Article

New Zealand Nurses' Perceptions of Spirituality and Spiritual care: Qualitative Findings from a National Survey

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Abstract: This paper presents the qualitative findings from the first national survey of New Zealand nurses' views on spirituality and spiritual care. The importance of spirituality as a core aspect of holistic nursing care is gaining momentum. Little is currently known about New Zealand nurses' understandings, perceptions and experience of spirituality. Design: A descriptive online survey. Method: A random sample of 2000 individuals resident in New Zealand whose occupation on the New Zealand electoral roll suggested nursing was their current or past occupation were invited via postcard to participate in an online survey. This paper reports on the free response section of the survey. Findings: Overall, 472 invitees responded (24.1%). From the respondents, 63% completed at least one of the optional free response sections. Thematic analysis generated three metathemes: 'The role of spirituality in nursing practice', 'Enabling best practice', and 'Creating a supportive culture'. Conclusions: Spirituality was predominantly valued as a core aspect of holistic nursing care. However, clarity is needed surrounding what constitutes spiritual care and how this intersects with professional responsibilities and boundaries. Participants' insights suggest a focus on improving the consistency and quality of spiritual care by fostering inter-professional collaboration, and improved provision of resources and educational opportunities.

Keywords: spirituality; spiritual care; nursing; holistic care

1. Introduction

The rise of the biopsychosocial spiritual model and the patient-centred approach to medical care has led to the inclusion of spiritual care as part of professional practice requirements (Stewart et al. 1995; Puchalski 2006; Baldacchino 2006). The provision of spiritual care is increasingly being referred to in government policy, professional practice guidelines and curricula (NHS Education Scotland 2009; Joint Commission on Accreditation of Healthcare Associations 2005; Puchalski et al. 2009; National Institute for Clinical Excellence 2004; Baldacchino 2008; Ministry of Health 2010). As David Tacey emphatically states, "Spirituality is a major social issue and requires immediate attention if we are

to creatively respond to the spiralling outbreaks of depression, suicide, addiction, and psychological suffering" (Tacey 2003, p.3).

Spiritual care in nursing practice, some argue, "has been present since its inception" (McSherry and Jamieson 2011; Nightingale 1996, p. 1758). Spiritual care is nationally and internationally mandated in nurses' ethical codes, guidelines, philosophy, training and competencies (Ross 2006; An Bord Altranais 2009; Nursing and Midwifery Council 2012; International Council of Nurses 2006; Tanyi 2002; Macrae 1995). It has nonetheless been described as one of the last taboos of nursing practice (Burnard 1998), and the place of spirituality in increasingly secular societies and clinical assessments tools and competencies has been the topic of recent debate (Paley 2008a; Paley 2008b; Paley 2009; Timmins and McSherry 2012; Timmins and Caldeira 2017). Given the context where the model of healthcare increasingly includes spirituality (Puchalski et al. 2014) it is important to understand the place of spirituality in nursing practice.

2. Background

The results of the 2010 Royal College of Nursing (RCN) spirituality survey (Royal College of Nursing 2011), affirm the centrality of spirituality and spiritual care to nursing practice. Capturing the perspective of over 4000 registered nurses, the RCN survey found spirituality and spiritual care to be a core element of nursing practice that enhances the overall quality of care (McSherry and Jamieson 2011; Royal College of Nursing 2011). Notably, the valuing of spirituality did not depend on nurses' religious affiliation. Alongside this high level of support for spirituality were nurses' reports of high demand for spiritual care: 95.5% of nurses surveyed had encountered patients with spiritual needs, 41.4% on a daily basis.

Similarly, despite being a largely secular country (Vaccarino et al. 2011), recent research has affirmed the importance of spirituality as part of holistic healthcare in New Zealand (NZ): in Egan's study of spirituality in end-of-life care (Egan et al. 2011), 99% of participants (patients, family members, health professionals and chaplains) "understood spirituality to be meaningful" (Egan et al. 2011, p.321). Whilst chaplaincy has traditionally led the provision of spiritual care, this appears to be changing as healthcare systems, patients' and spiritual needs change (Cobb 2007; Heelas 2006); there is some evidence that suggests nurses provide much of the psycho-social-spiritual care (Egan et al. 2013). Spirituality in healthcare encompasses both religious and non-religious beliefs (Egan et al. 2011), acknowledging that all humans have a spiritual dimension across the secular–religious continuum.

The spirituality and nursing literature has grown considerably in the last decade in such areas as nurse education (Wu et al. 2016; Ross et al. 2016; Timmins et al. 2015; Baldacchino 2011), communication (Wittenberg et al. 2016), nurse's self-care (Spadoni and Sevean 2016), experiences in the clinic (Nascimento et al. 2016; Cone and Giske 2016; van Leeuwen and Schep-Akkerman 2015), assessment (McSherry and Ross 2002; Adib-Hajbaghery and Zehtabchi 2016) and definitions (Tanyi 2002; Reinert and Koenig 2013). The research, exemplified by recent spirituality and cancer meta-analysis (Jim et al. 2015; Sherman et al. 2015; Salsman et al. 2015) confirms the importance of attending to this domain, is such that the Scottish National Health Service (NHS Education Scotland 2009), the US Joint Commission on Accreditation of Healthcare Organisations (Joint Commission on Accreditation of Healthcare Associations 2005), and New Zealand's Ministry of Health (Ministry of Health 2010) all call for spiritual needs to be addressed in various healthcare settings. Inevitably, there are challenges to this literature (Sloan et al. 1999), which affirms the need for more rigorous research. Thus, the present study, in the context of this worldwide growth of spirituality literature, policy and practice, seeks a baseline view of spirituality and New Zealand's nurses.

Of particular interest is the identification of potential gaps that may exist between the spiritual needs nurses encounter, and their perceived ability to attend to them. What is uncertain is the amount or quality of education in this area that nurses have previously been provided with. According to the RCN survey, 92.2% of respondents felt they were only 'sometimes' able to meet these needs. Whilst this result may be due in part to a lack of 'not applicable' response option for this survey question, it

nonetheless points towards a need for spiritual care professional development opportunities (Royal College of Nursing 2011). NZ research has similarly identified gaps in the provision of spiritual care and a corresponding need for professional development opportunities for those working in the hospice area (Egan et al. 2011).

2.1. The Present Study

National data concerning nurses' perception of, and ability to provide, spiritual care is lacking in NZ. This is a significant knowledge gap, as the identification of such understandings and perceptions is the first step to ensuring the provision of spiritual care to those receiving healthcare (Ramezani et al. 2014).

The present study sought to investigate NZ nurses' understandings, perceptions and experience of spirituality, patient spiritual needs, and spiritual care provision, policy and education. It constitutes the first national survey ascertaining such views, and was based on the 2010 RCN survey.

2.2. Research Questions

This survey was guided by three core research questions:

- What do NZ nurses understand by the terms spirituality and spiritual care?
- Do NZ nurses consider spirituality to be a legitimate area of nursing practice?
- Do NZ nurses believe that they receive sufficient support, guidance and training in spiritual matters?

3. Methods

3.1. Participants

A random sample of 2000 individuals citing 'nurse' in the listing of their occupation on the NZ electoral roll, between 30–64 years of age, were chosen by a random number generator. The number citing 'nurse' in their occupation for different age groups was compared to number of nurses registered with the Nursing Council of New Zealand (Table 1). For those under 30 years of age the number on electoral roll was considerably lower than that registered by the Nursing Council, suggesting greater misclassification of nurses at younger ages. Therefore, only those aged 30–64 years were selected.

Table 1. Comparison between the NZ Nursing Council and electoral roll numbers.

Age Group	NZ Council-Registered Nurses	Electoral Roll
< 25	1499	681
25–29	4060	2465
30–34	3861	3255
35–39	4173	3805
40–44	5890	5829
45–49	6242	6068
50–54	7671	7704
55–59	6948	7427
60–64	4504	5250
65+	2913	5599
Total	47,751	48,083

Of the 2000 subjects invited, four identified as being either a dental nurse or nurse aide, and 39 were resident overseas, leaving 1957 eligible subjects. The characteristics of those that cited nurse in their occupation and the eligible subjects as obtained from the electoral roll, along with the characteristics of the 472 participants (response rate 24.1%), are shown in Table 2. The random selection was largely representative of those listed on the electoral roll. The response rate of 24.1% was low.

Participants were more likely to be female, older, and from Auckland than in the representative sample selected. In addition, the use of the words used to describe occupation on the electoral roll may have misclassified, and omitted, some nurses from the study. The respondents who answered the open questions analysed represented only 63% of the respondents. Sixty-one per cent of all participants stated that they were practicing their religion while the 2013 population census identified that 44.8% of the population reported having no religion and a further 4.7% objected to being asked their religion (Statistics New Zealand Tatauranga Aotearoa 2013). The focus of the survey was identified by its name in the invitation postcard and it is possible that the nurses who responded were more likely to be practicing a religion than non-responders. Therefore, the results cannot be considered to represent the views of nurses in general.

Table 2. Characteristics of the potential participants and those that responded.

CHARACTERISTICS	Electoral roll * (%)	Selection ** (%)	Participants † (%)
Female	92.1	93.2	95.4
Age (years)			
30–39	18.7	20.1	16.5
40–49	29.5	28.7	28.1
50–59	38.0	37.0	40.9
60–64	13.6	14.2	14.4
District Health Board Region			
Auckland	8.4	9.1	16.7
Waikato	8.5	8.4	7.7
Canterbury	12.8	13.6	17.7
Southern	7.9	7.3	10.7
Other	62.4	61.6	47.2
Institution			
Public Hospital			48.8
Private Hospital			8.8
Public Health Organisation			7.2
Aged Care Facility			9.1
Other			26.1
Scope of Practice			
Registered Nurse	92.0	91.1	92.5
Enrolled Nurse	2.3	2.7	4
Nurse Practitioner	0.1	0.2	1.2
Other	5.6	6	2.3
Years Worked			
< 1 year			4.9
1–2 years			7.9
3+ years			87.2
Ethnicity			
New Zealand European			82.1
Maori	8.3	8.2	7.2
Indian			2.3
African			1.4
Other European			2.6
Other Asian			1.2
Religion			
None			35.3
Christian			57.9
Hindu			1.4
Other			2.1
Practicing their religion			61.5

*, ** Sex from title and names, District Health Board (DHB) from residence, scope of practice from occupational description, and Maori descent on the electoral roll; †: from self-reporting.

3.2. Measures

Like the RCN survey (Royal College of Nursing 2011; McSherry and Jamieson 2011), we utilised the Spirituality and Spiritual Care Rating Scale (SSCRS), which has shown consistent reliability and validity in establishing nurses' perceptions of spirituality and spiritual care (McSherry 2010; McSherry et al. 2002). Additional questions were added to explore NZ-specific issues: if and how Māori and Pacific patients' spiritual needs are being met, revisiting questions previously covered in NZ-specific studies (Egan et al. 2011; Egan et al. 2013), and examining the utilisation and attitude towards chaplaincy services. Ethics approval was granted by the University of Otago Human Ethics Committee (reference: D15/243).

3.3. Procedures and Data Analysis

A reminder letter was sent three weeks after postcard delivery, with an information sheet and consent form included. Two weeks after that, we called participants whose phone number was publically available to encourage participation and offer to complete the survey over the phone. The survey was made available for the three months between September and November 2015.

This paper specifically reports on the qualitative analysis of two free text response questions that were set at the end of the survey, an approach taken by McSherry and Jamieson in reporting the qualitative findings from the RCN survey (McSherry and Jamieson 2013). These questions asked participants to (1), comment about their understanding of spirituality, spiritual care or other issues and (2) comment on how they would enhance the spiritual care undertaken in their current workplace. A total of 274 participants responded (58% or participants, 14% of those invited) to the question regarding workplace improvements, and 177 (38% of respondents, 9% of those invited) to the question for other comments. There were 30 pages (1389 lines, 18,666 words) of free text in Calibri 12 font, which were analysed using thematic analysis (Braun and Clarke 2006). Initial coding and thematic mapping was developed by RL and reviewed by RE. The analysis included close reading of the text, coding meaningful segments, memo writing on possible implications and framing codes into themes and subthemes, with indicative quotes and possible implications. These tables (see Table 3 for example) were the basis for further reporting.

Table 3. Example of analysis framework.

Theme	Subtheme	Quote	Implication
The place of spirituality in nursing practice	*An integral component*	"When spiritual needs are addressed healing time, anxiety and prognosis all improve the patient's journey."	Many participants expressed a common idea that "spiritual healing will help the healing of sickness."
		"Identifying and addressing spiritual needs with clients/service users starts with the therapeutic relationship which in itself it a spiritual passage—the development of whakawhanaungatanga or connection between two human beings at the start of a journey of change . . . All in all nurses are provided a beautiful opportunity to spiritually experience the many journeys of the people we are privileged to work alongside."	The idea of the 'therapeutic relationship' signals the role of nurses in spiritual care—a connection of some sort that *does not* have to cross professional boundaries. Would framing spiritual care in terms of a 'journey' and 'therapeutic relationship' overcome some resistance?
		"Nursing is a spiritual job. If you don't believe in meaning and purpose, love and hope you shouldn't be doing it."	

Table 3. *Cont*.

Theme	Subtheme	Quote	Implication
		"Spirituality shapes, divides, draws close, separates individuals. It is part of the needs of an individual just as food is. If is clearly connected to the mental health and wellbeing of many people therefore must be given equal and considered care in its approach. It could be the difference in some people surviving or not surviving from illness therefore must be regarded as essential and on the spectrum of care."	
		"One of the distinguishing features of nursing is its focus on things unspoken—and that includes spirituality."	
	Not our role	"Whilst I understand that there are people who require spiritual care, I feel this will lessen as the population further identifies as not having a religion."	The idea that spiritual needs will decline contradicts some research on the rise of spirituality—and dual decline of religious affiliation—and highlights the need for education.
		"There are so many levels of spiritual care and I don't think nurses should be responsible for performing it themselves. Guidance in how to get appropriate help and the time/resources to do so should be part of our training and orientation to workplaces."	Is there a need to transform the idea of an 'amorphous' spirituality from a scary prospect to a necessary state to accommodate all needs? In this way, a nurse is not expected to be able to cater for all, but recognise, potentially help, but also have the capacity to refer on as required.

4. Results

Thematic analysis of the open-ended questions from the survey yielded three metathemes, with attendant subthemes: 'The place of spirituality in nursing practice', 'Enabling best practice' and 'Creating a supportive culture' (Figure 1). Each will be discussed in turn. Please note, all quotes give the gender, area of care and ethnicity of the respondents.

Figure 1. Map of metatheme and attendant subthemes.

4.1. The Place of Spirituality in Nursing Practice.

This meta-theme covers two key issues, addressed as separate sub-themes: 'What is our role?' regarding the provision of spiritual care, and a corresponding 'need for clarity' regarding the meaning, language and practice of spirituality and spiritual care. All quotes below are from the nurse participants.

4.1.1. What is Our Role?

Three strands of argument regarding the role of spirituality in nursing practice were identified: one affirmed the centrality of spirituality and spiritual care to nursing, one was ambiguous with respect to professional boundaries and expectations, and one emphasised the context-dependent nature of spiritual needs and spiritual care. Few responses directly opposed the relevance of, or expectation to engage with, spirituality.

The importance of spirituality and spiritual care to nursing practice was often placed within the bounds of the 'therapeutic relationship' between patient and nurse.

> Identifying and addressing spiritual needs with clients/service users starts with the therapeutic relationship which in itself it a spiritual passage—the development of whakawhanaungatanga or connection between two human beings at the start of a journey of change and enlightenment. The quality of this relationship will either aid or disable the journey. Hope is another essential spiritual aspect of nursing care which again is tied to the relationship and the vision of what could be achieved together. All in all nurses are provided a beautiful opportunity to spiritually experience the many journeys of the people we are privileged to work alongside. Female, mental health (community) NZ European.

In this way, spiritual care formed part of an interpersonal connection that sat within professional boundaries and expectations.

Others were less certain regarding what sat within or extended beyond professional boundaries:

> Where I work there exists a paucity of guidance around spirituality as mental health consumers can experience religious delusions resulting in an avoidance of the subject of spiritual beliefs altogether . . . The role of nurse is also considered neutral position therefore the nurse is strongly advised not to divulge his or her own beliefs. I remain uncertain whether this is a good thing or not? Female, mental health (inpatients), NZ European.

The potentially complicated connection of spirituality and spiritual care with mental health patients was frequently mentioned:

> I remain uncertain as to what the role of the nurse is in relation to the mental health consumer and their spirituality. I have witnessed both disaster and comfort when nurses have been of the same faith as the consumer and worshipped with them. Female, mental health (inpatients), NZ European.

> But living well with mental illness is very possible when spiritual care is taken seriously by client and team care members...utilising a recovery approach usually involves looking at spiritual care. Female, mental health (community) NZ European.

The relevance of spirituality and spiritual care to settings in which its provision is more challenging was doubted or challenged by some. One participant noted that *"As a theatre nurse I have very limited contact with awake patients, so spirituality does not seem to be an issue in my area"*. Female, perioperative care (theatre), NZ European.

The perspective that, *"spiritual healing will help the healing of sickness,"* (Female, intensive care/cardiac nurse, Indian) was frequently cited to support the need for spiritual care.

> Spirituality shapes, divides, draws close, separates individuals. It is part of the needs of an individual just as food is . . . It could be the difference in some people surviving or not surviving from illness therefore must be regarded as essential and on the spectrum of care. Female, no longer practicing, NZ European.

Others were less affirmative of the spiritual care expectations placed on nurses due to the amorphous nature of spirituality and spiritual needs:

> There are so many levels of spiritual care and I don't think nurses should be responsible for performing it themselves. Guidance in how to get appropriate help and the time/resources to do so should be part of our training and orientation to workplaces. Female, perioperative care (theatre), NZ European.

Some participants demonstrated hesitancy due to expectations that the presentation of spiritual needs will increasingly decline considering the current trend of waning religious identification in the NZ population. Nonetheless, various participants commented on the important distinction between the initiation of spiritual care and taking entire responsibility for a patients' spiritual needs—only the former being the role of a nurse.

The need for nurses to be active in their identification of spiritual needs was also emphasised:

> Sometimes it is difficult for [patients to] identify own needs—nurses role is always to instil hope and help find meaning. Female, nursing professional advice/policy, South African.

> I have been a registered nurse for 40 years, and have always had an awareness of spiritual care, but it has only been in the last 10 years that I have seen the importance [of spirituality] to the person and their family/whanau as this completes them as a whole person. Often they are unaware of this need, but if they feel accepted, and treated with respect and feel listened to and understood, this is spiritual care. Female, practice nursing [recently retired], NZ European.

Participants' comments suggest patients may not always be able to identify or articulate their own needs, however this does not mean spiritual needs are not present.

Conversely, not all participants advocated for a proactive approach: "If the patient needs to see a minister, it's available, it's at their request. We don't just offer it out of nowhere—it's at their request," (Female, mental health (inpatients), Māori). However, as other participants noted, if nurses do not initiate a conversation around spirituality and spiritual needs, it may result in those unable to identify or articulate their needs 'falling through the cracks' of service provision. Further, there is a need to create an environment of openness regarding spirituality, which may be difficult if nurses do not provide verbal recognition of the potential for spiritual needs and care. As noted by one nurse participant, "Patients will only express spiritual needs if they feel the environment is safe to do so and that staff will be receptive to it" (Female, intensive care/cardiac care, NZ European). The importance of creating a supportive environment will be further discussed under the metatheme of 'Creating a supportive culture.'

4.1.2. A need for Clarity

For many nurses who responded, spirituality was understood broadly as *"the essence of one's belief system that helps us through life"* (Female, nursing education, NZ European). It was distinct from—although not unrelated to—religion. Spiritual care was seen to focus on the provision of universally appreciated practices of compassion, tolerance, peacefulness, positive intention, and respect. In this way, *"It does not have to be complex"* (Female, assessment and rehabilitation, NZ European).

A common thread appeared to be the characterisation of spiritual care as kindness, where nurses connect with the lived experience and belief system of a patient, to help them navigate a trying situation or period of life. As one participant strongly stated, *"Nursing is a spiritual job. If you don't*

believe in meaning and purpose, love and hope you shouldn't be doing it," (Female, nursing education, NZ European). However, some participants argued against spiritual care being a nursing responsibility because it extends *beyond* the simple provision of compassionate care:

> I do not think it is the responsibility of the nurse to meet a patient's spiritual needs outside of the kind and caring environment. I think we need to be made aware then refer to someone appropriate. Female, intensive care/cardiac care (midwife/RN), NZ European.

From these comments, it appears that what some nurses regard as spiritual care, others see as the provision of standard compassionate care. For the latter individuals, spiritual care appears to extend to the realm of referring to other professionals, for example religious counselling. Some nurses specifically commented on the deleterious impact of confusion between religiosity and spirituality: *"Generally I don't think [spirituality] is taken seriously by many and many mistake it with religion, which may not have anything to do with individual's needs"* (Female, primary health care, NZ European).

Various participants affirmed the need for clarity regarding 'spiritual vocabulary', a spiritual literacy as it were, and the professional expectations that flow on from the use of such language:

> One of the challenges we have is the language. If we discuss religion, whatever that might mean for people, there is a common understanding, there is a religious vocab[ulary]. There is no spiritual vocab that has a shared understanding and to use religious vocab in this context can be a VERY problematic and inappropriate. It is a concept that only gets lip service on patient assessment sheets by way of tick box! Female, palliative care, NZ European.

> Most people in NZ are secular and non-religious and the concept of spirituality has been somewhat hijacked to cover a whole range of normal human emotions and the responses a nurse might have to them. Female, child health including neonatology, NZ European.

These comments reveal the broad spectrum of opinions concerning the term spirituality, thus highlighting the sensitive nature of the concept. Consequently, professional expectations around these terms are not well defined or articulated. As such, there is a need for common understanding of what spirituality entails to help navigate the multitude of individual perspectives on what are often highly personal issues while considering that achieving consensus or arriving at an authoritative definition may not be practical or appropriate.

Overall, this metatheme highlights that the place of spirituality in nursing is not unambiguous: some nurses feel it is precluded or potentially troublesome in their area, whilst others feel it is part of or even central to nursing care.

4.2. 'Enabling Best Practice'

Accepting spirituality and spiritual care as core parts of nursing practice, various respondents identified key factors that (would) enable best practice. These factors were explored as the separate sub-themes of 'Collaboration', 'Responding to a changing society,' and 'Competency, confidence and professional development.'

4.2.1. Collaboration

Some nurses expressed a need for collaboration on multiple levels: with community-based spiritual and religious groups, by way of multidisciplinary care teams, and amongst nurses themselves.

Many participants perceived a need for formal pathways to access appropriate resources and services for the widely varied needs of their multi-ethnic and multi-faith communities:

> I think it would be quite nice to work more with churches and spiritual groups in the community in getting their help with some of our patients . . . Spiritual groups are often not connected with the healthcare system. It would be better if they were. Female, nursing administration and management, Other European.

> Make it easier for health professionals to access a list of different spiritual support systems to assist all patients with "religious and non-religious beliefs." Female, nursing administration and management, NZ European.

The establishment of working relationships with community-based spiritual and religious groups would specifically assist in the continuity of care post-discharge, where there was a perceived gap in the ability of patients to access resources and services once back in the community.

The need for multidisciplinary teams (MDT) to consider quality spiritual care was also frequently mentioned. Such teams, it was suggested, could provide the various skill sets needed to address the widely varied spiritual needs encountered. More importantly, however, a team approach was thought to ensure patients were provided with sufficient opportunities and contact time for quality spiritual care.

> Time is a huge challenge and probably the most important element to being able to connect with a person where we can begin to discover their spiritual needs. One person alone can never provide this. Team! Female, continuing care (elderly), NZ European.

> Social work is one paid service that we actually have that is quite important to us and would be beneficial to have 24/7. People don't necessarily identify that they have a spiritual need, but they have it! They have a need and the social worker is an interdenominational multi-cultural touch-point. They are really undervalued in our health system for providing that. Female, emergency and trauma, NZ European.

To improve the efficacy of a team-based approach, some participants suggested that spiritual needs be more openly discussed during MDT meetings, and that a member of the team take on the role of 'spiritual care champion' and guide others in the provision of best practice spiritual care.

Some respondents also considered that collaboration amongst nurses themselves was a useful way to learn from others experience and promote consistency regarding the identification of spiritual needs and the practice of spiritual care.

4.2.2. Responding to a Changing Society

Respondents identified a need for religious and spiritual resources as a way to navigate the *"huge scope of spiritual/cultural/religious beliefs"* of the increasingly diverse NZ society.

> With the ever growing Indian community, and their beliefs of Hindu, Sikh, Christian, it would be helpful to be familiar with these beliefs so as to ensure their safety as well as for the nurses. Female, public health, NZ European.

> It would be useful to have practical values included e.g. is it considered disrespectful to look in the eye when talking to this group of people? Female, perioperative care (theatre), NZ European.

Such comments suggest a significant gap regarding the skills and knowledge of nurses to practice with competence. For some respondents there was concern regarding the management of professional boundaries around involvement in religious practice and rituals with patients and their families.

In addition to the provision of resources, increased education and discussion opportunities were seen as a way to transform understanding of spirituality and provision of spiritual care.

4.2.3. Competency, Confidence and Professional Development

To fulfil professional expectations, roles and responsibilities regarding spiritual care, many participants suggested a need for training and education opportunities, alongside the development of professional competencies and guidelines.

Participants painted a picture of an inadequate history of training opportunities: "This is an area of nursing that has very little training, resources, support. Even after more than 20 years in nursing I

can feel ill equipped to meet the clients' needs in this area." (Female, family planning/sexual health, NZ European). Such training was not seen as an 'optional extra', due to the "need for nurses to have a minimum level of awareness and skill to navigate the various situations they find themselves in." (Female, intensive care/cardiac care, NZ European).

The lack of training and education opportunities appeared to be exacerbated by the lack of informal discussion around spirituality: *"It would be nice if it became a common topic of conversation. The problem is that the majority of people in the workforce are not spiritual; it is a neglected part of life."* (Female, nursing administration and management, Other European). Participants' comments pointed to a gap between the awareness and practice of spirituality in the traditionally secular NZ society and the needs that arise in the healthcare context.

For those who wanted training, many were unsure where to access it outside of the palliative care setting. Understandably, the provider of such education and training opportunities was considered to be of particular importance. Various participants stated it would have to come from a source they would feel confident using, ideally provided by way of *"protected time and support with trained, trusted and respected colleagues."* (Female, medical, NZ European). E-learning modules were suggested as an easy initial platform for foundation education and training.

Various participants commented on what appeared to be the debatable question of whether spiritual care could be taught:

> Nurses need to know their spiritual beliefs, before they can educate other nurses, or aid patients. Not all staff able or willing to give spiritual support. Choice of individual. Female, continuing care (elderly), NZ European.

> Nurses are beautifully positioned to provide practical, effective spiritual care intervention and support...It does, however, depend upon organizational support, resource allocation and a requirement for maturity and insight on the part of the practitioner which is a lifetime journey. Male, nursing education, NZ European, Māori.

Whilst not all participants thought spiritual care could be taught, they believed that a respect for it and awareness of how spiritual needs may manifest could be. The above comments also point to the significant contribution of institutional support to the ability of spiritually-inclined nurses to provide effective spiritual care.

Participants also suggested that small interventions may spark changes in attitudes towards and practice of spiritual care:

> I will discuss having a spiritual care policy within our general practice as this is something that has never been discussed. Female, practice nursing, NZ European.

> Wow, this made me reflect on my practice. This is something I don't really address—I've always just thought that referring to the chaplain was all that I could do. I had never thought that by listening to the patient and providing guidance I'm providing spiritual care. Female, surgical, NZ European.

That this short survey induced re-evaluations of some nurses' scope of practice suggests a short and affordable nursing workforce intervention may be efficacious.

In addition to training and other educational opportunities, various respondents considered spirituality-related competencies, policies and guidelines valuable. These were seen to provide clarity around professional boundaries, normalise spiritual care practices, and extend spiritual care outside the scope of the palliative context. However, others disagreed with the need for the explicit specification of spiritual care practices by nursing professional bodies:

> I would not like to see spirituality put 'in a box' with guidelines and policies from any of our governing bodies. If this happens we run the risk of missing out a lot of people. Female, assessment and rehabilitation, NZ European.

> I believe that some nurses don't feel they want to be involved in the spiritual elements of nursing—I don't think these nurses should be forced to do this as more damage than good could be done for both the patient and the nurse. Female, medical, NZ European.

These comments indicate the need for clarification that the goals of spiritual care education, policies and competencies ought not to impose the provision of spiritual care on nurses.

Overall the metatheme *'Enabling best practice'* illustrates the nuanced complexities of establishing a common understanding and practice of, alongside professional processes around, spiritual care. The key message again appears to be that, if a more formalised approach is muted, a blanket approach is ill-suited to this task.

4.3. *'Creating a Supportive Culture'*

This metatheme describes various elements would be required for optimum spiritual care provision, above and beyond the foundation of understanding and practice guidelines. Three elements were key and are discussed as separate sub-themes: 'A supportive environment', 'Leadership and role modelling', and 'Overcoming religious tensions'.

4.3.1. A Supportive Environment

Many participants identified the need to overcome institutional constraints to the provision of spiritual care, largely concerning the time available to meaningfully connect with patients:

> Reduce the nurse workload so we have the time to sit with our patients and can listen to their needs. Allow a private quiet place on each ward where people can sit and reflect on what is happening to them. Female, surgical, NZ European.

> As ward tasks like washing have been delegated to healthcare assistants, the nurses no longer gain the opportunity to have quiet, private moments in which to address spiritual needs. Female, intensive care/cardiac care, Other European.

The time-pressured working environment was also attributed with the result of 'compassion fatigue'. Many felt that if a nurses' ability to ensure their personal psycho-spiritual wellbeing was precluded, it was impossible for that person to provide spiritual care to patients: *"Nurses also need to be cared for, allowing them to be in the right frame of mind to be receptive and caring"* (Female, nursing administration and management, NZ European).

In this way, nurses' spirituality is intertwined with spirituality of patients; to take care of one, there is a need to take care of the other. Some participants suggested the appointment of workplace spiritual/pastoral care role, where this individual was available to both staff and patients.

4.3.2. Leadership and Role Modelling

Other participants pointed to the need for *"role modelling and mentoring"* (Female, primary health care, Māori) regarding the importance of spirituality and spiritual care. Strong leadership was suggested as *"essential to making change in a negative cultural milieu that does not prioritise a person's wairuatanga* [spirituality]*."* (Female, primary health care, Māori).

A change in perspective in those in management or team leadership positions was proposed by at least one as the best pathway to overcome the barriers of lack of understanding and prohibitive organisational practices. Further, there was specific support for promoting Māori models of holistic healthcare: *"Māori model works well for NZ as they always include spirituality in daily life/models or care, whereas Europeans tend to 'tag' it on later."* (Female, medical, NZ European).

4.3.3. Overcoming Religious Tensions

Tension around the display or discussion of religious or spiritual knowledge and practices was mentioned by a number of participants.

Some felt that spirituality and religion were overall no-go areas in the predominantly secular NZ society:

> People are too scared to show any religious or spiritual leaning. It is frowned upon. Religion is also unpopular, not in vogue. You are thought of as weird. You have to be very careful to express or show spirituality, which is a sad reflection on society. Female, assessment and rehabilitation, Other European.

Others felt that particular religions were favoured more than others:

> In my work place there is a tendency to strong Christian beliefs and sometimes this is pushed a bit much onto some patients. Other religions and beliefs are not always accommodated very well by some staff. Female, palliative care, NZ European.

> I have always felt comfortable praying with my patients when I was in clinical practice and I saw many times that it was a help to both the patient and myself. I don't think that Christian nurses feel they have the freedom to do this with their patients and that is such a shame. Female, nursing education, NZ European.

This resulted in certain staff both over-stepping the line of professional spiritual care, or feeling obstructed from providing what should be considered standard practice.

Participants' comments suggest the need for increased familiarity around spiritual and religious issues, such that standards of appropriate practice can be openly discussed. Moreover, particularly important in the multicultural and multi-faith NZ society, there appears a need for increased tolerance of unfamiliar beliefs and practices held by both fellow staff and patients. Interdenominational pastoral support was thought worthwhile by some, calling for the enduring need for chaplains as *"often they are the ones who are equipped to assess and assist everyone's needs—not just Christians."* (Female, palliative care, NZ European).

'Creating a supportive culture' suggests an array of personal, management and organisational factors as required to enable the provision of best-practice spiritual care.

5. Discussion

The open-ended questions of the first national survey of NZ nurses' perceptions and practice of spirituality and spiritual care provide insight into the perceived value of, obstacles to and pathways forward in the provision of spiritual care. There are practical implications of respondents' perspectives on the value and practice of spirituality and spiritual care. Three issues are taken as a focus:

- Whether cultivating a common understanding of spirituality can be achieved;
- Attending to the needs of a traditionally secular, but increasingly multi-faith and multi-ethnic, society; and,
- Creating the conditions for a spiritually supportive environment for staff and patients.

5.1. Cultivating a Common Understanding of Spirituality.

Despite the historical place of spiritual care in nursing practice (Bradshaw 1994), the question of how best to formally integrate spiritual care training in pre-registration/undergraduate nurse education programmes is just starting to be addressed (Ross et al. 2014; Ross et al. 2016). As McSherry (McSherry et al. 2008, p. 1004) states, "teaching spirituality is ethically contentious". It can invoke the idea of religion, which is problematic for predominantly secular countries like the UK and New Zealand (Gill et al. 1998; Vaccarino et al. 2011).

Nonetheless, some respondents suggested that greater education on the meaning of spirituality and the practice of spiritual care is needed. However, the low response rate reduces the generalisability of the results. The knowledge gap many respondents conveyed is not surprising in light of recent literature that points to a general lack of structure or coherence to the inclusion of spiritual care in

core curriculum (Lucchetti et al. 2012; Abbasi et al. 2014; Timmins et al. 2015). This is supported by the results of recent studies that found the treatment of spirituality in UK and US nursing textbooks was inconsistent, unclear, tokenistic and unreflective of the 'holistic care' approach that textbooks otherwise proclaim to uphold (Timmins et al. 2015).

Specifically, respondents' comments suggested a need to make clear the 'amorphous' idea of spirituality. Indeed McSherry and Jamieson (McSherry and Jamieson 2011) have argued that the provision of spiritual care by nurses, and the development of training programs to equip nurses with the skills to do so, is likely complicated by a general lack of clarity regarding the definition of spirituality. While a formal authoritative definition of spirituality may not be possible, there is growing consensus about certain elements of spirituality that appear to be universally recognised, such as connection, transcendence, meaning and relationships (Weathers et al. 2015; Puchalski et al. 2014). This work provides much needed direction for practitioners regarding potential options for care.

What appears most important is the cultivation of a common understanding of the general principles and practice of spirituality and spiritual care to enable best practice (McSherry and Jamieson 2013). Progress on this front can be seen in the rise in 'functionalist' definitions that place emphasis on whether the definition and practice of spirituality is useful for the patient (King 1996; Egan et al. 2011; Clarke 2009; Swinton and Pattison 2010). The functionalist is reflected in the RCN's recent attempt to make clear the dimensions that do (and do not) come under the heading of 'spirituality' (Royal College of Nursing 2011), and is one that may help bridge the apparent gap between recognising definitions, and recognising behaviours, of spirituality and spiritual needs. This functionalist approach also aligns with what Swinton and Pattison (Swinton and Pattison 2010) term a 'thin and vague' definition of spirituality, that provides sufficient flexibility for nurses to address the broad range of spiritual needs that may arise in relation to different illness, in different contexts.

The various nuances of respondents' comments also point to an important disclaimer regarding spiritual care education: that it does not aim to force nurses to be '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. Both the literature and respondents note that a personal sense of spirituality is often required before the provision of spiritual care to others is possible (Cone and Giske 2016; Abbasi et al. 2014; Ross et al. 2014; van Leeuwen et al. 2008; Chan et al. 2006b; Lopez et al. 2014). In this way, spiritual care education can help establish the prerequisite understanding of one's personal spiritual needs such that the needs of others can be addressed (Morgan et al. 2015; Abbasi et al. 2014; Chan et al. 2006a).

5.2. A Secular, but Spiritual Society with Numerous Needs

Participants' feedback highlights the need for ongoing engagement of the nursing profession with up-to-date research on the state of spiritual practices in the NZ population, and international understandings of the scope of spirituality and spiritual care. One participant's expectation that spiritual needs will gradually wither in NZ's predominantly secular society contradicts recent research indicating the rise of spiritual identification and practices in NZ—although accompanied by a decline in religious affiliation (Vaccarino et al. 2011). Vaccarino, Kavan and Gendall found that almost one-third of their sample (n = 1027) identified themselves being spiritual despite not identifying with a religion, and almost half declared they had personal pathways to connect with God outside of formal religious services or institutions. These results highlight the importance of understanding the relationship, and distinction between, spirituality and religion. Some participants noted that they, or others, avoided the provision of spiritual care on the grounds that it crossed professional boundaries to the provision of religious counselling. Clarification that spirituality extends beyond that which is religious may increase engagement with the practice of spiritual care in those previously opposed to the idea.

It is also important to note the increasing cultural, ethnic and religious differences of NZ society. Whilst the latest national census revealed, among those stating a religious affiliation, an increasing decline in Christian religious affiliation, a drop from 55.6% in 2006 to 48.9% in 2013 (Statistics New

Zealand Tatauranga Aotearoa 2013), affiliations with other minority religions such as Sikh, Hindu and Islam increased. As participants expressed, there is a need for professional development opportunities and resources to enable nurses to remain culturally and spiritually 'safe' in their provision of care, in terms of both their and the patient's experience. There is some leadership from Scottish and Irish health organisations in this field (Health Service Executive 2011; NHS Education Scotland 2009).

5.3. Supporting Staff and Patients

It has been noted that organisational factors are an important influence on perceptions and practice around spiritualty and spiritual care (Timmins and McSherry 2012; Reimer-Kirkham et al. 2012; Biro 2012). Indeed, various participants pointed to the need for supportive institutional conditions to enable quality spiritual care.

This need is complicated, however, by professional atmospheres of intolerance towards the expression of religious or spiritual inclinations. Participants noted a particular intolerance of the expression of Christian faith, as found by the RCN 2010 spirituality survey (McSherry and Jamieson 2013). Other authors have found evidence of institutional intolerance of spiritual care associated with the recent rise in "pressure to be politically correct in public interactions" (Hubbell et al. 2006, p. 383; Taylor 2011). This has led to nurse practitioners not incorporating spiritual care into care plans or multi-disciplinary care meetings and discussions (Hubbell et al. 2006)—an area some of our participants suggested could be improved.

The development of professional competencies around spiritual care, as has recently been done in the area of cancer care in New Zealand (Central Cancer Network 2015), may provide clarification of the place of spiritual care in the workplace. National guidelines for spiritual care in aged care have been developed and could be usefully built on in the NZ context (Meaningful Ageing Australia 2016). The next challenge is working in a system or framework that has not traditionally made space for spiritual care. Therefore, policies, guidelines and standards, such as those in these documents, give direction to practice. However, as participants noted, efforts will need to be made to ensure such competencies are not mere 'tick box' affairs, but rather provide a professional atmosphere supportive of meaningful engagement with spirituality and spiritual care. These insights point to the need for policy makers and educators to keep in mind that a 'one size fits all' approach to spirituality and spiritual care is not an ideal pathway forward: policies, competencies and guidelines should be formulated and enacted in a way that does not encroach upon individual inclinations.

Such competencies may also help clarify the relationship between personal and professional boundaries regarding spirituality and spiritual care. Many participants expressed confusion regarding the place of personal spiritual or religious tendencies and beliefs in the professional workspace. Others have noted this trend and attributed it to the increasing secularisation of society (van Leeuwen and Schep-Akkerman 2015; McSherry and Jamieson 2013). Generating a supportive environment in which appropriate expression of spirituality and/or religiosity by nursing staff will likely improve work satisfaction, patient care and protect against psycho-physical exhaustion or 'burn out' (Taylor 2014). A recent review of the literature supports the recognition of the spiritual needs of nurses as a pathway to improving the provision of spiritual care to patients, due to the close relationship between spiritual expression and overall wellbeing in nurses (Cockell and McSherry 2012).

5.4. Strengths and Limitations

The findings arising from this investigation provide useful insights and evidence that may contribute to ongoing debates associated with aspect of nursing practice. The use of similar research methods enables cross-national comparisons regarding nursing and spirituality to be made; the RCN survey has also been recently replicated in Australia (Austin et al. 2016). Nationally, the study provides strategic direction regarding the study and practice of spiritual care in various ways:

- Providing baseline information to inform pre/post clinical training, current nursing practice, and policy development;

- Highlighting priority areas for future research;
- Establishing a baseline of evidence regarding nurses' views and practice of spirituality and spiritual care, enabling changes to be tracked over time.

Nonetheless, the insights able to be drawn are limited due to the small response rate. There is also a need to supplement these findings with the voice of those on the receiving end of care—patients themselves. Cockell and McSherry (Cockell and McSherry 2012) warn against the preponderance of research lacking the patient voice. Accessing the voice of patients will provide the important opportunity to determine whether nurses' perception of need (or lack thereof) aligns with patients' self-perception.

Further, as some participants noted, the presentation of need and ability to provide spiritual care will likely vary across different fields of nursing. This will affect nurses' ability to recognise and attend to spiritual care needs across different workplace settings. Indeed, van Leeuwen and Schep-Akkerman (van Leeuwen and Schep-Akkerman 2015) found hospital-based nurses had significantly lower scores in perceptions of spirituality and spiritual care competency than those in the mental health or home care setting. This may be due to greater priorities in restoring patients to better health in critical care. Educators and management may need to consider the development of spiritual competencies tailored to workplace settings of nurses (van Leeuwen and Schep-Akkerman 2015).

6. Conclusions

Our findings show that many nurses consider spirituality and spiritual care to be important dimensions of nursing practice. However, this was not universal. There appears to be a need for clarification of the professional boundaries regarding the place of personal spiritual or religious tendencies and beliefs in the professional workspace. The increasingly secularised state of society provides nurses with a complex terrain to navigate the subjective aspects of practice especially where the 'personal' and 'professional' overlap, often in the face of personal or patient spiritual needs. This study suggests NZ nurses need research-informed understandings of spirituality and spiritual care, supported by institutions and infrastructure, guided by meaningful policy, guidelines and competencies. Harnessing opportunities for interprofessional collaboration, alongside improved provision of resources and educational opportunities—tailored to workplace settings—will hopefully help in this regard. Further research, using other methods such as qualitative approaches, is needed to unpack more detail underlying these current findings. Considered "natural allies" (Weaver et al. 2008), nurses and healthcare chaplains have the potential together to develop this important area of healthcare.

7. Relevance to Clinical Practice

Participants' insights suggested that some nurses would like more leadership from NZ nursing institutions regarding spirituality and spiritual care. Such leadership applies not only to the cultivation of a common understanding of whether, or how, spirituality could be included in professional competencies. New Zealand nursing organisations could draw upon the many resources that now exist around the world, for example in the US (Spiritual Care Assocation), Australia (Meaningful Ageing Australia) or Scotland (NHS Education Scotland).

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