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Spiritual assessments and interventions in nursing

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Spiritual Assessments and Interventions in Nursing

A Project Presented to

the Faculty of the Undergraduate

College of Health and Behavioral Studies

James Madison University

in Partial Fulfillment of the Requirements

for the Degree of Bachelor of Science in Nursing

by Katie Elizabeth Ruefer

May 2014

Accepted by the faculty of the Department of Nursing, James Madison University, in partial fulfillment of the requirements for the Degree of Bachelor of Science in Nursing.

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ABSTRACT

Background: The spiritual dimension of nursing care is recognized as an important part of evidence-based practice. Several accrediting bodies, including the Joint Commission, American Nurses Association, and International Council of Nursing, have included spiritual care as part of their recommendations for practice. However, it has met many barriers to being integrated into routine nursing care. Evidence-based literature needs to be studied to promote proper spiritual care in the nursing profession. Method: Literature was systematically collected from four databases—CINHAL, PubMed, Cochrane and EBSCO—and then selected for inclusion into a comprehensive review. Included articles were integrated into an evidence-based review, and level of evidence of each was determined and reported. Results: Several spiritual assessment formats as well as several interventions were discovered. These were compared and contrasted to assist practicing nurses to select an evidence-based model for their own use. Generic assessment tools such as the FICA, HOPE, TRUST, and ETHNICS mnemonics can be useful for nurses to determine the initial spiritual needs of their patients, and whether further intervention is required. Conclusion: Nurses should integrate spiritual assessment and intervention into their routine nursing practice as part of evidence-based nursing care.

Keywords: spiritual care, spiritual assessment, spiritual interventions, nursing
BACKGROUND

Within the past several years spiritual care has gained recognition as a best practice in modern medicine. There is mounting research-based evidence showing its positive effects. Spiritual care has been linked to benefits such as fewer hospital stays, faster recovery times, lowered blood pressure, an increased sense of well-being, and a decrease in rates of depression (Helming, 2009). This is impactful for several dimensions of health, including the social, psychological and physical (Burkhardt & Hogan, 2008). Spiritual care also encourages more patient-centered, thoughtful treatment that promotes patient autonomy, builds trust when practitioners understand the world view of the patient, and identifies assets that could be useful for improved recovery (Hodge, 2013) (Schaefer, Stonecipher, & Kane, 2012).

With compelling evidence for the inclusion of spiritual care as a component of evidence-based practice, it has been adopted as a standard by many accrediting organizations within the profession. The Joint Commission, which certifies hospitals across the United States, requires spiritual care as part of a multidisciplinary environment (Burkhardt & Hogan, 2008). The American Nurses Association has incorporated spiritual care into the Scopes and Standards of Practice (Lind et al., 2011) (Burkhardt & Schmidt, 2012). Additionally the International Council of Nurses (ICN) has included spiritual care in the Code of Ethics, saying, “The nurse’s primary professional responsibility is to people requiring nursing care. In providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected” (ICN, 2012). As a result of the evidence and momentum across nursing accrediting bodies, spiritual care, including assessments and interventions, should be a priority of modern day nurses.
Despite being a clear component of holistic care and accrediting recommendations, according to one 2012 study, which examined barriers to spiritual care being performed by nurses, it was found that nurses still hesitate to put it into practice (Gallison, Xu, Jurgens, & Boyle). As these authors articulated, “The findings of current research on spiritual dimensions of nursing care consistently suggest that spiritual care is warranted but not given adequate attention. It is evident from the literature that patients are highly interested in exploring spirituality with nurses.” (Gallison et al., 2012). Even though patients in many studies have welcomed spiritual care from nurses, including in hospital settings, it has not been well integrated into nursing care (Lind, Sendelbach, & Steen, 2011). Nurses often stated in studies systematically reviewed by Lind et al. that they felt unequipped in their education to begin spiritual assessments and interventions with their patients (2011). However, researchers did find that after some education on the subject nurses would perform spiritual assessments and interventions more often and take advantage of chaplain services when necessary (Lind, Sendelbach & Steen, 2011).
DEFINING “SPIRITUAL CARE”

In attempting to integrate spiritual care within nursing practice, defining what exactly is meant by “spiritual care” is often a challenge. While there is an acknowledged difference between religion and spirituality, finding a balance is crucial for defining spiritual care (Gerbhardt, 2008). In addition, there is no decisive description of spiritual care that can be used in every nursing setting (Timmins & Kelly, 2008) (Gerbhardt, 2008). There has not been much theoretical critique of spirituality within nursing, and much more discussion needs to be done in order to compare evidence-based definitions (Clarke, 2009). Many authors also argue that there is no “one size fits all” approach to defining spirituality in nursing (Clarke, 2009). Some reviewed literature suggested that nursing units should come up with a definition for the meaning of spirituality to guide their spiritual care which reflects the values of their respective organization (Draper, 2012).

A literature review done in 2009 suggested that nurses have stayed away from religion when defining spirituality in an attempt to remain neutral and open to all faith traditions and not seem to proselytize while providing spiritual care (Clarke). Unfortunately this may lead to a lack of religious sensitivity (Clarke, 2009). As a result, it may be important to incorporate religion into some facet of a definition of spiritual care in order to respect the beliefs of each patient and utilize any community strengths they may have from a religious organization.

The author of this literature review has written a working definition of spirituality based on the articles which have been systematically examined for this thesis. This working definition is, “Spiritual nursing care is the process of assessing and addressing an individual’s sense of
purpose, source of meaning, and possible support systems within religious communities in order to build a therapeutic relationship of trust to promote the healing process of each patient.”
METHOD

A systematic literature review was performed, and a synthesis of the most common and pertinent findings was provided after the careful reading and analysis of each resulting article. There were four total search terms used, entered into four major databases, in order to obtain the broadest and most accurate literature on spiritual assessments and interventions in nursing. The search terms used were “‘spiritual care’ AND ‘evidence-based’ AND ‘nursing’”, “‘spiritual assessment’ AND ‘nursing’”, “‘nursing interventions’ AND ‘spiritual care’”, and “‘spiritual care interventions’ AND ‘nursing’”. These queries were entered into four databases used frequently for nursing—CINHAL, PubMed, Cochrane, and EBSCO—and all retrieved articles were considered for inclusion into this literature review.

After all of the articles were obtained from these search terms in each database, they were compiled and evaluated by the author to discern which of them met the inclusion criteria for this review. In order to be included, the article had to be recent (published during or after 2008), specific to nursing, specific to spiritual care (i.e. not just education or curriculum development), have a full text available in English, and be part of a scientific or academic journal. These inclusion criteria were created to limit the findings to articles which would be specific to nursing while also ensuring that they came from credible and accurate sources which were readable by the author.

After including all articles according to the prescribed criteria, they were individually assessed by the author for area of focus (for example: geriatrics, pediatrics, or hospice care), as well as country or origin and Level of Evidence (LOE). When LOE was not specified within the article, it was compared to a widely accepted hierarchy (see below) which was used to
objectively and systematically determine the depth of quantitative or qualitative evidence provided in each article. The results of all of these findings are recording in the “Results” section.

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I</td>
<td>Evidence from a systematic review of all relevant randomized controlled trials (RCT’s), or evidence-based clinical practice guidelines based on systematic reviews of RCT’s</td>
</tr>
<tr>
<td>Level II</td>
<td>Evidence obtained from at least one well-designed Randomized Controlled Trial (RCT)</td>
</tr>
<tr>
<td>Level III</td>
<td>Evidence obtained from well-designed controlled trials without randomization, quasi-experimental</td>
</tr>
<tr>
<td>Level IV</td>
<td>Evidence from well-designed case-control and cohort studies</td>
</tr>
<tr>
<td>Level V</td>
<td>Evidence from systematic reviews of descriptive and qualitative studies</td>
</tr>
<tr>
<td>Level VI</td>
<td>Evidence from a single descriptive or qualitative study</td>
</tr>
<tr>
<td>Level VII</td>
<td>Evidence from the opinion of authorities and/or reports of expert committees</td>
</tr>
</tbody>
</table>

Table 1. LOE definitions used for the purposes of this review are originally from evidence-based nursing literature (Adapted from “Levels of Evidence (I-VII)” by the University of Wisconsin Ebling Library. (2014).)
RESULTS

The most common area of focus was hospice nursing, or care planning for patients facing the possibility of hospice care. Nine articles originating from this focus. Following closely were eight articles focusing on nursing care within the hospital setting, and seven in the “Other” category. These articles included literature on nursing theory related to spiritual care or the integration of university level spiritual care education into hands-on patient care. These trends are depicted in Figure 1.

![Figure 1. Topical focus of literature included in systematic review.](image)

Knowing that spiritual care cannot be limited to one culture, the country of origin of each article was also taken into consideration in this review. It was discovered that most of the literature originated in the United States, followed by countries in Europe and Australia. However some data came from articles from South Korea and the Czech Republic. The results of these findings are detailed in Figure 2.
To gain a clear understanding of the type and validity of the data pulled into this systematic review, the level of evidence of each article was taken into consideration. All of the evidence collected fell within levels IV-VII, reflective of mostly qualitative data versus quantitative. Figure 3 shows the number of articles from each LOE included for review.
With data pulled from each included article, the process of critically comparing and contrasting their information was begun. Each article was searched for evidence-based information that would be helpful for practicing nurses seeking to know more about the spiritual dimension of nursing care. This critical review can be found in the discussion section below.
DISCUSSION

Spiritual Assessment

When considering spiritual assessments within nursing, it is important to know that often patients are open to nurses asking questions about their spirituality (Johnston-Taylor & Brander, 2013). In a mixed-method study done in New Zealand, researchers discovered that patients particularly appreciated when it was made clear that assessment questions were not intended to be evangelical (Johnston-Taylor & Brander, 2013). Additionally it is important to be clear with patients that the nurse is performing a spiritual assessment and that questions being asked are part of holistic care for the patient (Barss, 2011). This allows the patient the autonomy to refuse spiritual assessment or intervention, as with any other kind of care, but also informs them of the value and importance of assessing how their spiritual lives impact their health.

In a meta-synthesis of qualitative research done in 2012, it was suggested that spiritual assessment techniques can be categorized into three groups: generic, quantitative and qualitative (Draper). Generic assessments, such as the FICA tool (discussed in detail below), have the least attachment to a specific religion, and can be utilized quickly and easily in the clinical setting (Draper, 2012). This assessment technique is probably the easiest to incorporate into any nursing unit. On the other hand, the quantitative assessments are used most often in research to determine the effectiveness of spiritual care theories, and not necessarily in actual, hands-on care (Draper, 2012). Finally this article describes qualitative assessment, which takes a much more in-depth look into the patient’s spiritual journey to determine if further care is necessary, and is different from the generic approach in that it can focus more on the specific religious views of the patient.
This two-step assessment format was suggested by other authors as well, including a UK literature review which recommended a primary, brief assessment to determine if a second and more comprehensive stage was needed (Hodge, 2013). A generic mnemonic, such as FICA, the HOPE scale, or the TRUST model (all discussed below) was found useful by several evidence-based authors for the initial evaluation of a patient (Timmins & Kelly, 2008). In fact a 2013 study found that nurses actually preferred an assessment which came in a “checklist” format and gave them a concrete structure to follow (vanLeeuwen, Schep-Akkerman & vanLaarhoven, 2013). It is important for nurses to remember, however, that while mnemonics and checklists can be helpful for this first step of spiritual assessment, it is necessary to avoid this becoming a task with little meaning or importance for the patient (Timmins & Kelly, 2008).

The FICA spiritual assessment tool is an acronym suggested by several authors in this literature review, and can be used by nurses to recall assessment questions in order to glean insight into a patient’s spiritual needs and determine if further assessment is warranted (Draper, 2012) (Johnston-Taylor, 2013) (Timmins & Kelly, 2008) (Helming, 2009). Additionally this tool can be adapted for use with children when discussed in a developmentally appropriate way (Foster, Bell & Gilmer, 2012) (Mueller, 2010). It addresses what Faith the patient holds, how Important that faith is to them, what their Community supports are, and how they would like their spiritual needs Addressed. During this systematic review this tool was found to be very useful for nurses, as it is easily taught, remembered and implemented in a timely manner. Additionally, it can be helpful to have a structured assessment to rely on for nurses who might
otherwise be nervous to broach the subject of spirituality with their patients. See the figure below for questions suggested in reviewed literature.

![FICA Spiritual Assessment model with questions](image)

Figure 4. FICA Spiritual Assessment model with questions (Image from “An integrative review of spiritual assessment: Implications for nursing management.” by Draper, P. (2012). *Journal of Nursing Management*, 20(8), 970-980.).

The HOPE scale is another generic assessment which can be utilized by nurses (Lind, Sendelbach & Steen, 2011) (Helming, 2009) (Wynne, 2012) (Chrash, Mulich & Patton, 2011). Originally this tool was used for teaching physicians to initiate spiritual assessments with their patients, but was later accepted by researchers for nursing (Lind, Sendelbach & Steen, 2011). This assessment is also able to be adapted for use with children when the appropriate
developmental language is included (Foster, Bell & Gilmer, 2012). Table 2 gives example questions for this assessment based on educational testing performed by Lind, Sendelbach & Steen (2011).


| H | Sources of hope, meaning, and connection. What would you say gives you support for hope, strength, comfort, and peace? This might be related to religious beliefs or it could be a particular family member(s), friend(s), or other group(s), etc. |
| O | Organized religion. Do you consider yourself part of an organized religion/spiritual community? Which one? |
| P | Personal spirituality/practices. What aspects of your spirituality or spiritual practices do you find most helpful and important to you personally? (For example, medication, prayer, listening to music, reading sacred text, attending religious services, communing with nature, etc.). |
| E | Effects on medical care and end-of-life issues. Are you worried about any conflict between your beliefs and your medical care? Can we help you access the resources that usually support you spiritually? |

Similar to the HOPE assessment, the SPIRIT mnemonic tool is a generic assessment suggested in the reviewed literature which looks more into the patient’s religious history and how that directly impacts their medical care and community support system (Chrash, Mulich & Patton, 2011) (Timmins & Kelly, 2008) (Helming, 2009). SPIRIT was also suggested by Mueller (2010) for use with children when asked in context of the child’s family’s religious views. This assessment guides the nurse to ask the patient about their (S) spiritual belief system/affiliation, (P) personal spirituality/practices, (I) integration into a spiritual community, (R) rituals and restrictions, (I) implications for medical care, and (T) plans for terminal illness (Mueller, 2010). This helps nurses to determine what special needs a patient may have and how the multidisciplinary team may create a care plan that is sensitive to the patient’s wishes.
From a more broad and generalized point of view, the ETHNICS tool can guide nurses to uncover the patient’s thought process and how their spiritual beliefs impact their thoughts about their diagnosis (Timmins & Kelly, 2008). It has very little emphasis on religious views and identifies cultural needs of the patient in addition to spiritual ones. The ETHNICS mnemonic stands for explanation (Why do you think you have this?), treatment (What have you tried for this?), healers (Have you sought help for this?), negotiate (How best do you think I can help?), intervention (This is what could be done.), collaborate (How can we work together on this?), and spirituality (What role does faith/religion/spirituality play in helping you?) (Timmins & Kelly, 2008). While there are many benefits to incorporating the cultural aspect into this spiritual assessment, it may be harder for nurses to explicitly explain the intent of their questions to patients before they begin.

The TRUST model developed by Barss in 2011 takes a unique approach to spiritual assessment. This approach warrants further research and consideration for integration into nursing units. While this model utilized a mnemonic for easy memory, it tends toward more open-ended discussion versus the brief, concise generic questions. Created to meet the demands of the increasingly pluralist and post-modern context of American society, this model seeks to find a non-intrusive way to assess the patient with wording that is sensitive to all worldviews (Barss, 2011). It focuses on five topics for exploration between the nurse and patient: Traditions, Reconciliation, Understandings, Searching, and Teachers. Figure 5 is a visual representation created by the author of this model in order to depict how nurses can use this tool to ask therapeutic questions in a non-linear format that stems from carefully listening to the patient.
While there is no definitive assessment technique suggested by the current literature, it is clear that several models have been successfully used by nurses and researchers. It is important for nurses and nurse managers to consider what kind of nursing environment they are in to select an evidence-based generic model. If generic models are used with every patient, nurses can use critical thinking to determine if a more in-depth qualitative assessment needs to be performed (Hodge, 2013). This flow from generic to focused assessment is one suggested throughout literature reviewed and can help nurses consider a realistic spiritual assessment model for integration into practice.
Interventions

Spiritual interventions are best implemented when informed by quality assessment data. In fact, the nurse may find that one patient requires no intervention due to little or no spiritual distress while another may require intensive spiritual care planning by the nurse. It is the nurse’s role along with any other members of the multidisciplinary team to discern if a patient is in spiritual distress and needs intervention. If the nurse does decide to create a spiritual care plan, there are some suggestions made by the evidence-based literature on how this can be done.

When considering spiritual interventions, most of the review literature focuses on the idea of nurses having the ability to use “being” activities to strengthen patients’ spiritual health. According to Helming (2009), this can include providing a presence and non-judgmental listening ear, and even the simple act of touch when appropriate. In a 2013 study nurses reported that they believed talking and listening to their patients was the most effective way to understand their spiritual needs (Nixon, Narayanasamy & Penny).

A quantitative survey done in the US found that many nurses reported using prayer, as well as active listening and touch, as frequent Nursing Intervention Classifications (Solari-Twadell & Hackbarth, 2010). It is also important to use assessment findings to understand what community supports the patient currently possesses (Nixon, Narayanasamy & Penny, 2013). Identifying pre-existing spiritual communities can help the nurse to plan for discharge (for example, to see if there are members of the patient’s church who can assist them with driving, grocery shopping, and other tasks). Additionally this can inform the nurse about religious practices or rituals which the patient may need privacy for during their care so staff can plan accordingly.
Prayer is an intervention which remains somewhat controversial. Kim-Godwin’s 2013 article stated that a 2004 research study found that 83% of US adults reported praying within the last week. This indicates that the general public in the US is not opposed to the idea of prayer. The author suggested that while empirical studies do not demonstrate a direct correlation between prayer and improved health outcomes, prayer is a common coping mechanism used across ethnic and cultural backgrounds, and may simply help patients to feel at ease (Kim-Godwin, 2013). However more research needs to be done to see whether patients want their nurses to offer them prayer, or if that experience would be beneficial at all (French & Narayanasamy, 2011). There is also the possibility that even if prayer is offered to a patient as a nursing intervention, it may not be culturally appropriate for the patient, but instead rooted in the nurses’ beliefs about prayer and spirituality (French & Narayanasamy, 2011).

When working with children, it is important for nurses to consider the developmental level of the child before planning interventions. A 2010 discussion on the faith development theory, a widely accepted theory of the developmental “faith stages” which children progress through, created a helpful chart for understanding the levels of spirituality that children can understand (Mueller). This chart is depicted in Figure 6 (below). Not only can this be useful for planning nursing interventions appropriate for the child’s developmental age, but it can also assist nurses to facilitate discussions between the child and their families about spiritual topics (Foster, Bell & Gilmer, 2012).
In addition to nursing interventions which focus on the patient, much of the literature reviewed suggested the importance of nurses examining their own beliefs about spirituality in order to care well for their patients. In addition, Gerbhardt (2008) suggests that nurses need to gain experience caring for the spiritual needs of patients and that it is not an inherent quality they possess. Overall this indicates the need for research and education to be done among nursing students and current nurses to give them the tools and experience to perform spiritual interventions well.

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### Stages of Human Development: Optimal Parallels

<table>
<thead>
<tr>
<th>Eras and Ages</th>
<th>Erikson</th>
<th>Piaget</th>
<th>Kohlberg</th>
<th>Fowler</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infancy (0 to 1½)</td>
<td>Basic Trust vs. Basic Mistrust (Hope)</td>
<td>Sensorimotor</td>
<td></td>
<td>Undifferentiated Faith (mutuality, trust and pre-images of primary love)</td>
</tr>
<tr>
<td>Early childhood (2 to 6)</td>
<td>Autonomy vs. Shame and Doubt (Will)</td>
<td>Preoperational or Intuitive</td>
<td></td>
<td>Stage 1 Intuitive-Projective Faith (rise of imagination and formation of images)</td>
</tr>
<tr>
<td>Initiative vs. Guilt (Purpose)</td>
<td></td>
<td>Proconventional Level Stage 1 Heteronomous Morality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood (7 to 12)</td>
<td>Industry vs. Inferiority (Competence)</td>
<td>Concrete Operational</td>
<td>Stage 2 Instrumental Exchange</td>
<td>Stage 2 Mythic-Literal Faith (rise of narrative and stories of faith)</td>
</tr>
<tr>
<td>Adolescents (13 to 21)</td>
<td>Identity vs. Role Confusion (Fidelity)</td>
<td>Formal Operational</td>
<td></td>
<td>Stage 3 Synthetic-Conventional Faith (formation of personal identity and faith)</td>
</tr>
<tr>
<td>Young Adulthood (21 to 65)</td>
<td>Intimacy vs. Isolation (Love)</td>
<td>Proconventional Level Stage 4 Social System and Conscience Postconventional Principled Level</td>
<td>Stage 4 Individuative-Reflective Faith (reflective construction of ideology)</td>
<td></td>
</tr>
<tr>
<td>Adulthood</td>
<td>Generativity vs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maturity (60)</td>
<td>Stagnation (Care)</td>
<td>Stage 5 Social Contract, Individual Rights</td>
<td>Stage 5 Conjunctive Faith (paradox, depth and intergenerational responsibility for the world)</td>
<td></td>
</tr>
<tr>
<td>Integrity vs. Despair (Wisdom)</td>
<td></td>
<td>Stage 6 Universal Ethical Principles</td>
<td>Stage 6 Universalizing Faith (new quality of partnership with Being in and for the world)</td>
<td></td>
</tr>
</tbody>
</table>

*Source: Adapted with permission from Fowler, 1981.*

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Figure 6. Fowler's Faith Stage Theory compared with other developmental theories (Adapted from “Spirituality in children: Understanding and developing interventions” by Mueller, C. R. (2010). *Pediatric Nursing, 36*(4), 197-208)
IMPLICATIONS FOR NURSING PRACTICE

The data discovered in this literature review reveals several implications for current nursing practice. The first is that informed nurses know that evidence-based practice, along with several accrediting bodies within nursing, suggest that spiritual care is vitally important. Nurses have the unique opportunity within the multidisciplinary team to develop a professional relationship with the patient, which incorporates or facilitates observation and assessment of their spiritual needs.

The second implication is that spiritual care and spirituality do not have a succinct, universally acceptable definition. An explanation of the topic which might work in one nursing setting may not operate well in another. With this in mind, nurses may tailor their spiritual care to meet the needs of their particular clients. This flexibility allows creativity and autonomy among nurses, and encourages the choice of an assessment format that works the best with their unit’s definition of spirituality.

Finally, it is important that much more research and education be undertaken on this topic. As much of the evidence reviewed and discussed indicates, nurses feel unequipped to deal with the spiritual struggles of their patients, and this might inhibit them from initiating a spiritual assessment. With this in mind current nursing programs should incorporate spiritual care into their teaching. Additionally quantitative research should be done to determine the most effect nursing interventions.
CONCLUSION

Spiritual assessment and intervention as part of routine nursing care is important for the health and wellbeing of patients. It should be incorporated into nursing curriculum and adopted in nursing units. A generic assessment or mnemonic device can be chosen for use with every patient, with further in-depth discussion reserved for patients with obvious distress. This can be followed up by interventions carried out by nurses, supported by evidence-based practice.
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