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Lynne Denise Roy

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IDENTIFICATION OF THE SPIRITUAL NURSING CARE

PRACTICES OF VOLUNTEER PARISH NURSES

———————————

A Thesis

Presented to the

Faculty of

California State University,

San Bernardino

———————————

In Partial Fulfillment

of the Requirements for the Degree

Master of Science

in

Nursing

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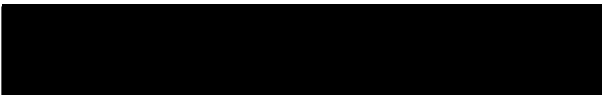
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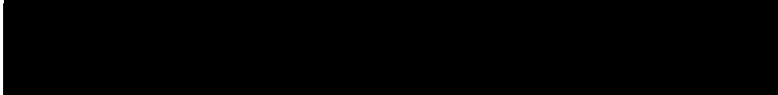Lynne Denise Roy

June 2003

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ABSTRACT

Parish nursing, a specialty nursing practice which
includes the spiritual component of integration of faith
and health, has been growing rapidly over the last decade.
Standards of Parish Nursing Practice developed in 1998 are
consistent with the nursing process and include the
spiritual dimension.

There is very little research regarding the spiritual
care practices of parish nurses. The purpose of this study
is to document and describe the spiritual nursing care
practice of volunteer parish nurses.

A qualitative design was undertaken using seven
purposefully selected volunteer parish nurses. Each study
participant completed a written questionnaire and then
participated in an interview with the researcher.

Common themes identified from the sample included
spirituality, defined as a personal relationship with God;
listening, used consistently when performing spiritual
assessment; formal written tools, used rarely to assess
the spiritual domain; prayer, consistently used as a
nursing intervention; religious rituals, frequently used
as a nursing intervention; evaluation of nursing
interventions, frequently completed by assessing client

response; and no common method of documenting spiritual
nursing practices.

Continued research relevant to parish nursing,
spiritual nursing care, and the spiritual nursing care
process was recommended. Nursing education relevant to the
spiritual realm at all levels of education is needed.

ACKNOWLEDGMENTS

This thesis has truly been a learning experience, yet it represents just a small step of my journey. There have been many individuals who have touched my life and helped me to reach this point:

Mom and Dad, parents extraordinaire. Supporters, encouragers, persons of faith. Thank you, I love you both.

My thesis committee: Ellen, for all your time and encouragement, by example you have demonstrated research can be attainable and fun; Susan, for your time and the hard work you put into making the MSN program a reality; and Al, for your friendship, influence, and guidance as my spirituality has blossomed, I can see Jesus in you.

Laura and Jermaine, my children whom I love. I strive to set the example for you. Passionately pursue your dreams as I have!

To my classmates, colleagues, and friends, you have enriched my life and helped to make me whole.

To the many that have gone before me, thank you for the foundation well laid.

To those who will follow, may this thesis be a stepping stone to a greater and deeper understanding of providing spiritual nursing care.

DEDICATION

This thesis and all that it represents is dedicated to my Heavenly Father. As an act of worship, I humbly offer it up. Father, use it to bring glory to Your Name.

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CHAPTER ONE

BACKGROUND

The beginnings of nursing can be traced back to many ancient cultures such as those in Egypt, Greece, Rome, and Israel (Griffin & Griffin, 1969; O'Brien, 1999). In its early years, nursing was closely entwined with religious orders and faith communities. During the Christian crusades, nursing orders such as the Knights of St. John, the Teutonic Knights, and the Knights of St. Lazarus were established, persisting even today (Griffin & Griffin, 1969). Individual deacons, deaconesses, and Roman matrons cared for sick individuals and were instrumental in the organization and building of places to care for the sick (O'Brien, 1999). Thus, nurses have practiced in religious communities in a variety of ways for centuries.

Religion has played an important part in the development of nursing as a profession. Florence Nightingale, known to many as the founder of modern nursing, has been described as receiving a 'call' to nursing through a divine or spiritual revelation (Griffin & Griffin, 1969; Macrae, 2001; O'Brien, 1999). The first school of nursing, Nightingale School of Nursing at St. Thomas' Hospital in London, was established at a

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religiously affiliated institution (Griffin & Griffin, 1969).

In the early 1900s, nursing followed medicine into the scientific realm (Griffin & Griffin, 1969). Unfortunately, nursing's focus on the spiritual domain began to fade and the domains of physical, emotional, psychological, social, and vocational received more attention. Thus, nursing's association with faith communities began to dwindle, although it did not die.

In the more recent decades, a new specialized nursing practice known as parish nursing, has emerged. Parish nurses perform services within and for the faith community and its surrounding community. The parish nurse movement has become more formalized and gained significant momentum, spreading across the continental United States since the 1980s. Parish nursing has gained popularity predominately with Christian churches, and like Nightingale, nurses have viewed parish nursing practice as a way to minister to others and respond to their 'calling'. Among traditional nursing roles such as health promotion and advocacy, the parish nurse also serves as an integrator of health and faith within the faith community.

Parish nursing was recognized as a specialty nursing practice by the American Nurses Association in 1997 and

Standards of Parish Nursing Practice were developed in 1998 (American Nurses Association, 1998). The Standards of Parish Nursing Practice are consistent with the nursing process and include the collection of health data, analysis of the data to determine a nursing diagnosis, identification of expected health outcomes, development of a health promotion plan, implementation of planned interventions, and evaluation.

<div align="center">Purpose of the Project</div>

The purpose of this study is to document and describe the nursing practice process of volunteer parish nurses. Answers to the following questions were sought: How do volunteer parish nurses define spirituality? How do volunteer parish nurses assess the spiritual needs of their clients? Do volunteer parish nurses utilize a specific assessment tool? What spiritual interventions do volunteer parish nurses use when working with clients? How do volunteer nurses evaluate the benefit of spiritual nursing interventions? How do volunteer parish nurses document the nursing process when providing spiritual care?

It is expected this study will contribute to the existing general knowledge about parish nursing and help

refine the theoretical framework for spiritual care.
Specific study aims include identification of current
nursing practices of volunteer parish nurses in the Inland
Empire, and comparison of study findings to the spiritual
nursing practice process for parish nurses described in
the nursing literature.

Context of the Problem

Nursing has long defined health and well being in
holistic terms, describing the individual as
multidimensional. Nursing research is rich in the
physical, psychosocial, mental and emotional domains;
however nursing literature and research is sorely lacking
in the spiritual domain, which includes such concepts as
purpose and meaning in life, transcendence, connectedness,
values, and beliefs. Only a few nursing theorists have
included any mention of the spiritual domain in their
discussions and definitions of nursing and nursing
interventions. The spiritual dimension is included in
nursing theories developed by Watson, Newman, Henderson,
Travelbee, and Blattner (Miller, 1996).

Assumptions

This study assumes the nursing specialty of parish
nursing plays an important role in community health,

professional nursing practice, and the delivery of nursing care to faith communities and the surrounding community. It is anticipated the role of parish nursing will expand and increase in magnitude as the delivery of health care services provided by government and other sources continue to shrink, leaving more individuals without health insurance or under-insured. Lastly, it is assumed that exploration of the nature and spiritual nursing practice of volunteer parish nurses will benefit the parish nursing specialty practice by identifying, categorizing and refining spiritual nursing care processes.

Limitations

The primary limitation for this study is the small sample size. Data was collected from just seven volunteer parish nurses. Because of this small sample size, the results can not be generalized outside of the sample population.

Additional study limitations are present. Six of the seven study participants were of Catholic denomination, so study results may not be representative of other denominations or faith beliefs. Additionally, during the latter stages of data collection, one study participant was identified as not meeting the study criteria of the

minimal volunteer hours per month. Despite this criteria discrepancy, participant data was included in study analysis. The methods of data collection (survey and interview) relied solely on self report. Thus, the perspectives and perceptions of each study participant may have been affected as a result of personal bias, relationship with the researcher, or the emotional state of the participant at the time of survey or interview completion. Finally, the qualitative research approach can be limited (or enhanced) by the researcher's skills, training, insights and capabilities (Patton, 1990). This study is representative of beginning efforts for this novice researcher.

Definition of Terms

The following terms are defined as they apply to the
project.

'Called' or 'calling' - A perceived personal beckoning
from God or one's Higher Power. It is a sense that
one is being asked to be and do much more than one's
own desires, goals or perceived capabilities.

Faith Community - An organization composed of families and
individuals who share common values, beliefs,
religious doctrine and faith practices which

influence their lives. Examples of faith communities include a church, synagogue, or mosque. The faith community functions as the focus for parish nursing practice.

Healing - A process, within parish nursing practice, of integrating the body, mind and spirit to achieve wholeness, health and a sense of well-being, even when the curing of disease does not occur.

Health - The experience of personal integration. Terms frequently used within the faith community to describe health include: wholeness; salvation; shalom and harmony with self, others, the environment and God.

Health Minister - A lay person or ancillary health professional within a faith community who is committed to facilitate wellness activities to meet identified health needs of the faith and surrounding community.

Health Ministry - The promotion of health and healing as part of the mission and ministry of a faith community to its members and the community it serves.

Inland Empire - A term used to describe the geographical area of San Bernardino and Riverside counties in southern California.

Illness - The experience of brokenness within any human dimension. Within the context of parish nursing, illness is the disintegration of body, mind, and spirit connectedness which results in disharmony with self, others, God, and/or the environment.

Parish Nurse - A registered nurse who serves to identify wellness needs, coordinates efforts to meet those needs, and promotes health as wholeness within the faith community, including its individuals, families, and the community. The parish nurse utilizes the nursing process (assessment, planning, intervention, and evaluation) to perform her services. The nurse (preferably) serves as a member of the ministry staff of the faith community.

Prayer - The primary pathway to a relationship with one's God or Higher Power (Tan & Gregg, 1997). In most faith traditions, prayer is considered to be one of the most important vehicles of communication with God. There are many different forms of prayer, including but not limited to: praise, worship, confession, petition, intercession, listening, gazing, meditation, and waiting. Prayer can be performed at any place individually, within small

groups, or corporately at any time of the day or
night.

Prayer as a nursing intervention - A specific type of
intercessory prayer performed by the parish nurse on
behalf of the client. There is no specific formula
rather the prayer is based on client concerns
identified during the spiritual assessment. Usually
the prayer intervention is a short, simple statement
to God about the client's needs and the recognition
that God has the ability to meet those needs (Shelly,
2000). Typically, the parish nurse leads the prayer
out loud while the client silently prays.

Spirituality - The essence of what makes man different
from animals. The 'soul'. The inner most being of an
individual in relationship to and with God, self,
other humans, and the environment. The term includes
such concepts as the meaning and purpose of life,
transcendence, connectedness, love, caring, and hope.

Spiritual Care - A key component in the practice of parish
nursing (Solari-Twadell & McDermott, 1999). The
interventions of the parish nurse or health minister
which are specifically focused on the client's
spiritual status. Spiritual care can include, but is
not limited to: active listening, coping enhancement,

hope instillation, prayer, presence, reading of
scripture or a sacred text, touching, and emotional
support. As with many nursing interventions, the
skill and personhood of the nurse is important.
Personal traits of the nurse which facilitate
spiritual care include empathy, vulnerability,
compassion, humility, commitment and establishing
boundaries (Shelly, 2000).

Wellness - A dynamic and continuous process of moving
toward greater awareness of one's self and the
environment. This holistic process within the faith
community includes the spiritual, emotional,
intellectual, occupational, social, vocational,
environmental and physical dimensions.

Wholeness - The harmonious functioning and integration of
a person's body, mind, and spirit. Within the context
of parish nursing, the person utilizes health
education and self-care to maintain this balance.

CHAPTER TWO

REVIEW OF THE LITERATURE

Nursing literature was reviewed for information relevant to spirituality, nursing theory, spiritual care, and parish nursing. A discussion of eight literature reviews; 32 discussions, informational articles or publications; 14 research studies; and one dissertation are presented in this chapter.

Spirituality in Nursing

Seven nursing literature reviews, one discussion, and one nursing research study relevant to spirituality are presented. In a review of the literature, Mansen (1993) discusses the conceptual development of individual spirituality, describing spirituality as being closely associated with religion and the psychosocial dimensions, but different and unique. Discussing the methods of intuition, concept derivation, and qualitative analysis for examining spirituality, Mansen recommends qualitative analysis as being the best approach to identifying the individual descriptions of the spiritual dimension. Despite referencing 57 nursing articles and publications, Mansen was unable to provide any additional clarity to the vague definition of spirituality.

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Oldnall (1996) performed a critical analysis of international nursing literature, finding spirituality was defined from two perspectives in nursing literature, religious or humanistic. Oldnall identifies only two nursing theories which include a spiritual component: Jean Watson's Caring Theory and Betty Neuman's Neuman Systems Model. Oldnall concludes if nursing theorists do not address spirituality in nursing models, it is not unusual that clinical practitioners also do not address the spiritual domain of patients. Oldnall raised many difficult but important questions regarding the issues of spirituality within nursing care and education.

In their review of spirituality in nursing literature, Dyson, Cobb and Forman (1997) found that inclusion of the spiritual dimension was viewed as a fundamental part of providing holistic nursing care; however, inadequate definitions and conceptual frameworks were noted throughout the 57 referenced articles. Dyson et al. caution against the assumption that spirituality is synonymous with religion, and recommend that nurses be inclusive, using the art and intuition of nursing in addition to scientific paradigms. Themes identified in the literature and discussed by Dyson et al. included self, others, and 'God'; meaning; hope; relatedness and

connectedness; beliefs; and expressions of spirituality. Dyson et al. were able to provide a framework for further exploration of spirituality within nursing.

Narayanasamy (1998) also provided a review of spirituality in nursing literature, referencing 38 articles and publications. Narayanasamy, a British nursing scholar, concludes that when spirituality is discussed in nursing literature, it is typically within the context of a holistic approach or from the perspective of a Christian theological tradition. Using a broad perspective to operationally define spirituality, Narayanasamy states spirituality is the need for meaning and purpose, identification, or a sense of harmonious interconnectedness when an individual faces emotional stress, physical distress or death.

Golberg (1998), in a literature review which included 31 articles and publications, identifies spiritual phenomenon to include: meaning, presencing, empathy/compassion, giving hope, connection, and love. Golberg helps to broaden the nursing definition of spirituality.

McSherry and Draper (1998) discussed three nursing debates considered to be 'central' to understanding the concept of spirituality at that time. The debates are

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identified as the pursuit of conceptual and theoretical unity in spirituality, the demise of spirituality and the rise of secularism within nursing, and spirituality as a unifying force at the foundation of holistic philosophy. McSherry et al. conclude additional research is necessary to identify nurses' perceptions of spirituality and spiritual nursing care; and a more universal definition of spirituality is needed, which should include the uniqueness of all individuals irrespective of beliefs, values, or religious orientation. Still no solution or answer is provided for the debates surrounding spirituality.

O'Brien (1999) agrees the term of spirituality remains vague and undefined within the nursing profession. In her review of the nursing literature, identified themes of spirituality include elements of love; compassion; caring; transcendence; relationship with God; and the connection of mind, body, and spirit.

Spirituality continues to have a vague, elusive definition within nursing. Sellers (2001) states nurses lack a definitive body of theoretical knowledge to understand spirituality and to address spirituality in nursing practice, education, and research. In a qualitative study of six key informants and 12 general

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informants residing in the state of Iowa, Sellers

identified five 'universal' spiritual themes. The themes

included: 1) Spirituality is defined as a motivating force

that searches for meaning and purpose in life through

connectedness; 2) Spirituality is a dynamic, life-long

search process that arises from life and spiritual

experiences; 3) Spirituality is expressed and practiced

uniquely; 4) Environmental context influences

spirituality; and 5) Nurses can enhance spirituality by

understanding the unique human experience of each person

through the establishment of a caring human relationship.

A caring relationship is characterized by Sellers as

the art of being present, listening, respecting, and

giving of self. Sellers describes the informants'

perceptions of nurses' effectiveness in addressing

spirituality as 'most revealing' since "half of the key

informants questioned whether nurses were taught to avoid

developing relationships with clients" (Sellers, 2001

p. 247). Sellers' study emphasizes the continued struggle

within nursing to define spirituality and spiritual

nursing care.

Burkhart and Solari-Twadell (2001) reviewed nursing

literature for the purpose of differentiating spirituality

and religiousness. Referencing 45 articles and

publications, the researchers conclude that spirituality and religiousness are two separate nursing diagnoses although they share common elements. Current nursing diagnoses related to spirituality in North American Nursing Diagnosis Association (NANDA) include spiritual distress, risk for spiritual distress, and readiness for enhanced spiritual well-being. The researchers recommend the diagnoses remain unchanged for spirituality, although enhanced definitions are provided. New nursing diagnoses related to religiousness are suggested: altered religiousness, risk for unmet religious needs, and potential for enhanced religiousness. Burkhart and Solari-Twadell state nursing practice will benefit from having clarity of terms and concepts, since clarity will improve the nursing processes of assessment, diagnosis, intervention, and outcome. Despite their contribution, nursing continues to struggle with clarifying and defining spirituality.

Parish Nursing

Seven informational articles or discussions, two research studies, and a dissertation relevant to parish nursing are presented. Parish nursing, as it is known today, was founded in the early 1980s by Granger Westberg,

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a Lutheran pastor and chaplain (O'Brien, 1999;
Solari-Twadell & McDermott, 1999). Westberg originated the
institutionally based paid model of parish nursing: a
model in which the nurse is paid by a health care facility
to provide nursing and preventative services for the
congregation and surrounding community (Solari-Twadell &
McDermott, 1999). Three additional parish nursing models
have since emerged, which include the congregationally
based volunteer, congregationally based paid, and
institutionally based volunteer (Solari-Twadell &
McDermott, 1999; Carson & Koenig, 2002). As described by
the names, each model is dependent upon whether the nurse
is paid for his/her services or chooses to volunteer; and
where parish nursing education and support is received.

The literature is rich with information describing
the functional roles of a parish nurse. The functional
roles include: health educator; personal health counselor
and consultant; volunteer trainer and coordinator;
facilitator; advocate; health resource and referral;
visitation at the home, hospital, or skilled care
facility; and integrator of faith and health (Djupe,
Olson, Ryan & Lantz, 1991; Ahrens & Goodnight, 1994;
Solari-Twadell & McDermott, 1999; O'Brien, 1999, Buijs &
Olson, 2001). The parish nurse does not duplicate services

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that are already available within the church or community, but seeks to 'fill in the gaps'. The nurse works in concert with the public health nurse and community health resources (Bay, 1997; Cassidy, 2001). No direct "hands-on" service is provided.

For her dissertation, Miller (1996) developed a nursing conceptual model grounded in Christian faith. Miller's work is self-described as a beginning effort to lay a broad foundation for an intentionally highly abstract theoretical model. Miller outlines nursing theories which include a spiritual component. Miller's list of nursing theorists include: Jean Watson, Betty Newman, Virginia Henderson, Joyce Travelbee, Sister Callista Roy, and Barbara Blattner. A review of important contributions from multiple Christian nurses is additionally provided by Miller which includes Florence Nightingale, Evelyn Adam, Ruth Stoll, Sharon Fish, Judith Shelly, and Arlene Miller. Miller defines parish nursing as a health promotion and preventative ministry which is based in Christian churches, where faith and health are clearly linked and spiritual care is essential. Four concepts identified by Miller as central to parish nursing include: love, gracious compassion, co-participation, and spiritual care. Miller identifies the continued need for

development of conceptual models and theory in order to provide common language and clearer thinking among all nurses. Miller recommends more attention be directed to developing nursing knowledge and skills related to the spiritual dimension.

Tuck and Wallace (2000) performed a descriptive, exploratory study regarding parish nursing in a southeastern U.S. city. The purpose of the study was to describe a parish nursing program from an ethnographic perspective. Data for the study was gathered from a variety of sources including site visits, document analysis, and structured interviews with key informants such as administrators, parish nurses, spiritual leaders, and clients. The researchers discovered that parish nursing was described according to the worldview of the interviewee. They conclude that parish nursing is an established method for health care delivery that is well received by the community and viewed as an alternative approach to community nursing. This article identifies parish nurse content categories, taxonomies of nursing attributes and parish nurse actions, and cultural themes. It is one of the first 'research' oriented articles regarding parish nursing.

Swinney, Anson-Wonkka, Maki, and Corneau (2001) performed a survey and focus group interviews within a large urban parish in central Massachusetts. The aims of the study included determination of the health status of the congregational members, identification of their perceived health needs, and to assist the newly employed parish nurse to develop a health program for their parish. Following the analysis of 421 questionnaires and six focus groups, results show 91% of the congregational members believed faith and spiritual beliefs were important in maintaining health and well-being and 70% think the church should play a role in helping members meet their health needs. Although the study findings can not be generalized to the overall faith community population, this study identifies and documents the use of the nursing process in parish nurse practice and links parish nursing assessment with community assessment.

Wallace, Tuck, Boland and Witucki (2002) re-examined the data from their 2000 article. Following their analysis, the following five themes in parish nursing are identified: being available, integrating spirituality and health, helping us to help ourselves, exploring parish nursing, and evaluating parish nursing. Further

exploration of the effectiveness of parish nursing as
nursing delivery model is recommended.

Spiritual Care

Spiritual Care in Nursing Practice

One literature review; 20 articles, discussions, or
publications; and 11 research studies relevant to
spiritual care in nursing practice are presented. In a
piece labeled an 'original article', Lane (1987) provides
a model for examining spiritual nursing care. The model
includes works or characteristics of the human spirit
identified to include transcending, connecting or
belonging, giving life, and being free. Activities of the
human spirit are described as inward turning,
surrendering, committing and struggling. Lane discusses
the nurse's role in caring for the spirit, emphasizing the
importance of the nurse first being in touch with her own
wounded self through inward turning or reflection, thus
resulting in a new vulnerability to the patient or client.
Lane emphasizes the need for the nurse to have a sense of
transcendence and compassion. Although theoretical in
nature, this article remains meaningful to nursing as it
helps provide a foundation from which to begin discussions
about spiritual nursing care and how to provide it.

Although not as theoretical as Lane, Soeken and Carson (1987) provide information and discussion about responding to the spiritual needs of the chronically ill. Soeken et al. describe spiritual care as occurring over time and within the context of the relationship between patient and nurse. Use of self is identified as the most effective tool in providing spiritual care.

Piles (1990) performed a survey to discover if, and to what extent, spiritual care was being provided to patients demonstrating spiritual needs. A Likert-scale questionnaire was mailed to 300 nurses across the continental United States. Following analysis of 176 completed surveys, Piles identifies five hypotheses which are statistically significant. The hypotheses include: 1) The level of practice of spiritual care is positively related to the nurse's perceived ability to provide spiritual care, 2) The level of practice of spiritual care is positively related to the degree of educational exposure in the nurse's basic nursing program, 3) The level of practice is positively related to the degree of importance the nurse places on the value of spiritual care, 4) The level of practice is positively related to the degree of obstacles the nurse perceives in providing spiritual care, and 5) the variables: ability, education,

opinion (values), and obstacles can be used to predict the extent of spiritual care being provided by nurses in the practice setting. This article clearly points to the need to provide additional education to nurses regarding spiritual care. It additionally serves as a partial explanation for the lack of consistent spiritual care giving within the nursing profession.

Highfield (1992) performed a descriptive cross-sectional survey among oncology patients and nurses using the Spiritual Health Inventory (SHI) developed by the author. The purpose of Highfield's study was to investigate the spiritual health of oncology patients and how well oncology nurses assess spiritual health. The SHI and demographic informational sheet was distributed to 40 lung cancer patient/oncology nurse pairs whom were hospitalized/employed at two religiously-affiliated medical centers in the southwest United States. Twenty-three patients and 27 registered nurses responded to the survey. In her analysis, Highfield identifies incongruence between paired patients and nurses, suggesting that nurses do not accurately assess the spiritual needs of their patients. The study does not identify the spiritual assessment tools used by the oncology nurses however, it does place continued emphasis

on the need for spiritual care nursing implementation and education.

Kerrigan and Harkulich (1993) provide an informational article which describes an Ohio nursing home staff's project to develop a spiritual assessment tool. Over the course of several meetings, a checklist was adapted from Stoll's spiritual assessment guide. In addition to the spiritual assessment checklist, a religious-spiritual intervention checklist is provided, thus giving nurses some concrete spiritual tools.

In an informational article by Schoenbeck (1994), the Ingleside Spiritual Assessment tool is introduced. Adapted by the author from a tool used at a nursing home and community-based retirement facility, the questionnaire provides a logical flow of questions for spiritual assessment. Yet another tool is provided for modern nurses to address the spiritual needs of their patients.

Millison (1995) performed a literature review regarding spiritual care and hospice. Referencing 64 articles and publications, Millison concludes there is no lack of information about spiritual care in the literature. Rather, the need for continued discussion and research is recommended. Millison's article serves as a good resource, listing spiritual assessment tools in the

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literature: the Spiritual Well Being Scale; the Purpose in Life Test; Fitchett's Model for Spiritual Assessment; Kuhn's Spiritual Inventory; and the Loneliness, Spiritual Well Being, and Quality of Life Scales.

Narayanasamy (1996) discusses spiritual care for oncology patients in an informational article. Linking the crisis of end of life with spiritual needs, Narayanasamy emphasizes the importance of oncology nurses to be highly skilled in self awareness, communication skills, giving hope, and being a catalyst for the patient's spiritual growth. A problem-solving approach is presented, using the nursing process. The only tool provided in the article is Stoll's spiritual assessment guide, which is recommended for nursing assessment.

Twibell, Wieseke, Marine, and Schoger (1996) performed a survey among 245 registered nurses who were members of the American Association of Critical Care Nurses. The purpose of the study was to validate the defining characteristics of the nursing diagnoses Spiritual Distress and Ineffective Individual Coping. Using the Nursing Diagnoses Validation Instrument-Spiritual and Coping Scales, the researchers identified major characteristics for each of the nursing diagnoses. Seven major characteristics identified for Spiritual

Distress include: spiritual emptiness, disturbance in beliefs, no reason for living, request for spiritual assistance, concern over the meaning of life, questioning of personal beliefs, doubting personal beliefs, inability to practice religious rituals, and detachment from self and others. Eight major characteristics are identified for the nursing diagnosis of ineffective individual coping. Twibell et al. suggest that by defining the characteristics of spiritual nursing diagnoses and assessment tools, nurses can increase their recognition of spiritual and coping needs.

Ross (1997) performed a pilot study to determine elderly patients' perceptions of their spiritual needs and care. A semi-structured interview was completed with 10 Scottish patients hospitalized for at least three months in an elderly assessment ward in a general hospital. The interview consisted of four sections: demographic information, exploration of the patients' thoughts on spiritual matters and their experiences of spiritual needs, the patients' experiences of specific spiritual needs identified in the literature, and identification of factors influencing spiritual care. Ross found that more than half of the patients experienced spiritual needs during their hospitalization, with the most prominent need

being the search for meaning and/or making sense of life's events. In this study, none of the patients received spiritual care or help from the nurses. Although this study sample was small, it highlights an important area for consideration- the patient's perception of spiritual needs and care. Ross recommends additional studies to compare nurses' and patients' perceptions of patient spiritual needs and care for the purpose of obtaining a deeper understanding of spiritual care.

In a discussion regarding the spiritual needs of caregivers, Carson (1997) notes that spiritual care is intimately linked with the desire to understand the meaning and purpose of life, to make sense of pain and suffering, to believe there is a reason for everything, and to feel connected to God. Through several individual stories and examples, Carson identifies spiritual care provision to include the loving and concrete action of others, presence and ability to listen, the willingness of others to share in a difficult life journey, and faithfulness to pray.

Wright (1998) expresses her belief that spiritual nursing care is a professional, ethical, and legal obligation. Since nursing has been traditionally viewed as embracing a holistic approach to practice, Wright believes

spiritual care should be embraced by nurses. According to Wright, providing spiritual care includes assisting patients to find meaning, hope, and clarification of their spiritual beliefs and values. Wright contends that provision of spiritual care will satisfy ethical issues associated with beneficence, nonmaleficence, autonomy, and advocacy. Wright identifies nursing's professional obligation to provide spiritual care as a nursing intervention.

Numerous informational articles or case studies are present in nursing literature describing spiritual care interventions (Beakman, 1981; Buckwalter, 1999; Dossey, 1998; Emblen & Peverall, 2002; Forbis, 1988; Fox, 1979; Highfield, 2000; Peterson, 1985; Praill, 1995; Simsen, 1988; Widerquist, 1991). Weber and Carrigg (1991) list examples of spiritual interventions to include: facilitation of honest expression of spiritual concerns by providing feedback and allowing expression of anger; showing interest in spiritual needs; respecting spiritual beliefs or absence of spiritual beliefs; focusing on belief in God to gain strength, wisdom, and healing; offering to contact a spiritual helper (i.e.: chaplain or pastor); promoting the involvement of family or significant other in spiritual support; providing support

for a religious environment; praying; assisting with acceptance of lack of control; and encouraging spiritually meaningful activities to enhance spiritual well being. This article, and many others, stimulates continued attention and discussion about spirituality in nursing.

A descriptive study was completed by Boutwell and Bozett (1990) to identify the extent to which nurses assess patient spiritual needs. A 76 item survey was developed by the researchers and distributed to a random sample of 817 nurses licensed in the state of Oklahoma. Analysis of the findings from 238 surveys meeting study criteria indicate nurses in Oklahoma assess their patients' spiritual needs from a moderate to a considerable extent, a finding which differs from other studies in the literature. The determining factors which identify if a spiritual assessment is most likely to be completed include patient acuity and setting. Boutwell and Bozett found the more acutely ill the patient, the less likely the nurse is to carry out a spiritual assessment, and nurses in settings where matters of acute physiology is less immediate are more likely to attend to concerns of the spirit. The most frequently reported items used for spiritual assessment include talking with the patient about medical procedures, source of strength, and feelings

of hope; and religious practices related to death and surgery. Another interesting finding of this study includes the identification of psychiatric nurses and nurses ages 50-59 as being the most likely to perform spiritual assessments.

A descriptive study of spiritual caring behaviors was performed by Hall and Lanig (1991). A questionnaire was developed by the researchers and completed by nurses attending the Network of Christian Nurses conference in Minnesota. Of 515 conference participants, 303 questionnaires were returned. Over half of the study participants practiced in a hospital setting, and more than half of the participants reported regular provision of spiritual care. Self reported spiritual care behaviors include talking about spiritual matters; offering to pray; and offering to read, share, or study scripture. The researchers additionally identify a statistically significant positive correlation between the years of having Christian beliefs and the corresponding degree of comfort in providing spiritual care.

Another descriptive study was completed by Taylor, Highfield, and Amenta (1994) involving cancer nurses. The aim of the study was to assess cancer nurses' definition of spiritual nursing care, their attitudes and beliefs

regarding spiritual nursing care, and demographic factors associated with those attitudes and beliefs. When defining spiritual care, the nurses' responses fell into the following categories identified by the authors: promoting well-being with holistic caring; respecting and supporting patient beliefs; providing emotional care to the suffering; promoting or offering transcendent qualities; sharing self; facilitating relationships with a Higher Power, family, or others; specific activities that met religious needs; and verbal interactions. Significant findings identified by the authors included those nurses which perceived themselves as very spiritual, attended religious services frequently, or were clinical specialists held more positive attitudes toward spiritual care than their counterparts. This article contributes additional knowledge to the growing foundation of spiritual nursing care.

Utilization of spiritual assessment strategies along the continuum of spiritual events associated with the diagnosis of cancer is discussed by Highfield (1997). Highfield recommends the use of the 'P-L-A-N' model, which assesses spirituality at increasingly complex levels. In addition to contributing an assessment tool, Highfield discusses the importance of the nurse finding the time,

the means, and the knowledge to incorporate spiritual assessment into nursing care.

Babler (1997) performed a study to investigate the spiritual care provided to hospice patients and families by various professional members of the National Hospice Organization. An adapted questionnaire was completed by 188 registered nurses, 58 social workers, and 50 spiritual care providers. Babler concludes that many nurses feel uncomfortable providing spiritual care and are less likely to render spiritual care than spiritual care providers. Babler additionally notes there is no consensual definition of spiritual care in hospice, no agreed upon standards regarding the provision of spiritual care, and little research done on the subject.

In an informational article, Clark (1997) uses the nursing process to discuss the provision of spiritual care to orthopedic patients. A wellness checklist is introduced to identify spiritual needs, vignettes are given for the diagnosis of spiritual distress, examples of spiritual nursing care plans are provided, and evaluation is discussed. Clark challenges orthopedic nurses to take responsibility in meeting the spiritual needs of their hospitalized patients and provides some clear concrete examples of how to so.

Taylor, Highfield and Amenta (1999) performed a descriptive, comparative study involving two groups of nurses. The purpose of the study was to describe the spiritual care perspectives and practices of oncology and hospice nurses. A research tool, the Spiritual Care Perspective Survey, was developed by the researchers and distributed to 1860 nurses in the United States. Results from 819 surveys were analyzed and the researchers conclude that an oncology or hospice nurse's personal spirituality best predicts their spiritual perspective on spiritual care and their perceived ability to provide spiritual care. This study made two important contributions to the study of spirituality. First, a reliable and valid instrument was developed to measure spiritual perspectives. Secondly, the study confirms the importance of recognizing one's own spirituality before addressing the spiritual needs of another, a concept emphasized by chaplains and pastors.

Stranahan (2001) performed a cross-sectional survey to investigate the attitudes and beliefs of nurse practitioners toward the role of providing spiritual care to patients in the primary care setting and to describe the extent to which spiritual care is practiced by them. The Spiritual Perspective Scale (SPS), Oncology Nurse

Spiritual Perspective Scale (ONSPS) and demographic

information sheet were mailed to 269 nurse practitioners

licensed in the state of Indiana. Following data analysis

from 102 completed surveys, Stranahan found that 57% of

the respondents rarely or never provided spiritual care,

and the most frequently practiced spiritual care

interventions utilized by study participants included

praying privately for a patient and referring a patient to

clergy or religious leaders. The article concludes with

recommendations for more intensive spiritual care

education for nurse practitioners, the need to identify

the reasons nurse practitioners do not practice spiritual

care, and the need for additional clarification of

conceptual definitions of spiritual care and religious

needs.

Narayanasamy and Owens (2001) performed a critical

incident study to describe what nurses consider spiritual

needs are, explore how nurses respond to the spiritual

needs of their patients, typify nurses' involvement in

spiritual dimensions of care, and describe the effect of

nurse's interventions related to spiritual care. Critical

incident surveys were distributed to 130 nurses attending

a modular course at the university where the study took

place. The following shared themes are identified and

discussed from the 115 surveys obtained: 1) Nurses

typically become aware of spiritual needs by

identification of the patient's religious background, a

spiritually/religiously loaded conversation, or a

diagnosis which prompts a response; 2) The nature of

patients' reported concerns or needs are either religious

or spiritual; 3) The nurse's actions can be categorized

into four types of approaches: personal, procedural,

cultural, or evangelical; and 4) The outcome of a nurse's

intervention have effects on the patient, family, and/or

the nurse. As the study of spiritual care continues, this

article, and others, has contributed a framework to reduce

confusion and promote organization of future findings.

Spiritual Care in Parish Nursing Practice

One research study and a discussion regarding

spiritual care in parish nursing practice are presented.

Throughout the parish nursing literature reviewed for this

study, parish nurse roles or functions include integrator

of faith and health (Ahrens & Goodnight, 1994; Buijs &

Olson, 2001; Djupe, Olson, Ryan & Lantz, 1991; O'Brien,

1999; Solari-Twadell & McDermott, 1999). As an integrator

of faith and health, spiritual assessment and provision of

spiritual care is assumed. Nursing literature is rich with

informational and case studies regarding spiritual care in parish nursing; however formal research is lacking.

Spirituality and provision of spiritual care by parish nurses was studied by Tuck, Wallace, and Pullen (2001). This study includes both quantitative and qualitative approaches. The researchers used three instruments: the Spiritual Perspective Scale (SPS) and the Spiritual Well-Being Scale (SWBS) to measure spiritual perspectives, and an open-ended interrogative survey to inquire regarding spiritual care interventions. The most frequently reported interventions by the parish nurses include praying and listening. The researchers divide the reported parish nursing interventions into four categories: 1) religious, which includes praying, offering communion or spiritual service, anointing; 2) interactional, which includes caring, being with, accepting, touching; 3) relational, which includes listening, visiting, singing, reading; and 4) professional, which includes referring, teaching, mediating, providing healing touch. Tuck et al. provide a good beginning for research of parish nurse practice.

Summary

The definition of spirituality and spiritual care has been elusive for the nursing profession. Multiple articles, publications, and literature reviews have been published over the recent decade in an attempt to clarify spirituality in nursing (Dyson, Cobb & Forman, 1997; Halstead & Mickley, 1997; Mansen, 1993; McSherry & Draper, 1998; Narayamasamy, 1998; Oldnall, 1996; O'Neill, 1998). Unfortunately, the definition of spirituality for nursing remains vague, with many suggested definitions. Perhaps the definition and practice of spiritual care has been slow to come forth because of the personal work required and the preference to avoid the issue. Spiritual care begins with the conscious effort of the nurse to cultivate his/her own spiritual journey, to struggle with his/her own eventual death, and to learn how to tell his/her own story (Praill, 1995).

Despite the unclear definition of spirituality, the profession of nursing has attempted to address the practice of spiritual nursing care. Nursing diagnoses related to the provision of spiritual care have been accepted by the profession (Twibell, Wieseke, Marine & Schoger, 1996; Burkhart & Solari-Twadell, 2001). However, the diagnoses continue to be refined. In nursing

literature, spiritual care has been more specifically discussed and researched in the nursing specialties of oncology, hospice, and gerontology.

The new nursing specialty practice of parish nursing, which integrates faith and health, has evolved during this decade. Literature relevant to parish nursing has emerged gradually, although very little research has been published. Given the infancy of this new specialty practice, it is expected more information and research will be forthcoming.

CHAPTER THREE

METHODOLOGY

There is limited research regarding the spiritual
care interventions of parish nurses. For that reason, a
qualitative approach with open ended questions was chosen.
The qualitative design is conducive to studying a specific
issue or situation in depth in order to produce a wealth
of detailed information (Patton, 1990). This qualitative
methodology was undertaken to understand and explain the
phenomenon of spiritual nursing care practices of
volunteer parish nurses.

Protection of Human Subjects

Prior to study implementation, approval to access
Redlands Community Hospital (RCH) Parish Nurse Health
Ministry Program records was secured from the Director of
the Pastoral Care Department (see Appendix A). Before any
contact with the parish nurses was initiated, approval was
sought and obtained from the Institutional Review Board of
California State University, San Bernardino (see Appendix
B).

Sampling

This study focused on individuals in the setting of volunteer parish nurse practice. Study participants were selected purposefully and comprised a convenience sample. Specific volunteer parish nurses were chosen by the researcher from a list of participants in the RCH Health Ministry Parish Nurse Program. Selection criteria for this study included the parish nurse's participation in the program at RCH and his/her current capacity as a parish nurse, volunteering no less than eight hours per week or 24 hours per month. Participation in the program at RCH was defined as submitting quarterly statistical reports of activity to the RCH program coordinator and attendance/participation at monthly networking meetings at least twice yearly.

Data Collection and Instruments

A survey was developed with demographic information and structured questions which followed the flow of the nursing process (see Appendix C). Requested demographic information consisted of age, ethnicity, gender, current faith denomination, total years as a registered nurse, type of parish nurse training (if any), total years as a volunteer parish nurse, average number of hours per week

spent volunteering as a parish nurse, average number of total hours spent in prayer per week, and an open ended question receipt of any training regarding prayer. Survey and interview questions consisted of the participant's definition of spirituality, spiritual assessment, use of spiritual assessment tools, spiritual intervention, evaluation of spiritual interventions, and documentation.

The use of a written questionnaire, followed by a personal interview strengthened reliability. Review of the questionnaire by two doctoral prepared nurses and one doctoral prepared theologian supported content validity.

Procedures

Data was collected by the researcher over a four week period in February and March 2003. Potential study participants were contacted by telephone, informed of the study, and asked to participate. If the parish nurse agreed to participate in the study, the informed consent was read and the qualifying minimum 24 volunteer hours per month quota was confirmed. The data gathering process was explained and an interview date scheduled. The nurse was advised a survey would be mailed to them for completion prior to the interview appointment. In most cases, the

interview was scheduled within seven to 10 days of the telephone contact.

Following the initial telephone call, a copy of the informed consent and survey were immediately mailed to the participants. No further contact was made with the participant until the scheduled interview.

On the day of the interview, the researcher and study participant met to review the survey previously completed by the participant. The researcher obtained the completed survey and informed consent forms from the participant. Blank copies of the same were given to the participant, if desired. Each question and written answer was verbally read by the researcher to the participant. The survey questions were completed in chronological order, always exhausting any discussion on each question before moving to the next.

Additional notes were taken during the discussion. Note taking was done on the same survey completed by the participant. Most interviews lasted approximately 60 to 90 minutes. Individual thank-you notes were written to each participant following the interview.

Data Analysis

Data analysis utilized methodology of grounded theory (Munhall & Boyd, 1993). The aim of constant comparative method for this study was to generate beginning theoretical constructs, categories, and patterns which would describe the spiritual nursing processes and interventions used by the study participants. The process included coding of the data, identification of the processes, and conceptualization of underlying patterns. Through inquiry and identification of current nursing practices of volunteer parish nurses in the Inland Empire, and comparison of study findings to the nursing practice process for parish nurses described in the nursing literature; categories and patterns were identified. During and after data collection, answers obtained in the interview were compared between all participants. Incidents were compared to incidents, incidents were compared to categories, categories were compared to other categories and constructs to distinguish similarities and differences between the parish nursing practices of the participants. By comparing similarities and differences the basic properties of a category or a construct were examined.

Summary

A qualitative design was undertaken in this study to obtain detailed information regarding the spiritual nursing care interventions of volunteer parish nurses. A total of seven volunteer parish nurses, six of who met study criteria, participated. Each parish nurse completed a written questionnaire and participated in an interview with the researcher. The survey and interview data was analyzed by the grounded research qualitative method of constant comparison.

CHAPTER FOUR

RESULTS AND DISCUSSION

Presentation of the Findings

A total of seven parish nurses were interviewed for
the study. All were registered nurses and female. (See
table 1). Six nurses were Caucasian and one Mexican
American. Six of the nurses were Catholic, two of which
are members of a religious order. One nurse self reported
as a non-denominational Christian.

All study participants had completed the health
ministry preparation class at Redlands Community Hospital,
and three had taken additional formal parish nurse
training. All seven nurses reported some type of training
regarding prayer.

Table 1. Demographic Characteristics of Study Participants
(n = 7)

Demographic characteristics	Min	Max	$\underline{M}$	$\underline{SD}$
Age (yrs)	48	75	60.7	8.9
Licensed as a registered nurse (total yrs)	14	48	32.2	10.8
Active as a volunteer parish nurse total yrs)	1.5	13	6.5	4.7
Average volunteer time (hrs/wk)	3	37	14.4	11.3
Average time spent in prayer (hrs/wk)	5	14	8.3	2.9

Discussion of the Findings

Defining Spirituality

Spirituality was defined by the study participants in a variety of terms. All the nurses agreed that spirituality included a belief in and a relationship with God. "Meeting God in my daily life. Opening myself to be an instrument of the Holy Spirit"; "It can be a relationship with God that is deep within a person"; "The belief a person has that there is a God"; "Awareness that each person has a spirit and a need to connect with and worship God." Two participants provided a written definition which went beyond a personal view and included the community, "One's relationship with God and the church"; "Spirituality encompasses our relationship with God, each other, and the entire earth. There's an inherent mystery in life and our spirituality enables us to put our trust in a loving God who gives us hope and shows us how to transcend earthly concerns and look beyond to an afterlife."

During the interview process, most participants expressed difficulty in providing a definition for spirituality since "it means different things to different people" and "is very personal." Three study participants continued to describe spirituality in terms of a personal

relationship with God during the follow up interview however, two participants verbalized a broader definition which included relationship with each other and the church.

Assessing Spirituality

All study participants documented the importance of listening when assessing spiritual needs. "Listening is the key in how they share their needs," "just being present and listening" and "I carefully listen to their concerns and try to get a sense of who God is to them and how they believe God affects their life." Two participants documented the need to observe nonverbal cues, "I assess spiritual needs by the mood and attitude my client demonstrates to me"; "I listen to the tone of voice in the person I talk to. The body language…looking at the face and the expression of the eyes"; "the way they look or appear, the words that they use" and "I observe and listen to the justifications given for certain choices that have affected the person's life." One participant described assessing as she intervened, "By talking with them and praying with them."

During the interview, most study participants were eager to provide clarification of their documented answers and required no leading questions. One participant

described spiritual assessment as "an undercover assessment" since she gathered spiritual information as she assessed her client's other needs, "usually I am determining their physical, emotional or social needs while I am determining how much or what type of spiritual support they need." Two participants described a background in home health nursing, expressing feelings of comfort when performing home spiritual assessments.

Only one study participant documented using a specific spiritual assessment tool. The tool was used "25% of the time," and had been obtained as a handout in a parish nurse class. The participant was unable to recall the name of the tool, but documented the assessment questions to "focus on 1) Concepts of God, 2) Sources of Strength and Hope, 3) Meaning of Life and Illness, 4) Support Systems and 5) Any grief or loss." During her interview, the participant stated "I use the tool periodically since I was forced to use it in class and feel comfortable with it now." The same participant also documented "Christian Caregiving by Kenneth Haugk" as an important tool. In response to the survey question inquiring about the use of a specific assessment tool, another participant wrote "I generally interview in an informal way and try to be tuned in to where the person

seems to be spiritually or emotionally at the particular time. I take the approach of the 'supernatural builds on nature' and I try to bond with someone before getting into deeper spiritual or more intimate issues." Another participant documented her intent to "Assess the Body-Mind-Spirit Disconnect."

During the interview, most study participants expressed a reluctance to utilize a specific assessment tool. Some participants appeared defensive and attempted to justify the lack of using a tool: "I assess primarily by intuition, I don't want to be pushy" and "No, I do not use a form because it would scare them and they would feel threatened." One participant expressed an openness to using a formal tool in certain situations "I would consider a form only if the client was comfortable with it." One participant described her spiritual assessment process as "I look at whether they are personalizing events and ask myself if they are spiritually integrated or compartmentalized." When asked during the interview, most study participants were able to provide specific leading questions they used when assessing the spiritual domain. Questions included: "Are you a member of this church?"; "Is the church a source of support?"; "Is there anything troubling you? Would you like to talk about it?";

"What is your primary difficulty? What brings you here?"
and "I ask them if they would like to receive communion in
the home, if they would like to see a priest, and if we
can pray together."

Spiritual Interventions

The only specific spiritual intervention documented
by every study participant was prayer. During the
interview process, it was discovered that only two study
participants prayed with their clients 100% of the time.
The remaining participants provided a wide variety of time
spent praying with their clients: 90%, 70-80%, 50%, 40%,
and 10% of the time.

The use of religious rituals as an intervention was
documented by five study participants. Religious ritual
interventions included: scripture reading, reading of
denominational devotional materials, communion, offering
of the sacraments, anointing and Bible study. Additional
interventions listed were: presence; use of self such as
keeping the client in prayer, being compassionate and
nonjudgmental; listening; touching; healing touch; sharing
of one's own spirituality; the recommendation of books,
tapes, or spiritual direction; relaxation and/or
visualization; and centering prayer.

Using open ended questions during the interview, most participants agreed that only a partial list of spiritual nursing interventions had been provided on their survey. Those who had documented only brief or limited answers did verbally expand their list of spiritual interventions during discussion, including many of the interventions listed above.

Two study participants documented the importance of self reflection/preparation before meeting with clients. "I spend time in prayer and reflection of scripture in preparation for my visits" and "I am practicing centering myself before meeting with someone or a group."

Evaluation of Spiritual Nursing Interventions

None of the study participants listed a formal process or tool when evaluating the benefit of spiritual nursing interventions. Two study participants misinterpreted the survey question to be asking their personal opinion/evaluation of spiritual nursing interventions, rather than as a nursing process evaluation. Some participants described the process of evaluation by documenting activities such as follow up phone calls and visitation. Several participants described evaluation in terms of client response. Examples of client response included: "find out how they are feeling";

"physical improvement such as reduced pain or pain relief,
increased emotional strength to deal with problems and
less reliance on me"; "by the emotional reactions
(positive) of the client and their eagerness to speak of
God"; and "expressed new knowledge, active participation
during the intervention time, a decrease in negative
energy such as hopelessness, and an ability to express
hope and love." One participant documented the use of her
intuition: "Their smile, touch, handshake is a physical
sign of appreciation. It could be a twinkle in their eye
or a hug. Their expressions show me that they are at peace
with God. I listen to their joys and needs."

During the interviews, most of the study participants
just acknowledged the information they had provided on the
evaluation portion of the survey and did not provide any
further input or clarification. One participant stated
evaluation was "difficult to assess my interventions if
the client is not spiritual." Two participants reported
performing evaluation after several contacts with a client
instead of after each visit.

Documentation

Two of the study participants indicated they do not
maintain documentation for spiritual interventions, "So
far I haven't but the question makes me aware I should"

and "This is where I am at a loss. The experiences I have not documented, but the numbers of visits, the amount of time spent are included with our statistics." The remaining five study participants described various documentation systems, "I chart spiritual care just as I do physical care, and keep records," "just next to the person's name- spiritual intervention, time spent- outcome," "I state the emotional attitude or condition of the client on my first assessment and document the words I have used in trying to elevate their mood," and "I generally use my encounter sheet to document a few words that indicate to me pertinent issues or needs that I need to be conscious of. This helps me in the process of counseling or visiting a person or following through the next time I see them. This also helps me set some goals and evaluate how things are going." Most participants utilized a narrative type of entry, keeping individual files for each client. Four participants maintained their client files in a secure area at the church and three participants maintained files in their home office.

·Summary

The data collected from seven volunteer parish nurses
was presented. Data was obtained from a completed survey
and a personal interview with each study participant.

Each participant provided their definition of
spirituality, and described their spiritual nursing
process practices. Common themes identified from this
sample group included spirituality, defined as a personal
relationship with God; listening, used consistently when
performing spiritual assessment; formal written tools,
used rarely to assess the spiritual domain; prayer,
consistently used as a nursing intervention; religious
rituals, frequently used as a nursing intervention;
evaluation of nursing interventions, frequently completed
by assessing client response; and no common method of
documenting spiritual nursing practices.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

The purpose of this study was to investigate spiritual nursing care practices of volunteer parish nurses. The culminating activities of qualitative studies are the analysis, interpretation, and presentation of findings (Patton, 1990). This chapter represents the 'essence' of the collected data.

Conclusions

The definitions of spirituality provided by study participants were reflective of the various definitions of spirituality found in current nursing literature. Most study participants expressed difficulty in providing a definition for spirituality since "it means different things to different people" and "is very personal," a similar conceptualization in nursing literature. Multiple articles and publications in nursing literature reflect the vague and broad concepts of spirituality within nursing practice.

As a professional practice, parish nursing is in its infancy. This especially holds true when identifying the spiritual nursing care practices of the volunteer parish nurses participating in this study. The study participants

do not formally utilize the nursing process when providing spiritual care. Despite the availability of reliable and valid spiritual assessment tools in nursing literature, tools are being used rarely by the study participants. Only one of the seven study participants used an assessment tool, even so just "25% of the time." Two study participants expressed a reluctance to use a formal spiritual assessment tool. Additionally, the assessment process reported by the majority of study participants is best captured by one participant's statement of "an undercover assessment," an informal spiritual assessment completed during the formal assessment of another domain or issue.

Unlike assessment, each study participant documented the use of at least two spiritual interventions and verbally described at least three additional interventions during the interview when discussing the spiritual interventions used while working with a client. All study participants did not take credit for providing many spiritual interventions until their examples or stories of parish nursing care were given and then discussed with the researcher.

The findings of this study support the findings of Tuck, Wallace, and Pullen (2001) in which the most

frequently reported interventions of parish nurses are praying and listening. Like Tuck et al., prayer was consistently reported as the primary intervention of study participants. Most of the spiritual nursing care interventions identified in this study, including reading, communion, offering of the sacraments, anointing, Bible study, presence, being, listening, touching, using healing touch, sharing, and offering information, were listed in the intervention categories presented by Tuck et al. Spiritual care interventions identified in this study, but not listed by Tuck et al. included: offering compassion, establishing a nonjudgmental environment, relaxation, and visualization techniques.

Evaluation and documentation of spiritual care nursing interventions by study participants is sorely lacking. None of the study participants use an evaluation tool, and one participant described the evaluation process to be based upon "intuition." Several participants described evaluation in terms of vague client responses. Documentation of spiritual nursing interventions is completed by five of the study participants, however there is no consistent pattern of what is documented and how. Nursing records are reported to be securely stored in either the study participant's home or office at the

church. A review of research in parish nursing and spiritual care provides very little information regarding evaluation and documentation of spiritual interventions. Results of this study are reflective of this identified lack of knowledge in nursing literature.

Recommendations

If nursing is to maintain its claim to a holistic approach to health care, spirituality must be included. Adaptation of a universal definition for spirituality is imperative. As suggested by many nursing scholars, definition of the term must be broad and inclusive (Narayanasamy, 1998; O'Brien, 1999; Sellers, 2001). Rather than getting stuck on rhetorical terms, it would be wise to capture the essence or intent of spirituality. Clues to an appropriate nursing definition for spirituality might be found in other disciplines such as theology or pastoral care, which have long addressed the struggle of defining and intervening in the spiritual realm.

Second to defining spirituality, spiritual interventions are the most widely discussed topic in nursing literature relevant to spiritual nursing care. Study findings reflect this availability of information, as participants were able to provide the most direct and

informative responses to the survey question: what spiritual interventions do you use when working with a client(s)? Additional research regarding spiritual interventions, in general or specifically, would be of great benefit to practitioners. Since prayer is the most consistently utilized intervention among parish nurses, it would be of interest to learn more about the intervention.

Additional research, including case studies, is needed in the areas of spiritual assessment, evaluation of spiritual interventions, and documentation of spiritual nursing care. Certainly nurses, and most especially parish nurses, could benefit from additional information and education relevant to the spiritual care nursing process.

As the nursing literature suggests, it is vitally important the nurse be comfortable with his/her own spirituality. This is imperative for the parish nurse, since the role of integrator of faith and health is a specific function associated with the specialty practice of parish nursing. Certainly additional education and training relevant to spirituality and spiritual care should be integrated into all levels of nursing education.

Lastly, a personal commitment to one's own spirituality and spiritual growth is needed. A nurse

should model healthy lifestyles, of which spiritual health should be included.

Summary

Despite historical roots in religion, professional nursing knowledge regarding spirituality and spiritual care is limited. Much of the literature and resulting knowledge relevant to spiritual nursing care is yet in its infancy, as is the specialty practice of parish nursing. This study was completed to identify and investigate the spiritual nursing care practices of volunteer parish nurses. It was found that, reflective of nursing literature, spiritual interventions are the most commonly acknowledged and provided function of the nursing process. Although spiritual assessment tools are available in nursing literature, use of those tools is rare. Evaluation and documentation is not consistently performed.

Additional research in the areas of spirituality and the spiritual nursing care process is required. Education relevant to spiritual care is needed at all levels, as is the nurse's personal commitment to spiritual growth and development.

APPENDIX A

APPROVAL TO ACCESS REDLANDS
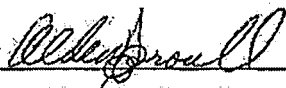
COMMUNITY HOSPITAL RECORDS

December 31, 2002

This letter grants Lynne Roy, RN permission to access parish nurse/health minister mailing and information files at Redlands Community Hospital for the purpose of her Master's Thesis in Nursing study. I understand the study is supervised by Dr. Ellen Daroszewski, Professor in the Department of Nursing at California State University, San Bernardino and approved by the Institutional Review Board, California State University, San Bernardino. I have been assured the information will be used for the sole purpose of investigating the spiritual nursing practices of volunteer parish nurses and information will remain confidential.

_12/31/02_

Date

Chaplain Alden Sproull
Director of Pastoral Care Department
Redlands Community Hospital

APPENDIX B

INSTITUTIONAL REVIEW BOARD

APPROVAL

**CALIFORNIA STATE UNIVERSITY
SAN BERNARDINO**

5500 University Parkway, San Bernardino, CA 92407-2397

January 28, 2003

Ms. Lynne D. Roy, RN.
c/o: Dr. Ellen Daroszewski
Department of Nursing
California State University
5500 University Parkway
San Bernardino, California 92407

Dear Ms. Roy:

Your application to use human subjects, titled, "Identification of the Spiritual Nursing Care Practices of Volunteer Parish Nurses" has been reviewed and approved by the Institutional Review Board (IRB). Your informed consent statement should contain a statement that reads, "This research has been reviewed and approved by the Institutional Review Board of California State University, San Bernardino."

Please notify the IRB if any substantive changes are made in your research prospectus and/or any unanticipated risks to subjects arise. If your project lasts longer than one year, you must reapply of approval at the end of each year. You are required to keep copies of the informed consent forms and data for at least three years.

If you have any questions regarding the IRB decision, please contact Michael Gillespie, IRB Secretary. Mr. Gillespie can be reached by phone at (909) 880-5027, by fax at (909) 880-7028, or by email at mgillesp@csusb.edu. Please include your application identification number (above) in all correspondence.

Best of luck with your research.

Sincerely,

Joseph Lovett, Chair
Institutional Review Board

JL/mg

cc:

APPENDIX C

SURVEY

Demographic Information

Age _____   Ethnicity _____

Gender (circle)   F   M

Current Faith Denomination _____

Total years licensed as a registered nurse _____

Type of Parish Nurse Training (circle): None; RCH Health Ministry Program;
PN curriculum endorsed by IPNRC; Other (describe) _____

Total years as a volunteer parish nurse _____

Average number of hours per week spent volunteering as a parish nurse ____

Average number of total hours you spend in prayer per week _____

If you have received any training regarding prayer, please describe:

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