianita et al., 2018; Kaddourah et al., 2018; Tirgari et al., 2013).

There were two studies which took place in a primary care setting: Carron and Cumbie (2011) and Tanyi et al. (2009). Similarly, to the PNs in this study, participants in these two American studies, described the trust that develops over time between patient and practitioner due to patients returning repeatedly for ongoing management of chronic conditions. Only Tanyi et al. (2009) discussed the business aspect as a barrier to addressing spiritual needs; a situation expressed also by the PNs. This is explored further in this chapter.

5.3 Discussion

The themes derived from the literature and described in chapter two, have a number of differences to the four themes derived from the findings in chapter four. Whilst the literature revealed that spirituality and spiritual care are not universally understood or practiced by nurses; the PNs experienced spiritualty and spiritual care both personally and in their work practice as highly individualised entities which also have a very individualised ranking of importance to them and to their patients. Person-centred care was important to the participants who viewed spiritual care as an aspect of person-centred care. This led to descriptions of person-centred spiritual care practice.

Similar to those in the literature, were the participants descriptions of barriers and enablers to addressing spiritual needs. The impact of ethnic and workplace culture which was seen in the literature substantiated the assumption that General Practice is a unique nursing context. The literature also highlighted challenges in assessing and documenting spiritual care. The PNs noted that document templates used in General Practice do not generally address spiritual matters. The headings in this chapter encompass the principal concepts of the literature and the research findings.

5.3.1 Spirituality and Spiritual Care

Participant views on spirituality and spiritual care presented in this study, were not unlike the diversity of ideas and views about spirituality found in the literature. In relation to spiritual care, the concepts of respect, compassion, and kindness were common findings both within this study and the literature; as seen particularly in the studies by Bakir et al. (2017); Deal and Grassley (2012); Herlianita et al. (2018); Kaddourah et al. (2018); Keall et al. (2014); Ormsby et al. (2017) and Tirgari et al. (2013). It is clear from the findings and the literature that defining spirituality and spiritual care is not straight forward as there are diverse cultural, religious and personal views about the matter. It is posited that the definition of spirituality quoted in chapter one by Narayanasamy (2010): *'spirituality is the essence of our being and one that gives meaning and purpose to our existence' (p. 37*) has a broader application to cultures and beliefs, than the previously favoured definition from Puchalski et al. (2014), chosen to give context to this study:

> *'Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self,*

family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices.' (Puchalski et al., 2014, p. 646).

Although the above definition was devised by a group of people from a range of cultural backgrounds, it could be said to appeal more to people who have more metaphysical approach to their spirituality due to the use of *'transcendence'* and *'sacred'*.

5.3.2 Person-centred spiritual care practice

The literature often speaks of spiritual care as an aspect of holistic or person-centred care, concepts which are often used interchangeably. The studies which mentioned or alluded to spiritual care in relation to holistic and/or person-centred care in their findings were Dhamani et al. (2011) (Tanzanian hospital-based), Egan et al. (2017) (New Zealand, mixed settings), Ormsby et al. (2017) (Australian, military-based), Ronaldson (2012); Ronaldson et al. (2017) (Australian acute and palliative care settings), and Tirgari et al. (2013) (Iranian hospital-based). Overall, the participants in this study and findings in the literature are in agreement about spiritual care being an aspect of person-centred/holistic care. However, only the participants in the Egan et al. (2017) study highlighted as the PNs did, the need to allow patients to determine the importance of spiritual care. In the Egan et al. (2017) study, participants raised the issue of using prompting questions about spiritual needs as patients may not express those needs themselves. The aim was to create a comfortable environment for patients to talk, which participants in this study also aimed to do. Participant PNs felt hesitant to ask patients about spiritual matters, fearing to be perceived as imposing their beliefs on patients, thus making patients feel uncomfortable. A similar fear was expressed by the participants in the study by Atarhim et al. (2019).

Placing patients at the centre of their care, and as the experts in their care is a significant part of the role of any nurse, and no less for the PN when working with patients on plans of care. By spending time finding out what is important to patients and understanding the patients' lived experiences, the most significantly different spiritual care practice described by the PNs, was the need to discuss with patients any potential conflict between religious beliefs and recommended care. This respect for patient beliefs is written into the Australian nursing standards for practice, as previously described (AHPRA, 2016), as well as being a criterion in the Royal Australian College of General Practitioners standards for General

Practice (the Standards) with which, as employees in General Practice, PNs are obliged to comply. The Standards criterion considers the impact of care on patient rights, beliefs, religious and cultural backgrounds (The Royal Australian College of General Practitioners, 2020). Suggested indicators for meeting the criterion, include policies pertaining to documentation about patient beliefs and cultural matters. However, the participant PNs identified that addressing spiritual needs was not routinely part of care planning, nor is assessing spiritual health currently included in health assessments; although one nurse did report spiritual matters arising in connection to some of the questions about quality-of-life in health assessments of older people. This is in contrast to the reviewed studies which took place in the acute or palliative sectors where, at the very least, there was a religion tick box on an admission form. This practice however, was considered to inadequately indicate spiritual needs as expressed by participants who commented on it in the studies by Egan et al. (2017) and Wong and Yau (2010).

5.3.2.1 Prayer

Offering prayer was mentioned as a strategy by one of the PNs, but expressed on more than one occasion in the literature (Deal & Grassley, 2012; Dhamani et al., 2011; Wong & Yau, 2010). The reasons for this, varied from being an accepted part of their culture as in Dhamani et al. (2011) to being something a nurse felt comfortable to offer in the other two studies. Findings in all three studies indicated that praying for patients was a frequently practiced spiritual care intervention, either with the patient or later in private. In some nursing practice settings, and with some patients it may be appropriate to pray should the nurse be comfortable to do so, but this should only be with the consent of, or a request by the patient, and not be an expected part of spiritual care practice (Johnson, 2010). The participants in the study by Egan et al. (2017) believed nurses had the skills and compassion to address existential spiritual needs, but believed patients are best referred to a spiritual leader to address metaphysical needs. The need for a collaborative approach to spiritual care was expressed by participants in the study by McSherry and Jamieson (2013) and in Donesky et al. (2020).

5.3.3 Barriers and enablers

Creating spaces where patients feel comfortable to talk about deeply personal or spiritual matters can be a challenge in environments which lack privacy for spiritual conversations;

an issue found in studies which asked participants about barriers and enablers to providing spiritual care (Deal & Grassley, 2012; Giske & Cone, 2015; Keall et al., 2014; Ronaldson et al., 2012).

5.3.3.1 Time

Lack of time is the number one barrier to providing spiritual care identified by participants in this study and the literature. In the literature lack of time was often associated with heavy workloads, other priorities and/or insufficient staff (Bakir et al., 2017; Dhamani et al., 2011; Herlianita et al., 2018). In the General Practice setting time is a barrier when allocated time is brief, such as administering a flu vaccination, or during longer encounters for care planning or assessments when there are many other topics to discuss such as medication management, activities of daily living, lifestyle modification and the salient details of the patient's particular conditions. However, PNs identified that time can also be an enabler to provide spiritual care due to the repeated patient encounters and relationship development over time. The nurse or practitioner/patient relationship which develops over time was seen as an important factor in spiritual caring in a number of studies, including Carron and Cumbie (2011); Deal and Grassley (2012) and Tanyi et al. (2009).

5.3.3.2 Knowledge, education and preparedness

Inadequate knowledge, education or nurse preparedness was a frequently cited barrier in the literature (Chan, 2010; Cone & Giske, 2017; Herlianita et al., 2018; McSherry & Jamieson, 2013; Tanyi et al., 2009; Walker & Waterworth, 2017). The PNs in this study described a lack of suitable assessment tools and education which meant that in their experience, spiritual needs were not regularly considered. Of the four PNs who did indicate having had some degree of spiritual care training, three had some undergraduate education which focussed mostly on cultural and religious beliefs. Understanding cultures and religions is a very limited aspect of spiritual care as it does not address the existential questions patients may ask such as 'Why me?' 'why is this happening?' as described in the study by Tanyi et al. (2009). Spiritual care education isn't about making nurses more spiritual, *'but rather to increase their awareness of the importance of spiritual needs, how to identify them in self and others, and refer on to appropriate support and services as required.'* (Egan et al. (2017, p 14). An approach such as this would require a spiritual care assessment tool with a broad application to cultures and beliefs, and a step-wise approach to manage the spiritual

needs raised in the assessment. As quoted in the previous chapter by a Practice Nurse participant, there is an assumption in the nursing practice standards that nurses will address spiritual needs along with physical, mental, emotional, environmental, social and cultural needs; but as she identified, there is need for training and instruction in order to so effectively. Furthermore, the templates often used in General Practice for care planning and assessments, do not address spiritual issues as noted by study participants. It is posited that this could be quite easily rectified with the insertion of some simple questions or prompts around resilience and coping, as well as the question about potential discrepancies between care and beliefs as raised by the study participants. The recording of a patient's social history in General practice software also offers scope to include spiritual needs if important to the patient. The dilemma of being an income generating business, remains an issue, if addressing spiritual needs is not given the same value as addressing physical and mental needs.

5.3.3.3 Spiritual self-awareness

Nurses with an awareness of their own spirituality are more likely to incorporate spiritual care into their practice as found in the studies by Chan (2010); Cone and Giske (2017); Deal and Grassley (2012); Herlianita et al. (2018); Ronaldson et al. (2017) and Walker and Waterworth (2017), as well being incidentally expressed by PNs in this study. However, having different beliefs was perceived as a barrier by some participants in this study as well as in the studies by Atarhim et al. (2019), Dhamani et al. (2011) and Keall et al. (2014) One PN participant expressed the importance of being aware of one's own spirituality and beliefs in order to be aware of any biases those beliefs might generate. This, she expressed, helped to stay open, non-judgemental and compassionate towards patients who have different beliefs.

5.3.3.4 Priorities

The low priority placed on spiritual care and seen as a barrier, was raised in the literature by Wong and Yau (2010), albeit for different reasons than raised by participants in this study. In an acute care setting, clinical triage gives greater priority to life-threatening needs. Higher priority is given to income generation in General Practice. The income generating business aspect was also raised by Tanyi et al. (2009). The business aspect is unique to privately owned primary health care practices such as General Practice. Practice owners want to

ensure that the time taken to do the work they do attracts some degree of remuneration. In a standard 10–15-minute consult, GPs have obligations that include reviewing medications, prescription and progress note writing, checking blood pressure, ordering tests as well as addressing the specific need for which the patient is attending. PNs play an active, complementary role to address needs that require more time. However, even in this, the PNs are often constrained by management expectations as previously discussed.

5.4 Limitations of study

Although the sample of eight was deemed appropriate for a qualitative study design; a larger number was desirable for the anticipated wide range of views on a topic as personal as spiritual care. The twelve months that it took to obtain participants who completed a written response to the questions or agreed to an interview; due to the previously discussed problems arising from the COVID 19 pandemic; made it difficult to procure more data.

Whilst the views of the PNs in this study may not represent the views of all PNs, the group was deemed homogenous enough to be representative of the broader nursing population. Similar to other studies on spiritual care, it is likely that the participants have an interest in the topic. Therefore, it is difficult to gauge what type of responses would be obtained from nurses who do not ascribe to spiritual matters.

The preferred option by most of the participants to provide a written response did not allow for interaction to obtain elaboration or clarification of their answers. In hindsight, the question sheet could have been adjusted to prompt more in-depth responses, although a more in-depth questionnaire may have been a deterrent to prospective participants.

Despite the limitations of the study, there has been sufficient data collected to give consideration to what might be needed to improve spiritual care practice in the General Practice setting. Possibilities for further research is also considered.

5.5 Recommendations for practice and further research

Practice Nurses respect patients' beliefs and values, and adopt a person-centred care approach when asking how health care strategies might impact or be influenced by those beliefs and values. Nurses need to be able to assess for and recognise spiritual distress and possess the tools and skills to be able to address it, either themselves or by directing the person to help, regardless of the personal beliefs of nurse and patient. Participants in this

study suggested the possibility of questions about spirituality being incorporated into health assessments and GP Management Plans (care plans). Time allocated for care plans and health assessments is used to discuss many issues as the study participants highlighted. However, it is possible that spiritual matters may be important to a patient. Therefore, nurses need to feel competent with the skills needed to identify spiritual distress and/or discuss spiritual issues raised by the patient. Currently there is no formal provision for referral to a spiritual care professional; it is up to the patient to source such a person. In the same way that patients can be referred to psychologists through Mental Health Treatment Plans, a proposed initiative could include referral to spiritual counselling.

The lack of definitions for spirituality and spiritual care, described in the literature, could be overcome by having agreed concepts and principles to follow, along with basic assessment and planning tools which are applicable to any belief set. McSherry (2010) recommends that a spiritual assessment tool should be safe, adaptable, easy to administer, non-intrusive, inclusive and ethical. One possible assessment tool which has these features is the HOPE model, which was originally designed to help medical students and physicians incorporate questions about spirituality into their patient history taking. Anandarajah and Hight (2001) describe the concepts of HOPE: '*H—sources of hope, strength, comfort, meaning, peace, love and connection; O—the role of organized religion for the patient; P—personal spirituality and practices; E—effects on medical care and end-of-life decisions' (P. 81)*; as well as offering questions that can be used sensitively to ask about each concept.

The participants in this study who reported having received spiritual care education during their undergraduate studies, stated briefly that there was little more than discussion in their courses about different religious and cultural beliefs. According to Cooper et al. (2013), there is no standard curriculum requirement for spiritual care education in undergraduate nursing programs. A review of the content of spiritual care education is needed to ensure nurses have an understanding of the existential and metaphysical aspects of spirituality; the various religious and/or spiritual practices in which people may engage; how to recognise and address spiritual distress; and a referral pathway for issues relating to a person's beliefs. Such a program would also require research to evaluate its effectiveness. Similar content would also to be desirable in post-graduate nursing programs.

Further research is needed to understand whether patients visiting General Practices in Australia expect spiritual care from the doctors, nurses and allied health practitioners they see.

5.6 Thesis conclusion

This study explored PNs' experiences of spiritual caring in the Australian General Practice setting. Practice Nurses described their understanding of spirituality and experiences of providing spiritual care. By using an Interpretive Descriptive design, the findings were examined and interpreted alongside what is known about spirituality and spiritual caring.

The themes of the findings in the study were: 1. The individualised importance of spiritualty and spiritual care. 2. Spiritual care as an aspect of person-centred care. 3. Person-centred spiritual care practice. 4. Barriers and enablers to addressing spiritual needs. They have been contrasted to those in the literature review: 1. Spirituality and spiritual care are not universally understood or practiced by nurses. 2. The impact of ethnic and workplace culture. 3. Challenges in assessing and documenting spiritual care. 4. Barriers and enablers to providing spiritual care. The implications for Practice Nursing have been considered and recommendations for further research made.

In this closing chapter as noted in the literature and in this study, the incorporation of spiritual care is not yet standard nursing practice in Australia, except perhaps in the Palliative care sector, as indicated by the reviewed studies. Where spiritual care is practiced it is not necessarily performed consistently or universally. It is well documented that spirituality and spiritual care have different meanings among cultures and individuals. Care strategies such as listening, touch, and giving comfort are employed by nurses. Other needs specific to a patient's beliefs may require referral to a spiritual care professional. The conclusion drawn therefore by this author is that PNs generally have the compassion and respect to attend to spiritual needs of their patients, but need to have the skills and assessment tools to recognise and explore those needs with patients, and the opportunity to assist them within the constraints of an income generating business.

REFERENCES

Adrian, A. (2009). *Primary Health Care in Australia: A nursing & midwifery consensus view, April 2009*. Rozelle, NSW: Australian Nursing Federation.

Aghadiuno, M. (2010). Spiritual Distress. In M. Aghadiuno (Ed.), *Soul Matters: the spiritual dimension within healthcare*. Oxford: Radcliff Publishing.

AHPRA. (2016). Registered Nurse Standards for Practice. Melbourne: Nursing and Midwifery Board of Australia. Retrieved from https://nursingmidwiferyboard.gov.au

Anandarajah, G., & Hight, E. (2001). Spirituality and medical practice: using the HOPE questions as a practical tool for spiritual assessment. *American family physician, 63*(1), 81-89. Retrieved from https://www-proquest-com.ezproxy.flinders.edu.au/

APNA. (2020). *APNA Annual Report 2019*. (pp. 68). Retrieved from https://apna.asn.au/files/APNA%20Annual%20Report%202019%20Web-ready.pdf

Atarhim, M. A., Lee, S., & Copnell, B. (2019). An Exploratory Study of Spirituality and Spiritual Care Among Malaysian Nurses. *Journal of Religion & Health, 58*(1), 180-194. doi:10.1007/s10943-018-0624-0

Austin, P. D., Macleod, R., Siddall, P. J., McSherry, W., & Egan, R. (2016). The Ability of Hospital Staff to Recognise and Meet Patients' Spiritual Needs: A Pilot Study. *Journal for the Study of Spirituality, 6*(1), 20-37. doi:10.1080/20440243.2016.1158453

Australian Bureau of Statistics. (2018). Religion in Australia. *2071.0 - Census of Population and Housing: Reflecting Australia - Stories from the Census, 2016.* Retrieved from https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by+Subject/2071.0~2016~Main+Features~Religion+Data+Summary~70

Australian Bureau of Statistics. (2019). Australia's population by country of birth. *3412.0 - Migration, Australia, 2017-18.* Retrieved from www.https://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/3412.0Main%20Features22017-18?opendocument&tabname=Summary&prodno=3412.0&issue=2017-18&num=&view=

Australian Human Rights Commission. (n.d.). Constitutional reform: Fact Sheet - Recognising Aboriginal & Torres Strait Islander people in the Constitution. Retrieved from https://humanrights.gov.au/our-work/constitutional-reform-fact-sheet-recognising-aboriginal-torres-strait-islander-people

Australian Medicare Local Alliance. (2012). *2012 General Practice Nurse National Survey Report*. Manuka, ACT: Australian Medicare Local Alliance.

Australian Nursing and Midwifery Federation. (2014). *National Practice Standards for Nurses in General Practice*. Melbourne: Australian Nursing and Midwifery Federation - Federal Office.

Bakir, E., Samancioglu, S., & Kilic, S. P. (2017). Spiritual Experiences of Muslim Critical Care Nurses. *Journal of Religion and Health, 56*(6), 2118-2128. doi:10.1007/s10943-017-0382-4

Baldacchino, D. R. (2006). Nursing competencies for spiritual care. *Journal of Clinical Nursing, 15*(7), 885-896. doi:10.1111/j.1365-2702.2006.01643.x

Battey, B. W. (2009). *Theory of spiritual care for nursing practice* (Kindle ed.). USA: Xlibris Corporation.

Bouma, G. (2009). *Australian Soul: Religion and spirituality in the twenty-first century*. Port Melbourne, Victoria, Australia: Cambridge University Press.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology, 3*(2), 77-101. doi:10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2014). What can "thematic analysis" offer health and wellbeing researchers? *International Journal of Qualitative Studies on Health and Well-being, 9*(1), 26152-26152. doi:10.3402/qhw.v9.26152

Carron, R., & Cumbie, S. A. (2011). Development of a conceptual nursing model for the implementation of spiritual care in adult primary healthcare settings by nurse practitioners.

Journal of the American Academy of Nurse Practitioners, 23(10), 552-560. doi:10.1111/j.1745-7599.2011.00633.x

CASP UK. (2018). CASP Checklist. Retrieved from https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist-2018.pdf

Chan, M. F. (2010). Factors affecting nursing staff in practising spiritual care. *Journal of Clinical Nursing, 19*(15-16), 2128-2136. doi:10.1111/j.1365-2702.2008.02690.x

Cockell, N., & McSherry, W. (2012). Spiritual care in nursing: an overview of published international research. *Journal of Nursing Management, 20*(8), 958-969. doi:10.1111/j.1365-2834.2012.01450.x

Cocksedge, S., & May, C. (2005). Pastoral relationships and holding work in primary care: affect, subjectivity and chronicity. *Chronic Illness, 1*(2), 157-163. doi:10.1177/17423953050010020101

Cone, P. H., & Giske, T. (2017). Nurses' comfort level with spiritual assessment: a study among nurses working in diverse healthcare settings. *Journal of Clinical Nursing (John Wiley & Sons, Inc.), 26*(19-20), 3125-3136. doi:10.1111/jocn.13660

Cooper, A., & Brown, J. (2017). Maximising nurses' and midwives' response rates to surveys. *Nurse Researcher, 25*(3), 31-35. doi:10.7748/nr.2017.e1494

Cooper, K., Chang, E., Sheehan, A., & Johnson, A. (2013). The impact of spiritual care education upon preparing undergraduate nursing students to provide spiritual care. *Nurse Education Today, 33*(9), 1057-1061. doi: 10.1016/j.nedt.2012.04.005

Deal, B., & Grassley, J. S. (2012). The Lived Experience of Giving Spiritual Care: A Phenomenological Study Of Nephrology Nurses Working in Acute And Chronic Hemodialysis Settings. *Nephrology Nursing Journal, 39*(6), 471-496. Retrieved from https://go-gale-com.ezproxy.flinders.edu.au

Department of Health. (2019). *Australia's long term national health plan: to build the world's best health system*. Canberra: Australian Government.

Department of Health. (2021a). General Practices join the COVID-19 vaccination program. Retrieved from https://www.health.gov.au/news/general-practices-join-the-covid-19-vaccination-program

Department of Health. (2021b). National Immunisation program schedule: Flu (influenza) vaccines. Retrieved from https://www.health.gov.au/health-topics/immunisation/immunisation-throughout-life/national-immunisation-program-schedule#flu-influenza-vaccines

Dhamani, K. A., Paul, P., & Olson, J. K. (2011). Tanzanian nurses understanding and practice of spiritual care. *International Scholarly Research Network (ISRN) Nursing*, 7p-7p. doi:2011/534803

Donesky, D., Sprague, E., & Joseph, D. (2020). A New Perspective on Spiritual Care: Collaborative Chaplaincy and Nursing Practice. *Advances in Nursing Science, 43*(2), 147-158. doi:10.1097/ANS.0000000000000298

Egan, R., Llewellyn, R., Cox, B., MacLeod, R., McSherry, W., & Austin, P. (2017). New Zealand Nurses' Perceptions of Spirituality and Spiritual care: Qualitative Findings from a National Survey. *Religions, 8*(5), 79. doi:10.3390/rel8050079

Egan, R., Macleod, R., Jaye, C., McGee, R., Baxter, J., & Herbison, P. (2011). What is spirituality? Evidence from a New Zealand hospice study. *Mortality, 16*(4), 307-324. doi:10.1080/13576275.2011.613267

Elliott, R., Wattis, J., Chirema, K., & Brooks, J. (2020). Mental health nurses' understandings and experiences of providing care for the spiritual needs of service users: A qualitative study. *Journal of Psychiatric & Mental Health Nursing (John Wiley & Sons, Inc.), 27*(2), 162-171. doi:10.1111/jpm.12560

Farlex Inc. (2012). Medical Dictionary for the Health Professions and Nursing. Retrieved from holistic care

Frame, T. (2009). *Losing my Religion: Unbelief in Australia*. Sydney, Australia: University of New South Wales Press Ltd.

Frankl, V. E. (2006). *Man's search for meaning*. (Kindle Edition). Boston, Massachusetts: Beacon Press.

Giske, T., & Cone, P.H. (2015). Discerning the healing path - how nurses assist patient spirituality in diverse health care settings. *Journal of Clinical Nursing, 24*(19-20), 2926. doi:10.1111/jocn.12907

Groot, M., Ebenau, A. F., Koning, H., Visser, A., Leget, C., van Laarhoven, H., van Leeuwen, R.,Ruben, R., Wulp, M., and Garssen, B. (2017). Spiritual care by nurses in curative cancer care: Protocol for a national, multicentre, mixed method study. *Journal of Advanced Nursing, 73*(9), 2201-2207. doi:10.1111/jan.13332

Halcomb, E., McInnes, S., Williams, A., Ashley, C., James, S., Fernandez, R., Stephen, C., and Calma, K. (2020). The Experiences of Primary Healthcare Nurses During the COVID-19 Pandemic in Australia. *Journal of Nursing Scholarship, 52*(5), 553-563. doi:10.1111/jnu.12589

Harrington, A. (1993). *Registered nurses' perceptions of spiritual care a descriptive study.* Thesis (M.Nsg.)--Flinders University of South Aust., 1994.

Harrington, A. (2016). The importance of spiritual assessment when caring for older adults. *Ageing and Society.* 36(01), 1-16. doi:10.1017/S0144686X14001007.

Harrington, A., Williamson, V., & Goodwin-Smith, I. (2018). Understanding the Diverse Forms of Spiritual Expression of Older People in Residential Aged Care in Australia. *Journal of religion and health.* doi:10.1007/s10943-018-00742-1

Herlianita, R., Yen, M., Ching-Huey, C., Fetzer, S. J., & Lin, E. C.-L. (2018). Perception of Spirituality and Spiritual Care among Muslim Nurses in Indonesia. *Journal of Religion and Health, 57*(2), 762-773. doi:10.1007/s10943-017-0437-6

Heywood, T., & Laurence, C. (2018). The general practice nurse workforce: Estimating future supply. *Australian Journal for General Practitioners, 47*, 788-795. Retrieved from https://www-proquest-com.ezproxy.flinders.edu.au

Hilbers, J., Haynes, A. S., & Kivikko, J. G. (2010). Spirituality and Health: An Exploratory Study of Hospital Patients' Perspectives. *Australian Health Review, 34*(1), 3-10. doi:10.1071/AH09655

Hunt, M. R. (2009). Strengths and Challenges in the Use of Interpretive Description: Reflections Arising From a Study of the Moral Experience of Health Professionals in Humanitarian Work. *Qualitative Health Research, 19*(9), 1284-1292. doi:10.1177/1049732309344612

Jones, K., Dorsett, P., Briggs, L., Simpson, G. (2018) The role of spirituality in spinal cord injury (SCI) rehabilitation: exploring health professional perspectives. *Spinal cord series and cases* 4(1) 1-6. doi:10.1038/s41394-018-0078-3.

Kaddourah, B., Abu-Shaheen, A., & Al-Tannir, M. (2018). Nurses' Perceptions of Spirituality and Spiritual Care at Five Tertiary Care Hospitals in Riyadh, Saudi Arabia: A Cross-Sectional Study. *Oman Medical Journal, 33*(2), 154-158. doi:10.5001/omj.2018.28

Keall, R., Clayton, J. M., & Butow, P. (2014). How do Australian palliative care nurses address existential and spiritual concerns? Facilitators, barriers and strategies. *Journal of Clinical Nursing, 23*(21-22), 3197-3205. doi:10.1111/jocn.12566

Koenig, H. G. (2012). Religion, Spirituality, and Health: The Research and Clinical Implications. *International Scholarly Research Network (ISRN) Psychiatry, 2012*. doi:10.5402/2012/278730

Johnson, C. (2010). Dilemmas of spiritual assessment. In W. McSherry & L. Ross (Eds.), *Spiritual Assessment in healthcare practice* (Kindle edition). Keswick, Cumbria: M & K publishing.

Lally, R., & Costello, S. (2013). *Angles in shoes: care of the spirit*. Charleston, SC, USA: authors.

Luck, L., Ng Chok, H., & Wilkes, L. (2017). Nurses as participants in research: an evaluation of recruitment techniques. *Nurse researcher., 25*(2), 44. Retrieved from https://www-proquest-com.ezproxy.flinders.edu.au/

McCrindle, M. (2017). *Faith and belief in Australia*. Baulkham Hills, NSW: McCrindle Research Pty Ltd.

McInnes, S., Peters, K., Bonney, A., & Halcomb, E. (2017). A qualitative study of collaboration in general practice: understanding the general practice nurse's role. *Journal of Clinical Nursing, 26*(13-14), 1960-1968. doi:10.1111/jocn.13598

McMurray, A., & Clendon, J. (2015). *Community health and wellness: primary health care in practice* (5th edition). Australia: Elsevier.

McSherry, W. (2010). Spiritual Assessment: definition, categorisation and features. In W. McSherry & L. Ross (Editors), *Spiritual assessment in healthcare practice* (Kindle edition). Keswick, Cumbria,: M&K Publishing.

McSherry, W., & Jamieson, S. (2011). An online survey of nurses' perceptions of spirituality and spiritual care. *Journal of Clinical Nursing, 20*(11-12), 1757-1767. doi:10.1111/j.1365-2702.2010.03547.x

McSherry, W., & Jamieson, S. (2013). The qualitative findings from an online survey investigating nurses' perceptions of spirituality and spiritual care. *Journal of Clinical Nursing, 22*(21-22), 3170-3182. doi:10.1111/jocn.12411

McSherry, W., & Ross, L. (2002). Dilemmas of spiritual assessment: considerations for nursing practice. *Journal of Advanced Nursing, 38*(5), 479-488. doi:10.1046/j.1365-2648.2002.02209.x

Meaningful Ageing Australia. (2016). *National guidelines for spiritual care in aged care*. Parkville: Meaningful Ageing Australia.

Minton, M., Isaacson, M., Varilek, B. M., Stadick, J. L., & O' Connell-Persaud, S. (2018). A willingness to go there: Nurses and spiritual care. *Journal of Clinical Nursing, 27*(1-2), 173-181. doi:10.1111/jocn.13867

Narayanasamy, A. (2010). Recognising spiritual needs. In W. McSherry & L. Ross (Editors), Spiritual Assessment in Healthcare practice (Kindle edition). Keswick, Cumbria: M & K Publishing.

National Health Priority Action Council (NHPAC). (2005). *National Chronic Disease Strategy*. Canberra: Australian Government Department of Health & Ageing.

Neergaard, M. A., Olesen, F., Andersen, R. S., & Sondergaard, J. (2009). Qualitative description - the poor cousin of health research? *BMC Medical Research Methodology, 9*(1), 52-52. doi:10.1186/1471-2288-9-52

Neville, S., & Whitehead, D. (2020). Analysing Data in Qualitative Research. In D. Whitehead, C. Ferguson, G. Lobiondo-Wood, & J. Haber (Editors), *Nursing and Midwifery research: methods and appraisal for evidence-based practice* (6th edition, pp. 136-155). Chatswood, NSW: Elsevier Australia.

Ormsby, A., Harrington, A., & Borbasi, S. (2017). 'You never come back the same': the challenge of spiritual care in a deployed military nursing context. *Journal of Clinical Nursing, 26*(9-10), 1351-1362. doi:10.1111/jocn.13685

Palliative Care Australia, & Meaningful Ageing Australia. (2017). Joint Position Statement. Spiritual care: integral to pallaitive care in aged care. Retrieved from https://palliativecare.org.au/wp-content/uploads/dlm_uploads/2017/05/Spiritual-Care-Position-Statement.pdf

Polit, D. F., & Beck, C. T. (2017). *Nursing research : generating and assessing evidence for nursing practice* (10th edition): Philadelphia : Wolters Kluwer Health.

Polzer Casarez, R. L., & Engebretson, J. C. (2012). Ethical issues of incorporating spiritual care into clinical practice. *Journal of Clinical Nursing, 21*(15-16), 2099-2107. doi:10.1111/j.1365-2702.2012.04168.x

Powell, R. (2019). Community and Church Summit Presentation. Retrieved from www.ncls.org.au-news-australians-opinions-about-church

Puchalski, C. (2001). The role of spirituality in health care. *Proceedings (Baylor University. Medical Center), 14*(4), 352-357. doi:10.1080/08998280.2001.11927788

Puchalski, C., Vitillo, R., Hull, S., & Reller, N. (2014). Improving the Spiritual Dimension of Whole Person Care: Reaching National and International Consensus. *Journal of Palliative Medicine, 17*(6), 642-656. doi:10.1089/jpm.2014.9427

RACGP. (2008). General approach to medical care of residents. In *Medical care of older persons in residential aged care facilities (Silver Book)* (4th edition.). South Melbourne: The Royal Australian College of General Practitioners.

Ronaldson, S. (2012, 2012/09//). Spiritual caring in nursing. *Australian Nursing Journal, 20,* 26.

Ronaldson, S., Hayes, L., Aggar, C., Green, J., & Carey, M. (2012). Spirituality and spiritual caring: nurses' perspectives and practice in palliative and acute care environments. *Journal of Clinical Nursing, 21*(15-16), 2126-2135. doi:10.1111/j.1365-2702.2012.04180.x

Ronaldson, S., Hayes, L., Aggar, C., Green, J., & Carey, M. (2017). Palliative care nurses' spiritual caring interventions: a conceptual understanding. *International Journal of Palliative Nursing, 23*(4), 194-201. doi:10.12968/ijpn.2017.23.4.194

Rosmarin, D., & Koenig, H. (Editors)(2020) *Handbook of Spirituality, Religion, and Mental Health (Second Edition)*. San Diego: Elsevier Science and Technology.

Ross, L. (2006). Spiritual care in nursing: an overview of the research to date. *Journal of Clinical Nursing, 15*(7), 852-862. doi:10.1111/j.1365-2702.2006.01617.x

Ross, L. (2010). Why the increasing interest in spirituality wirthin healthcare? In W. McSherry & L. Ross (Editors), *Spiritual asseement in healthcare practice* (Kindle Edition). Keswick, Cumbria: M & K Publishing.

Ross, L., & McSherry, W. (2010). Considerations for the future of spiritual assessment. In W. McSherry & L. Ross (Editors), *Spiritual Assessment in healthcare practice* (Kindle edition). Keswick, Cumbria: M&K Publishing.

Rushton, L. (2014). What are the barriers to spiritual care in a hospital setting? *British Journal of Nursing, 23*(7), 370-374. doi:10.12968/bjon.2014.23.7.370

Saldaña, J. (2016). *The coding manual for qualitative researchers*. (Kindle Edition). London: SAGE Publications Ltd.

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health, 23*(4), 334-340. doi:10.1002/1098-240X(200008)23:4<334::AID-NUR9>3.0.CO2-G

Sandelowski, M. (2010). What's in a name?: Qualitaitve description revisited. *Research in Nursing & Health, 33*(1), 77-84. doi/abs/10.1002/nur.20362

Services Australia. (2021a). Education guide - Chronic disease GP Management Plans and Team Care Arrangements. Retrieved from https://www.servicesaustralia.gov.au/organisations/health-professionals/topics/education-guide-chronic-disease-gp-management-plans-and-team-care-arrangements/33191

Services Australia. (2021b). Education guide - Health assessments and your record keeping responsibilities. Retrieved from https://www.servicesaustralia.gov.au/organisations/health-professionals/topics/education-guide-health-assessments-and-your-record-keeping-responsibilities/32851

Smyth, T., & Allen, S. (2011). Nurses' experiences assessing the spirituality of terminally ill patients in acute clinical practice. *International Journal of Palliative Nursing, 17*(7), 337-343. doi:10.12968/ijpn.2011.17.7.337

Suchanek, F. (2006-2019). Where does the spirit go after death? In The Atheist Bible: Fabian Suchanek. Retrieved from https://suchanek.name/texts/atheism/index.html#TOC.

Swinton, J. (2010). The meanings of spirituality:a multi-perspective approach to 'the spiritual'. In W. McSherry & L. Ross (Eds.), *Spiritual Assessment in Healthcare Practice* (Kindle edition ed.). Keswick, Cumbria, UK: M & K Publishing.

Tacey, D. J. (2020). *The postsecular sacred : Jung, soul, and meaning in an age of change*: London, New York, New York : Routledge.

Tanyi, R. A., McKenzie, M., & Chapek, C. (2009). How family practice physicians, nurse practitioners, and physician assistants incorporate spiritual care in practice. *Journal of the American Academy of Nurse Practitioners, 21*(12), 690-697. doi:10.1111/j.1745-7599.2009.00459.x

Teodoro, I. P. P., Rebouças, V. d. C. F., Thorne, S. E., Souza, N. K. M. d., Brito, L. S. A. d., & Alencar, A. M. P. G. (2018). Interpretive description: a viable methodological approach for nursing research. *Escolar Anna Nery, 22*(3). doi:10.1590/2177-9465-ean-2017-0287

The RoyalAustralian College of General Practitioners. (2015) *Smoking, nutrition, alcohol, physical activity (SNAP): A population health guide to behavioural risk factors in General Practice*. East Melbourne, Vic. RACGP.

The Royal Australian College of General Practitioners. (2018). *General Practice: Health of the Nation 2018.* East Melbourne, Vic. RACGP.

The Royal Australian College of General Practitioners. (2020). *Standards for general practices. 5th edition*. East Melbourne, Vic. RACGP.

Thompson Burdine, J., Thorne, S., & Sandhu, G. (2021). Interpretive description: A flexible qualitative methodology for medical education research. *Medical Education, 55*(3), 336-343. doi:10.1111/medu.14380

Thorne, S. (2016). *Interpretive description : qualitative research for applied practice* (Second Edition). New York, NY : Routledge.

Thorne, S., Kirkham, S. R., & Macdonald-emes, J. (1997). Interpretive description: A noncategorical qualitative alternative for developing nursing knowledge. *Research in Nursing & Health, 20*(2), 169-177. doi:10.1002/(SICI)1098-240X(199704)20:2<169::AID-NUR9>3.0.CO2-I

Thorne, S., Kirkham, S. R., & O'Flynn-Magee, K. (2004). The Analytic Challenge in Interpretive Description. *International Journal of Qualitative Methods, 3*(1), 1-11. doi:10.1177/160940690400300101

Tiew, L. H., & Drury, V. (2012). Singapore Nursing Students' Perceptions and Attitudes About Spirituality and Spiritual Care in Practice. *Journal of Holistic Nursing, 30*(3), 160-169. doi:doi:10.1177/0898010111435948

Tirgari, B., Iranmanesh, S., Ali Cheraghi, M., & Arefi, A. (2013). Meaning of spiritual care: Iranian nurses' experiences. *Holistic Nursing Practice, 27*(4), 199-206. doi:10.1097/HNP.0b013e318294e774

Van Leeuwen, R., & Cusveller, B. (2004). Nursing competencies for spiritual care. *Journal of Advanced Nursing, 48*(3), 234-246. doi:10.1111/j.1365-2648.2004.03192.x

van Leeuwen, R., & Schep-Akkerman, A. (2015). Nurses' Perceptions of Spirituality and Spiritual Care in Different Health Care Settings in the Netherlands. *Religions, 6*(4), 1346. doi:10.3390/rel6041346

Walker, H., & Waterworth, S. (2017). New Zealand palliative care nurses experiences of providing spiritual care to patients with life-limiting illness. *International Journal of Palliative Nursing, 23*(1), 18-26. doi:10.12968/ijpn.2017.23.1.18

Walker, L., Patterson, E., Wong, W., & Young, D. (2010). *General Practice Nursing*. North Ryde, NSW: McGraw-Hill Australia Pty Ltd.

Whitehead, D. (2020). Critically searching and reviewing the research literature. In D. Whitehead, C. Ferguson, G. Lobiondo-Wood, & J. Haber (Editors), *Nursing and midwifery research:methods and appraisal for evidence-based practice* (6th edition, pp. 55-80). Chatswood, NSW: Elsevier Australia.

Whitehead, D., & Disler, R. (2020). Common Qualitative Methods. In D. whitehead, C. Ferguson, G. Lobiondo-Wood, & J. Haber (Editors), *Nursing and Midwifery Research: methods and appraisal for evidence-based practice* (6th edition, pp. 98-117). Chatswood, NSW: Elsevier Australia.

Wong, K. F., & Yau, S. Y. (2010). Nurses' experiences in spirituality and spiritual care in Hong Kong. *Applied Nursing Research, 23*(4), 242-244. doi:10.1016/j.apnr.2008.10.002

APPENDICES

APPENDIX 1

Literature Review Summary Table

Author surnames and year	Study Purpose	Study design/methodology	Setting and purpose	Main findings	Relevance and implications for practice
Atarhim, Lee, and Copnell, 2019	Explore Malaysian nurses' perceptions of and spiritual care	Descriptive cross-sectional design using an online survey	208 responses from a Facebook closed group 160 responded in English, 48 in Malay Majority Islamic Malay females (80-89%)	Religion and spiritualty closely linked with little separation seen between the two. Insufficient education to feel competent to give spiritual care. Uncertainty providing spiritual care to people with different beliefs	Offers a cultural perspective where spiritual and/or religious beliefs vary between patients and nurse
Bakir, Samancioglu and Kilic, 2017	determine views and perceptions of Muslim intensive care nurses (ICNs) about spirituality and spiritual care in nursing practice, detect the effective factors, and raise the awareness about spirituality and spiritual care	descriptive study, data collected by a completed questionnaire	145 ICNs from a Turkish university hospital	44% had some spiritual care training, 64% provided spiritual care. Spiritual care described as: therapeutic touch, listening, psychological support, talking, making person comfortable. Barriers included high workload, insufficient staff and time plus fatigue. Level of education and personal awareness were significant factors.	Offers the Islamic religious/cultural perspective Offering spiritual care takes knowledge, time, sensitivity

Carron, and Cumbie, 2011	To develop and propose a conceptual nursing model which provides a framework for the delivery of spiritual care to adults in primary healthcare settings	Qualitative descriptive design using grounded theory and phenomenology Participant interviews	Sample: Purposive sampling 14 participants: 5 adult patients, 3 nurse practitioners, 4 community spiritual leaders/educators, 2 Benedictine nuns; 28-84 years old; 11 women, 3 men Setting: A small US community local to the authors	The importance of the nurse/patient relationship. Spiritual care can be described as receiving kindness and care.	Background information about spiritual care. Valuable insights into the place of spiritual health care.
Chan, 2010	Examine nurses' attitudes and associated factors to practising spiritual care	A quantitative retrospective study using a Structured self-reported questionnaire	110 nurses in a public hospital in Hong Kong	Significant factors in the practice of spiritual care included personal religious beliefs, marital status, past experience of hospitalisation, the ward environment (obstetrics and gynaecology) and higher perception levels of spiritual care	Spirituality as individual philosophy, values and meaning given to life, beyond religious affiliation. It involves inspiration, reverence, awe, meaning and purpose, harmony with the universe. Spiritual care as love and compassion expressed in interpersonal care Improve spiritual care giving as part of holistic care, care plans to indicate spiritual needs beyond a religion tick-box

Cone and Giske, 2017	Understand nurse comfort levels in assessing spiritual matters and the questions used	Mixed methods, cross-sectional exploratory survey	172 Norwegian nurses from diverse settings	Nurse comfort with spiritual assessment was influenced by preparedness or experience. Preparedness was related to years of experience, degree of spirituality and religiosity, importance of spiritual assessment Indirect observation of patients was more often used than direct questioning about spiritual matters	The context categories were medical, surgical, home health, nursing home, other. The concept of preparedness was a little difficult to follow in parts Cultural taboos and intolerance in discussing spiritual matters Nurses need to be better prepared to make spiritual assessments, patient spirituality needs to be discussed and reflected upon in everyday practice, assessment tools need to be culturally tailored
Deal and Grassley, 2012	explore the lived experiences of nephrology nurses giving spiritual care in acute and chronic haemodialysis settings	phenomenology, interviews	10 nurses with current or recent dialysis experience with a mix of hospital or community-based contexts	Five themes were identified: a) drawing close, b) drawing from the well of my spiritual resources, c), sensing the pain of spiritual distress, d) lacking resources to give spiritual care, and e) giving spiritual care is like diving down deep. Barriers: lack of time, lack of privacy, lack of energy – spiritual caring can be emotionally tiring (similar to compassion fatigue), fear of offending.	The close relationships formed have similarities to general practice. ‘’Spiritual care is conveyed by being caring and respectful, which can assist the patient to regain meaning and purpose in life, faith or trust, hope, love, and forgiveness.’’ (p. 472) Identifying spiritual distress Documentation
Dhamani, Paul and Olson, 2011	Examine how Tanzanian nurses understand	Interpretive description in-depth interviews	15 registered nurses from a Tanzanian hospital,	Mostly similar findings to those from other countries.	Cultural influences Lists interventions used

	spirituality and spiritual care			Some unique elements reflecting the African context – e.g., influence of witchcraft, devils, traditional healers. Curing as medical; healing as spiritual Lack of time and staff barriers to spiritual care giving Religious based interventions quite commonplace in comparison to other countries	Demographics of participants not typical of the general population Collaborative approach to spiritual care to involve chaplains, pastors or imams – the implications for general practice is around not having spiritual leaders or chaplains easily at call. It falls to the patient to make contact with a spiritual leader of similar persuasion
Egan, Llewellyn, Cox, MacLeod, McSherry and Austin, 2017	present the qualitative findings from a survey of New Zealand nurses' views on spirituality and spiritual care	descriptive online survey	472 responses. 63% (n=274) of these answered the (qualitative) two open ended questions Diverse settings	Three major themes, each with 2-3 subthemes – the role of spirituality in nursing practice: what is our role? A need for clarity; enabling best practice: collaboration, responding to a changing society, competency, confidence and professional development; creating a supportive culture: a supportive environment, leadership and role-modelling, overcoming religious tensions	The role of the therapeutic relationship, hope. Spiritual care in terms of compassion, tolerance, peacefulness, positive intention, respect, kindness, Responses indicate that many nurses relate the existential aspect of spiritual care to the compassionate care of their work, but consider the metaphysical aspects needing referral to the appropriate spiritual leader.
Elliott, Wattis, Chirema and Brooks, 2020	Explore mental health nurses' understandings of spiritual need and	qualitative data collected through semi-structured Interviews	17 mental health nurses working in an NHS mental health service in the north of England	4 themes: personal perspectives on spirituality, perspectives on spirituality as a nurse, nursing	Nurses' experiences

	their experiences of delivering this care for service users			spirituality, permeating anxiety (anxiety around giving care)	Not clear if services users were inpatients, outpatients, in community settings Australia does not have clear broad-based policies on spiritual care The use of a pragmatic approach to spiritual care may overlook true spiritual needs, especially in the use of standardised assessments. A spiritually empathetic approach is needed Consistency is needed in education and policy documents
Giske and Cone, 2015	examine nurses' experiences in spiritual care in diverse clinical settings other than palliative care	grounded theory 8 focus groups	22 Norwegian nurses recruited from a post-graduate course, a Masters course and a small local hospital. A range of work experiences, cultural backgrounds and beliefs	Main concern: *how to assist the patient to alleviation* is summed up in the grounded theory of *discerning the healing path*: tuning in on spirituality, uncovering deep concerns, facilitating the healing process; achieved by a willingness to overcome own comfort zone, and build a trusting relationship. Barriers – knowledge & experience, spiritual self-awareness, lack of privacy and time, workload, culture of the workplace,	Need for 'spiritual literacy' which goes further than religious literacy and probably better suited to secular societies

Herlianita, Yen, Ching-Huey, Fetzer and Lin, 2018	examine the perception of spirituality and spiritual care among Muslim nurses in Indonesia	cross-sectional study. A translated version of the Spirituality and Spiritual Care Rating Scale (SSCRS) was used. Six statements were added which addressed specific Islamic practices	convenience sampling. 256 out of a potential 274 Muslim nurses from 5 private Islamic hospitals in East Java who were in direct care roles with at least a year's clinical experience.	A high degree of agreement about the importance of belief in Allah and Islamic way of life. High level of spiritual awareness and positive attitudes toward spirituality and the provision of spiritual care. Majority reported giving spiritual care although they had received little education. Spiritual care incorporates therapeutic touch, listening, psychological support, talking. Barriers include insufficient staff and time, fatigue. Enablers include nursing specialty, education level, clinical seniority, spiritual care training	Draws comparisons with the findings of similar studies in largely secular or Christian countries. Lack of time and education are common to other studies. Spiritual self-awareness a common enabler Whilst still a minority religion in Australia, it is important that nurses understand that in Islam (and in other world religions also) the concept, of religion is embedded in spirituality, there is no distinct differentiation. ''Religion provides a path for a spiritual way of life.'' This contrasts with the non-Muslim view that does not equate religion with spirituality. 21% of the world's population is Muslim. (In Australia it's around 2%?)
Kaddourah, Abu-Shaheen and Al-Tannir, 2018	To identify the perceptions towards spirituality and spiritual care among nurses at tertiary care hospitals in Riyadh, Saudi Arabia	cross sectional study, SSCRS used	978 out of a potential 1180 nurses from 5 tertiary hospitals	''Spirituality exists in all religions…'' (p.157). Spiritual care is demonstrated in kindness, concern and cheerfulness when giving care, respect for privacy, dignity, religious and cultural beliefs. Spirituality is about having a sense of hope in life.	Good for the cultural perspective Sensitivity to spiritual needs and beliefs is as important as cultural sensitivity.

				Nurses showed a strong orientation towards spirituality and saw spiritual care as important. No differentiation between religion and spirituality	
Keall, Clayton and Butow, 2014	To investigate the facilitators, barriers and strategies that Australian palliative care nurses identify in providing existential and spiritual care for patients with life-limiting illnesses	qualitative study, semi-structured interviews;	20 Palliative care nurses from a range of areas with a range of experience and personal beliefs	Main Facilitator: nurse-patient relationship: confidence and experience, walking alongside the patient, patient openness. Main barrier: time. Main strategy: further education. Other barriers: fear of what you may uncover, unresolved symptoms, lack of privacy, lack of skills in others, differences of belief. Other facilitators: Communication skills: active listening, be genuine/human/know your limitations, allowing silence, compassion; helpful questions. Other strategies: making appropriate referrals, maintain realistic expectations, setting the scene: accepting an unwanted cup of tea to extend the visit, ask about photos/objects in the room, undertake counselling courses, documentation: the dilemma of the importance of documenting vs what to document,	Participants were voluntary so potential for bias, An Australian perspective Problems around effective and privacy-respecting documentation
McSherry and Jamieson, 2013	To provide opportunity for members [of	Qualitative findings from an online survey	2327 out of 4054 RCN members provided additional comments	Five broad themes	The personal and uniquely interpreted nature of spirituality

	RCN] to express understandings of spirituality and spiritual care			Understandings of spirituality among nurses are diverse and the majority consider spirituality to be an integral and fundamental element of the nurses' role. Spirituality is a fundamental dimension of nursing practice	makes developing an authoritative definition difficult. The response rate was considered small, but proffered a good range of views. Limited to UK.
Ormsby, Harrington and Borbasi, 2016	Explore the experience of spirituality and spiritual care by military nurses on deployed operations; perceptions on the impact of spirituality to resilience	Qualitative, phenomenology informed by philosophical hermeneutics	10 Australian military nurses In depth interview	Spirituality and spiritual care are important both to patients and colleagues, and the nurses themselves Spirituality as a protective factor; often overlooked during pre-deployment training	A different nursing context not previously studied Nurses are constrained by military protocols and have the added pressure of deployment Spiritual care examples, definition difficulties
Ronaldson, Hayes, Aggar, Green and Carey, 2012	Identify and compare spiritual caring practice by palliative care and acute care registered nurses (RNs), determine any correlation between nurses' spiritual perspective and their spiritual caring, and to	Cross sectional study	42 Palliative care nurses and 50 nurses from Acute care from 7metropolitan health services in Sydney	Palliative care nurses had a stronger perspective of spiritual care and a more advanced spiritual caring practice than their acute care peers Lack of time and patient privacy were common barriers to both groups	The areas from which the acute care nurses were recruited were limited Australian perspective helping to further raise the profile of spiritual care within nursing Scope for further research Spiritual care examples, an aspect of person-centred care

	investigate perceived barriers to spiritual caring.				
Ronaldson, Hayes, Aggar, Green & Carey, 2017	Investigate and describe, conceptually, palliative care nurses' spiritual caring interventions	Open-ended questionnaire collecting qualitative data, thematic analysis	42 palliative care registered nurses from 7 palliative care services in Sydney	4 major concepts: being with, listening to, facilitation of, engaging in; 3 sub-theme categories: humanistic, pragmatic and religious interventions	Spirituality and spiritual care integral to holistic care Self-awareness, education, experience, culture/policy of the facility, - facilitators od spiritual caring
Smyth and Allen, 2011	Explore and describe how nurses define spirituality and incorporate spiritual care into clinical practice	Two phase, mixed methods, explanatory descriptive Questionnaire and 3 unstructured focus group interviews	16 nurses from an acute medical ward in a rural hospital, caring for terminally ill patients	4 themes: understanding spirituality, assessment of spirituality, difficulties meeting spiritual needs, education	Australian Acute sector Barriers to spiritual care provision: time, organisational constraints, staffing levels, heavy workloads Spirituality & spiritual care important to health but inconsistently defined Spiritual care examples Spirituality and spiritual care are not formally in everyday clinical nursing language

Tanyi, McKenzie, Chapek, 2009	To investigate how primary care family practice providers incorporate spirituality into their practices in spite of documented barriers	A phenomenological qualitative design was used. Semi-structured interviews.	three physicians, five nurse practitioners, and two physician assistants three large clinics in the Minneapolis/St. Paul area. There were five men and five women.	(1) discerning instances for overt spiritual assessment; (2) displaying a genuine and caring attitude; (3) encouraging the use of existing spiritual practices; (4) documenting spiritual care for continuity of care; (5) managing perceived barriers to spiritual care.	Primary care focus One localised area, which the authors note doesn't give a generalised view. However, respondents showed a broad view of spirituality
Tirgari, Iranmanesh, Cgeraghi, Arefi, 2013	elucidate the meaning of nurses' experiences of giving spiritual care in southeast Iran	phenomenological, hermeneutics. In-depth unstructured interviews	11 female staff nurses from 3 university hospitals, all Shia Muslim with no formal spiritual care education	spiritual care is meeting the patient as a unique being. 3 themes: meeting patient as a being in relationship (presence, touch), meeting patient as a cultural being (respect, non-judgemental, tension in telling the truth against the cultural code of preserving hope), meeting patient as a religious being (meaning, coping, maintaining rituals and practices,	There is no distinction between religion and spirituality. Religion is embedded in spirituality, at the core. Culture influences the definition of spirituality Education about spirituality & spiritual care as well as spiritual and cultural assessment criteria should be part of continuous education for nurses. Struggling to make a balance between the holistic and medical perspectives Similar values in religions: truth telling, doing what is right, fulfilling family duties.

Walker and Waterworth, 2017	explore palliative care nurses' experiences providing spiritual care to patients with life-limiting illness	qualitative, narrative description. Semi-structured interviews	9 nurses working across 3 large, culturally diverse hospices in New Zealand. 5 from inpatient environment, 4 from community	4 categories: assessment of spiritual needs, recognition of spiritual distress, provision of spiritual care, documentation. Spiritual care involves: Individuality and respect; connection; love and compassion; meaningful touch and presence; communication; divine-related spiritual care provision and referral; death preparation; post-mortem spiritual care	Influences: personal comfort level and/or spirituality of nurses, Maintaining respect for individual beliefs Integrating cultural differences, being receptive to patient cues, Language for documentation; Familiarity and ability to use spiritual assessment tools as appropriate – need caution to avoid a checkbox approach, Understanding and identifying spiritual distress Availability of chaplain or other spiritual care specialist
Wong and Yau, 2010	Nurses' perspective of spirituality and spiritual care	Descriptive phenomenological, Unstructured interview,	10 nurses from different units within a Hong Kong general hospital; 5 males, 5 females	The nurses found spiritual care was regarded as complementary therapy and was left to the discretion of the nurse whether to address spiritual needs or not. It did not have high priority, despite being seen as beneficial.	Views from a variety of spiritualities, The impact of culture as a factor in spiritual care provision

				The most frequently used interventions were praying privately or referring to a religious leader. Difficulties: lack time, lack of knowledge, lack of managerial support, insufficient resources, cultural factors - particularly views on death & dying	

APPENDIX 2

Participant information package

2a. Letter of introduction

College of Nursing and Health Sciences
GPO Box 2100
Adelaide SA 5001
[redacted]
CRICOS Provider No. 00114A

10/10/2019

LETTER OF INTRODUCTION

Dear Sir/Madam

Christine Schreiber is a Master of Nursing student in the College of Nursing and Health Sciences at Flinders University and is a Registered Nurse currently working in general practice. I would like to introduce you to her Master of Nursing research project.

Christine is undertaking research that explores practice nurses' perceptions of spirituality and the associated integration of spiritual care within their work. This will culminate in the production of a thesis and associated publications which can be made available to participants.

Her research will consist of the collection of data via 40-60-minute semi structured interviews with practice nurses who have at least one-year experience in general practice. The venue for this interview will be negotiated between the interviewee and Christine. She will produce her student card, which carries a photograph, as proof of identity. It is anticipated the interviews will take place between September and October 2020.

All information provided will be treated in the strictest confidence and all personal identifying data will be removed. If the interview is conducted within the workplace, it may not be possible to guarantee complete anonymity, however all efforts will be made to do so. All participants will be free to discontinue the interview at any time or to decline to answer particular questions. It is important that no potential participant feel an obligation to be involved because one of the researchers is an acquaintance.

Christine intends to make an audio recording of the interview, and will seek consent, to use the recording or a transcription of it to assist in the preparation of her thesis. Christine has prepared a participant information sheet and consent form.

Christine and I would welcome any opportunity to discuss her research with you and the possibility of your assistance in recruiting participants.

Any enquiries you may have concerning this project can be directed to me either via the email or telephone number listed above.

Thank you for your attention and assistance.

Yours sincerely, 

Claire Verrall Dip App Sc, RN, BN, MN (Emerg) PhD candidate.

Lecturer in nursing, Flinders University College of Nursing and Health Sciences

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee in South Australia (Project number 8540). For queries regarding the ethics approval of this project please contact the Executive Officer of the Committee via telephone on [redacted] *or email human.researchethics@flinders.edu.au*

PARTICIPANT INFORMATION SHEET

Title: '*Spiritual care in Australian general practice nursing: An Interpretive descriptive study*'

Researcher

Mrs Christine Schreiber

Master of Nursing (coursework and research)

College of Nursing & Health Sciences

Flinders University

Email: [redacted]

Supervisors

Claire Verrall

College of Nursing & Health Sciences

Flinders University

Tel: [redacted]

Dr Dean Whitehead

College of Nursing & Health Sciences

Flinders University

Email: [redacted]

Description of the study

Practice nurses with at least one year's experience in general practice will be asked to share their experiences providing spiritual care to patients. It is a component of a Masters in Nursing degree by coursework and research at Flinders University, Bedford Park.

This project is supported by Flinders University, College of Nursing & Health Sciences.

Purpose of the study

The research project will explore what spirituality and spiritual care mean to practice nurses and how it is integrated into their practice. The literature indicates spirituality and spiritual care are integral aspects of person-centred care, but are frequently overlooked. Spirituality and spiritual care are personal, individual and yet to be universally defined, so I will be seeking your own understandings and experiences. While there will be similarities, it is anticipated there will also be findings that are different to other nursing contexts.

What will I be asked to do?

You are invited to attend a one-on-one interview with the researcher who will ask you questions regarding your experiences related to spiritual care. Participation is entirely voluntary. The interview will take place in a quiet location convenient to you and take approximately 40-60 minutes. The interview will be audio recorded using a digital voice recorder to assist the analysis of the collected data. Once recorded, the interview will be transcribed (typed-up) onto a secure, password-protected computer file, which will be destroyed after five years. If desired, you may review the transcription of your interview. This will be discussed at the interview.

Addendum: due to the challenges brought about by COVID 19, the option to provide a written response to the interview questions is available. Returning the anonymous question sheet is taken as consent. Unless an email address is added to the space provided on the question sheet, no contact information will be retained.

What benefit will I gain from being involved in this study?

The study will add a dimension to your reflective practice. Whilst there is no immediate personal benefit to you; you will be contributing to existing nursing research related to spirituality and spiritual caring within the general practice context, in order to complement and expand existing knowledge.

Will I be identifiable by being involved in this study?

We do not need your name and you will be anonymous in terms of any collected and reported data. Any identifying information will be removed, and should your comments be quoted in the study, a pseudonym or other moniker will be used so there is no direct link to you. All information and results obtained in this study will be stored in a secure manner, with access restricted only to relevant researchers.

Are there any risks or discomforts if I am involved?

The researcher anticipates few risks from your involvement in this study. However, given the nature of the topic, some participants could experience emotional discomfort. If any emotional discomfort is experienced, you will be encouraged to express your feelings. If needed the researcher will suggest possible counselling services.

If you have any concerns regarding anticipated or actual risks or discomforts, please raise them with the researcher.

If any of the researchers are known to you, it is important you feel no obligation to participate. Your involvement is strictly voluntary.

How do I agree to participate?

Participation is voluntary. You may answer 'no comment' or refuse to answer any questions, and you are free to withdraw from the interview at any time without effect or consequences. A consent form accompanies this information sheet. If you agree to participate please read and sign the form and return in the enclosed stamped and addressed envelope.

How will I receive feedback?

On project completion, a summary of the research will be available to all participants via email, provided an email address has been supplied. Dissemination of overall findings will also occur through publications and conference proceedings.

Thank you for taking the time to read this information sheet, and hope that you will accept this invitation to be involved.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee in South Australia (Project number 8540 For queries regarding the ethics approval of this project please contact the Executive Officer of the Committee via telephone on [redacted] *or email human.researchethics@flinders.edu.au*

2c. Participant Consent for Interview

CONSENT FORM FOR PARTICIPATION IN RESEARCH
(Interview)

'Spiritual care in Australian general practice nursing: An interpretive descriptive study'

I ……

being over the age of 18 years hereby consent to participate as requested in the ……interview…… for the research project with the title listed above.

1. I have read the information provided.
2. Details of procedures and any risks have been explained to my satisfaction.
3. I agree to audio recording of my information and participation.
4. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.
5. I understand that:

   - I may not directly benefit from taking part in this research.
   - Participation is entirely voluntary and I am free to withdraw from the project at any time; and can decline to answer particular questions.
   - The information gained in this study will be published as explained, and my participation will be anonymous and confidential.
   - Whether or I participate or not, or withdraw after participating, will have no effect on my current employment
   - I may ask that the audio recording be stopped at any time, and that I may withdraw at any time from the session or the research without disadvantage.

6. I understand that only the researchers on this project will have access to my research data and raw results; unless I explicitly provide consent for it to be shared with other parties. If the need to seek my consent to share your research data with other parties does arise, I will be contacted by the researchers via email.

Participant's name…….....

Best Telephone number…….... (to arrange an interview time)

Email address: If you would like to review the transcript of your interview, please provide an email address. You will be asked to sign the approval section below. You may also indicate

whether you would like a copy of a summary of the findings. Another opportunity will be offered at the interview.

I would like to review my interview transcript. Yes No

I would like to receive a copy of the summary of the research findings. Yes No

Email address…….

Participant's signature……Date……...

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher's name…….....

Researcher's signature……... Date…….

NB:	*Two signed copies should be obtained (one for researcher; one for participant). The copy retained by the researcher may then be used for participant review and approval of interview transcripts (point 7) where relevant.*

Review / Approval of Interview Transcriptions

7. I, the participant whose signature appears below, have read a transcript of my interview participation and agree to its use by the researcher as explained.

Participant's signature……Date……...

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee in South Australia (Project number 8540). For queries regarding the ethics approval of this project please contact the Executive Officer of the Committee via telephone on [redacted] *or email human.researchethics@flinders.edu.au*

Signed consent forms can be returned by email to [redacted] **or posted to** [redacted]**, SA 5095**

APPENDIX 3

Ethics approval letter

From: Human Research Ethics
To: [redacted]
Subject: 8540 ETHICS approval notice (21 January 2020)
Date: Tuesday, 21 January 2020 10:55:00 AM
Attachments: image001.png
8540 Conditional approval response (11 December 2019).msg
8540 Conditional approval response - Additional Info PROVIDED (19 January 2020).msg
8540 application (16 November 2019).pdf
image002.png

Dear Christine,

Your conditional approval response for project 8540 was reviewed by the Deputy Chair of the Social and Behavioural Research Ethics Committee (SBREC) and was **approved.** The ethics approval notice can be found below.

Project No.:	**8540**
Project Title:	Spiritual care in Australian general practice nursing: an interpretive descriptive study
Principal Researcher:	Mrs Christine Schreiber
Email:	[redacted]
Approval Date:	21 January 2020
Ethics Approval Expiry Date:	**31 December 2022**

The above proposed project has been **approved** on the basis of the information contained in the application, its attachments and the information subsequently provided.

RESPONSIBILITIES OF RESEARCHERS AND SUPERVISORS

1. Participant Documentation

Please note that it is the responsibility of researchers and supervisors, in the case of student projects, to ensure that:

- all participant documents are checked for spelling, grammatical, numbering and formatting errors. The Sub-Committee does not accept any responsibility for the above-mentioned errors.

- the Flinders University logo is included on all participant documentation (e.g., letters of Introduction, information Sheets, consent forms, debriefing information and questionnaires – with the exception of purchased research tools) and the current Flinders University letterhead is included in the header of all letters of introduction. The Flinders University international logo/letterhead should be used and documentation should contain international dialling codes for all telephone and fax numbers listed for all research to be conducted overseas.

- the SBREC contact details, listed below, are included in the footer of all letters of introduction and information sheets.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project Number 'INSERT PROJECT No. here following approval'). For more information regarding ethics approval of the project the Executive Officer of the Committee can be contacted by telephone on [redacted] *or by email human.researchethics@flinders.edu.au.*

2. Annual Progress / Final Reports

In order to comply with the monitoring requirements of the *National Statement on Ethical Conduct in Human Research 2007 (updated 2018)* an annual progress report must be submitted each year on the **21 January** (approval anniversary date) for the duration of the ethics approval using the report template available from the Managing Your Ethics Approval web page.

Please note that no data collection can be undertaken after the ethics approval expiry date listed at the top of this notice. If data is collected after expiry, it will not be covered in terms of ethics. It is the responsibility of the researcher to ensure that annual progress reports are submitted on time; and that no data is collected after ethics has expired.

If the project is completed *before* ethics approval has expired please ensure a final report is submitted immediately. If ethics approval for your project expires please either submit (1) a final report; or (2) an extension of time request (using the modification request form).

First Report due date:	**21 January 2021**
Final Report due date:	**31 December 2022**

Student Projects

For student projects, the SBREC recommends that current ethics approval is maintained until a student's thesis has been submitted, assessed and finalised. This is to protect the student in the event that reviewers recommend that additional data be collected from participants.

3. Modifications to Project

Modifications to the project must not proceed until approval has been obtained from the Ethics Committee. Such proposed changes / modifications include:

- change of project title;

- change to research team (e.g., additions, removals, researchers and supervisors)
- changes to research objectives;
- changes to research protocol;
- changes to participant recruitment methods;
- changes / additions to source(s) of participants;
- changes of procedures used to seek informed consent;
- changes to reimbursements provided to participants;
- changes to information / documents to be given to potential participants;
- changes to research tools (e.g., survey, interview questions, focus group questions etc); · extensions of time (i.e., to extend the period of ethics approval past current expiry date).

To notify the Sub-Committee of any proposed modifications to the project please submit a Modification Request Form available from the Managing Your Ethics Approval SBREC web page. Download the form from the website every time a new modification request is submitted to ensure that the most recent form is used. Please note that extension of time requests should be submitted prior to the Ethics Approval Expiry Date listed on this notice.

Change of Contact Details

If the contact details of researchers, listed in the approved application, change please notify the Sub-Committee so that the details can be updated in our system. A modification request is not required to change your contact details; but would be if a new researcher needs to be added on to the research / supervisory team.

4. Adverse Events and/or Complaints

Researchers should advise the Executive Officer of the Ethics Committee on [redacted] or human.researchethics@flinders.edu.au immediately if:

- any complaints regarding the research are received;
- a serious or unexpected adverse event occurs that effects participants;
- an unforeseen event occurs that may affect the ethical acceptability of the project.

Kind regards
Andrea

Andrea Mather and Rae Tyler
Human Research Ethics Officers (Social and Behavioural Research Ethics Committee)
Research Development and Support
Union Basement Building
Flinders University
Sturt Road, Bedford Park, South Australia, 5042
GPO Box 2100, Adelaide, South Australia, 5001

Content removed for privacy reasons
human.researchethics@flinders.edu.au
www.flinders.edu.au/research/researcher-support/

APPENDIX 4
Interview Documents

4a. Interview questions

Research Project NURS9614

Spiritual care in Australian general practice nursing: an interpretive descriptive study

Interview questions

Thank you for making time to participate in my research project. If you wish to decline answering any of the questions, please say so. I remind you also, you are free to withdraw at any stage.

1. Obtain demographic data not collected on consent form: age, gender (age and gender can be excluded if participant wishes), years registered, years as a practice nurse, size & type of practice; i.e., number of GPs, sole owner, consortium or large corporate chain (not all practices have websites from which to collect these details).
2. This study is about spiritual care in general practice nursing. How would you describe spiritual care and spirituality?
3. The nursing standards for practice stress person-centred care which respects the patient's culture, beliefs and values. When you think of person-centred care, what do you think of? What does it mean to you?
4. If not mentioned, ask: The literature includes spiritual care as an aspect of person-centred care. Tell me what you think about the place of spiritual health as an aspect of person-centred care.
5. If spiritual care is mentioned, ask: do you include spiritual care as part of person-centred care in your practice? Tell me more about that.
6. Have you had opportunity to provide spiritual care to patients?
7. If yes, how do you do this?
8. If no, would you like to and how might you do this?
9. What are the enablers and barriers to providing such care?
10. Do you or would you feel confident to provide spiritual care?
11. Did you receive any education or training about spiritual care?
12. If yes, please describe.
13. Thank you once again. Is there anything you would like to add in relation to this interview?
14. Would you like to receive a copy of the findings? – Obtain email address

4b. Interview questions for written response

Research Project NURS9614

Spiritual care in Australian general practice nursing: an interpretive descriptive study

Thank you for making time to participate in my research project. If you wish to decline answering any of the questions, please do so. I remind you also, you are free to withdraw at any stage. Please note that these questions were designed to be part of an interview and may seem repetitive.

Please return your responses to [*email removed for privacy reasons*]

Interview identifier …….

Demographic data

Age: 18-25 26-35 36-45 46-55 56+ not provided

Gender: male female non-binary prefer not to say

Years registered:

Years as a practice nurse:

size & type of practice; i.e., number of GPs, sole owner, consortium or large corporate chain, rural/urban

…….

15. This study is about spiritual care in general practice nursing. How would you describe spiritual care and spirituality?
16. The nursing standards for practice stress person-centred care which respects the patient's culture, beliefs and values. When you think of person-centred care, what do you think of? What does it mean to you?
17. The literature includes spiritual care as an aspect of person-centred care. Tell me what you think about the place of spiritual health as an aspect of person-centred care.
18. Do you include spiritual care as part of person-centred care in your practice? Tell me more about that.
19. Have you had opportunity to provide spiritual care to patients?
20. If yes, how do you do this?
21. If no, would you like to and how might you do this?
22. What are the enablers and barriers to providing such care?
23. Do you or would you feel confident to provide spiritual care?

24. Did you receive any education or training about spiritual care?
25. If yes, please describe.
26. Thank you once again. Is there anything you would like to add in relation to this interview?
27. Would you like to receive a copy of the findings? – Please provide email address:

Counselling numbers if needed:

- GP for referral to a psychologist through Better Access.
- Lifeline (131114)
- Beyond Blue (1300224636)
- pastoral support from a local church/spiritual leader

4c. Interview notes sheet

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Interview notes

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Gender: male female non-binary prefer not to say

Years registered:

Years as a practice nurse:

size & type of practice; i.e., number of GPs, sole owner, consortium or large corporate chain

…….

Spiritual care training undertaken: No Yes If yes, type:

Notations:

Counselling numbers if needed:

- GP for referral to a psychologist through Better Access.
- Lifeline (131114)
- Beyond Blue (1300224636)
- pastoral support from a local church/spiritual leader