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Comparing Nurses' and Patients' Comfort Level with Spiritual Assessment

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Abstract: This paper presents and compares similarities and differences between nurses' and patients' reports on comfort levels with spiritual assessment. Spiritual care is a part of nurses' professional responsibilities; however, nurses continue to report that they are poorly prepared for this. There is limited research on patients' expectations or perspectives on spiritual care. For the original mixed-method, two-phased study, a 21-item survey with 10 demographic variables, and some open-ended questions related to the comfort level of assessing/being assessed in the spiritual domain were distributed to 172 nurses and 157 hospitalised patients. SPSS was used to analyse and compare the results from nurses and patients; thematic analysis was used to examine the open-ended questions. Nurses reported a higher high degree of comfort with spiritual assessment than patients reported towards being assessed spiritually. Both nurses and patients saw respect and trust as key to building a relationship where open questions related to spirituality can be used as a helpful way to assess patients spiritually. Increased understanding of the best approach toward a patient must be based on the beliefs, values, and practices of that patient so that spiritual care can be individually tailored, and nurses can help patients move along the path to healing.

Keywords: spiritual assessment; comfort level; nurse and patient perspectives; mixed methods; spiritual care

1. Introduction

Spirituality is a part of holistic nursing and the professional nurse's responsibility. The International Council of Nursing (International Council of Nursing 2012) states that nurse promotes an environment in which values, customs and spiritual beliefs are respected. Nursingtheorists such as Joyce Travelbee and Betty Newman, and Scandinavian nursing philosophers Kari Martinsen and Katie Eriksson (Alligood and Tomey 2017) all address spirituality as an integrated part of nursing. Most introductory books on the fundamentals of nursing (examples Kristoffersen et al. 2016; Potter et al. 2017) also introduce their readers to spirituality. Moreover, nursing documentation systems such as the International Council of Nurses' International Classification for Nursing Practice (ICNP) System (2020) or the NANDA-I (NANDA International, Incorporation) (Herdman and Kamitsuru 2018) and NIC (Nursing Interventions Classification) (Bulechek et al. 2012) all include spirituality as a part of nursing.

Based on this background, we argue that spiritual assessment and spiritual care are parts of the nurse's professional role. However, nurses continue to report that they do not feel well prepared for spiritual care in clinical practice (Cone and Giske 2017). Reasons for feeling ill prepared are mainly related to being poorly equipped during their nursing education (Edwards et al. 2010; McSherry and Jamieson 2013). Limited continued education in clinical practice, a lack of leadership and role models, lack of time, and an environment that is not conducive towards spiritual care have also been reported as reasons for nurses to feel inadequately prepared to assess and address

spirituality in healthcare (Carpenter et al. 2008; Cockell and McSherry 2012; Giske and Cone 2015; Batstone et al. 2020).

There are few research reports on patients' experiences and preferences related to spiritual assessment and care when in the hospital, as well as to what degree they expect and want to be assessed spiritually by nurses. Most of the research related to spirituality has been carried out within palliative care or end-of-life care of patients, so we chose not to focus on those patient groups. However, international research indicates that spirituality and religiosity have an impact on patient health, and thus, attention should be paid to these domains of care (Koenig et al. 2012; Büssing et al. 2013; Salsman et al. 2015; Torskenæs et al. 2015; Caldeira et al. 2016).

The cultural context of spiritual care should also be given attention, as how spirituality and religion are perceived and how they can be spoken about varies from country to country. In Norway, where this study was conducted, a majority of the population belongs to Christian dominations; however, church attendance is low, and people see spirituality and religion as very private and almost taboo to speak about openly (La Cour and Hvidt 2010; Ødbehr et al. 2015; Cone and Giske 2017).

With this context, we decided it was important to investigate how comfortable nurses, from diverse backgrounds, were towards assessing patients spiritually (Cone and Giske 2017). We also chose to use the same questionnaire, but from the patient's perspective, to explore how comfortable hospitalised patients were towards being assessed spiritually by nurses (Cone and Giske 2020). Here we focus on the findings from these parallel studies.

Aim of the Article

The aim of this article is to compare similarities and differences between nurses' and patients' comfort level with spiritual assessment in an acute health care setting.

2. Methods

2.1. Design

The design of the original study was a cross-sectional mixed method two-phased explorative survey with both quantitative and qualitative aspects, examining nurses' (phase 1) and patients' (phase 2) comfort levels with spiritual assessment. The study was first conducted among nurses (Mixed-method: Cone and Giske 2017) and later among patients (Mixed-method: Cone and Giske 2020). In this article, we compare and contrast findings from the survey among nurses in phase 1 and patients from phase 2 of the original study.

2.2. Participants and Settings

The study took place at a hospital and two universities in a city in western Norway between 2014 and 2016. Inclusion criteria for the survey among nurses were that they were currently working, had a bachelor's degree in nursing, and had a willingness to take part in the study. We targeted a diverse group of nurses, since we aim to develop knowledge about nurses working mainly outside palliative care, as there is a significant amount of research related to spiritual care from that perspective. In total, this convenience sample of 172 nurses was recruited from a local district hospital and two graduate nursing programs.

Inclusion criteria for patients were that they were hospitalised in a local 150-bed hospital and were willing to take part in the study. Exclusion criteria were patients at end-of-life or in palliative care and patients with traumatic or extremely stressful diagnoses, such as terminal cancer, or those who, according to the nurse's clinical judgment, might experience an undue burden from spending time and effort on a survey. Recruitment was carried out in several waves until we reached 157 responses from hospitalised patients, which was beyond the power analysis of 130.

2.3. Instrument

The questionnaire we used for this survey was the Nurse Spiritual Assessment Questionnaire (NSAQ) and it has 21 items, arranged in no particular order. It was developed by Taylor (2014) from American and British health care literature advocating the importance of spiritual assessment. The NSAQ was tested for reliability and validity among hospice patients and nurses in New Zealand (Taylor and Brander 2013; Taylor 2014). The survey contains background variables such as age, gender, cultural influence, and for nurses, place of work and years of experience as a registered nurse. Patients were asked which unit they were admitted to and the length of their hospital stay. The 21 items of the NSAQ measures the comfort level of nurses when assessing patients spiritually (Taylor 2014), and for patients, how comfortable they are with being assessed spiritually by nurses (Taylor and Brander 2013). The NASQ uses a Likert scale for measuring the level of comfort. Table 1 shows the introduction to the questions for nurses and patients in our study and the places nurses and patients were asked to tick the box for what best showed how comfortable they were with each of the 21 questions. Both nurses and patients were invited to comment on each question.

Table 1. Nurses' and patients' introductions and response options for all 21 questions in the Nurse Spiritual Assessment Questionnaire (NSAQ).

Nurses: Please tick the box that best shows how comfortable you would be in doing an initial spiritual assessment of a patient. Remember, your answer is to reflect how you would feel asking these questions of a patient—NOT how you would feel answering them.	**Patients:** Please tick the box that best shows how comfortable you are with a nurse (not a chaplain, doctor or another person) asking you these questions.
1: Extremely uncomfortable	1: I do not relate to this question
2: Somewhat uncomfortable	2: I would not want to be asked this question
3: Somewhat comfortable	3: I would be okay with being asked this question
4: Quite comfortable	4: I would like to be asked this question
5: I don't understand the question	5: I don't understand the question

The survey questions themselves had a 4-point Likert scale from least to most comfortable, with an additional spot if they did not understand the question. The demographic section of the survey also had some Likert-type questions on a 5-point scale that measured personal spirituality and religiosity of both nurses and patients. In addition, nurses were asked about perceived importance of spiritual assessment and about perceived preparedness to conduct spiritual assessment. Patients were asked who they were most comfortable with for addressing spirituality.

The survey ended with some open-ended questions. For nurses, these include: What spiritual assessment questions or prompts do you use in your work? In what other ways do you go about to gather information for spiritual assessment? Any other questions or comments? Patients were asked: If a nurse was required to assess how your spirituality or religion influenced the way you cope with illness, how would you want the nurse to ask you about this? In general, if you were asked a question about your spirituality or religion, who would you prefer to ask you? (Nurse, physician, social worker, hospital chaplain/priest). Please set up the list in order of priority. 1 = the one I most want to ask me about my spirituality, to 4 = the one I least want to ask me

With Taylor's permission, the first author translated the survey from English to Norwegian, since deeply personal issues can usually be best understood in one's primary language. According to standard translation protocol, a separate bilingual scholar back-translated it to validate its accuracy in the new language (Duffy 2006). Experts in both languages served as a consulting panel to assess its reliability and validity as a Norwegian instrument, though it was only pilot tested in the new language. Since "spiritual" (*åndelig* in Norwegian) has a religious connotation for many in Norway, we used "spiritual/existential" in the introduction of the questionnaire to keep the concept broad.

2.4. Data Collection

In the first phase of the survey study, nurses in the district hospital received written information about the study from their professional development leaders, and nurses in postgraduate education were informed by key teachers. The questionnaire was available at the units and in class. Those who took part in the study returned the survey anonymously in an envelope addressed to the first author. For the second phase of the survey study, nurses assessed patients to determine if they might fit the study criteria and if any undue burden would occur when filling out a survey, and they only offered it to those who were considered strong and healthy enough to participate without significant risk. Hospitalised patients who fit the inclusion criteria received written information about the study from the nurses. Those indicating an interest returned the survey in an envelope addressed to the first author, either via the organizational mail service while in hospital or by post after discharge.

2.5. Data Analysis

The quantitative data from the survey were entered and analysed thorough SPSS version 22. Using this software, we built the analytical platform, entered data, and ran statistical tests to determine differences and relationships between demographic variables and levels of comfort with each of the 21 questions. We used *t*-tests, Chi-squares, and Spearman's Correlations for non-parametric data. We used thematic content analysis (Polit and Beck 2020) for analysing all comments on the questions as well as answers to the open-ended questions. The two authors first analysed the nurses' qualitative data individually and later worked together to reach consensus on selective codes and emergent patterns. The qualitative data from patients was first analysed by two PhD students and finally by the two authors, which provided a form of cross-checking analytical outcomes. This triangulation served to strengthen trustworthiness of the results. A detailed description of the analytic processes for the survey studies were reported in two articles presenting our findings (Cone and Giske 2017; Cone and Giske 2020).

2.6. Ethics

The Norwegian Data Protection Services approved the mixed-method, two-phased study among nurses and patients (NSD # 36839 http://pvo.nsd.no/prosjekt/36839). The researchers obtained permission to conduct the study from the leaders in the hospital, for both phases with nurses and patients, and from the leaders at the university for recruitment of the post-graduate students working in diverse healthcare settings. Written information about the study was given to nurses and patients fitting the inclusion criteria. No information that could identify the individual respondent was collected, and the return of a completed survey in the designated envelope denoted informed consent.

3. Results

3.1. Participants Characteristics

Table 2 presents the demographics of the nurses and the patients who took part in the study. Some questions had missing data, so results were analysed according to each total. Overall, patients were older than nurses, meaning they come from different cohorts in time. The percentage of men in the study mirrors the percentage of male nurses in Norway. In the sample we have from patients, there were more women than men. Patients stay in the hospital was longer than the national average, which is around 3 days, and more patients were in medical units than in surgical units. Nurses came from diverse backgrounds in health care work, with the majority coming from acute hospitals. The cultural influence of both nurses and patients were mainly Norwegian. It is interesting to see that the majority of nurses reported that they have had no spiritual care education, and that they report a score of 2.9 (1–5 scale) in preparedness. Nurses report a much higher importance of spiritual assessment than patients do, and it is worth noticing that the SD is higher for nurses than for patients. Self-reported religiosity is almost the same for nurses and patients; however, nurses report noticeable

higher spirituality than patients do. Nurses report a higher degree of the importance of spiritual assessment (3.7) than patients do (2.6). When patients were asked who they preferred to carry out a spiritual assessment, more patients reported that they wanted the hospital chaplain/priest to do so (48%), with nurses in second place (30%).

Table 2. Participants' demographics.

Variables	Nurses (n = 172)	Patients (n = 157)
Age in years (average/range)	38 (22–62)	59 (17–94)
Gender		
Females	157 (91%)	95 (61%)
Males	15 (9%)	61 (39%)
Years' experience (average/range)	11.1 (5–40)	
Days in hospital (average/range)		5.6 (1–56)
Health care setting		
Medical	71 (41%)	
Surgical	40 (23%)	87 (55%)
Home care	33 (19%)	70 (45%)
Nursing home	15 (9%)	
Diverse others (admissions, emergency, float to various units)	13 (8%)	
Primary influencing culture		
Norwegian	162 (96%)	150 (96%)
Other	5 (3%)	5 (3%)
Spiritual education		
Yes	65 (38%)	
No	105 (62%)	
Self-reported spirituality (M/SD)	3.0 (1.1)	2.4 (1.2)
Self-reported religiosity (M/SD)	2.8 (1.2)	2.9 (1.1)
Importance of spiritual assessment (M/SD)	3.7 (0.8)	2.6 (1.0)
Sense of preparedness (M/SD)	2.9 (0.9)	
Who do you most want to ask you about your spirituality?		Priest: 75 (48%) Nurse: 47 (30%) Doctor: 22 (14%) Social worker: 13 (8%)

3.2. Quantitative Findings

Nurses reported a rather high level of comfort in assessing patients spiritually, with a range from a mean of 3.58 as the highest to 2.56 as the lowest mean (range 1–4) on the 21-item questionnaire. Patients scored their level of comfort with being assessed spiritually by nurses with a range from 2.90 as the highest mean to 2.33 as the lowest mean, meaning that this group of hospitalised patients were more comfortable than not to be assessed by nurses. The questions where nurses and patients scored highest and lowest are presented in Table 3. It is worth noticing that nurses and patients share three of the highest and three of the lowest mean scores among the 21 questions.

For nurses, we found highly significant relationships between how prepared they were ($p < 0.001$), how important they thought spiritual assessment was ($p < 0.01$), and how comfortable nurses were in assessing patients. Education did not come through as highly significant to the level of comfort; however, it showed a weak significant relationship to sense of preparedness ($r = 0.277$, $p < 0.001$) and to the workplace ($r = 0.157$, $p < 0.044$). Further analysis showed that the nurse's sense of preparedness for spiritual care was moderately correlated and highly significant with self-reported spirituality ($r = 0.381$,

$p < 0.001$), with importance of spiritual assessment ($r = 0.321$, $p < 0.001$), with having education ($r = 0.277$, $p < 0.001$), and with self-reported religiosity ($r = 0.258$, $p < 0.001$).

Table 3. Comparison of the highest and lowest scores on questions regarding comfort of spiritual assessment by nurses and patients, with means (*M*) and standard deviation (SD).

Questions	Nurses *M* (SD)	Patients *M* (SD)
Highest for nurses compared with patient standing		
Who/what supports you when you are ill?	(1) 3.58 (0.73)	(2) 2.88 (0.98)
What do you rely on in times of illness?	(2) 3.44 (0.87)	(4) 2.83 (0.87)
Do you have someone to talk to about religious matters?	(3) 3.44 (0.77)	2.53 (0.98)
Are there any spiritual needs or concerns I/we can help you with?	(4) 3.44 (0.80)	2.59 (1.01)
When life is hard, how have you kept going? Is there anyone or anything that has helped you? How helpful are these supports?	(5) 3.3 (0.83)	(3) 2.85 (1.01)
Are you at peace?	3.01 (0.99)	(1) 2.90 (0.96)
Would you describe yourself—in the broadest sense of the term—as a believing/spiritual/religious person?	2.91 (1.00)	(5) 2.63 (0.81)
Lowest for nurses compared to patients		
Would you like to explore religious matters with someone?	(17) 2.94 (1.03)	(21) 2.33 (0.81)
What is the place of spirituality in your life?	(18) 2.92 (1.01)	2.53 (0.80)
Would you describe yourself—in the broadest sense of the term—as a believing/spiritual/religious person?	(19) 2.91 (1.00)	2.63 (0.81)
Spirituality often influences how people deal with illness. How, if at all, has your spirituality influenced how you have dealt with your medical condition?	(20) 2.81 (0.99)	(17) 2.39 (0.86)
How integrated are you in a spiritual community	(21) 2.66 (1.02)	(19) 2.38 (0.81)
What role would you like to assign to your healthcare team with regard to spirituality?	2.97 (1.04)	(18) 2.39 (0.88)
What can I/we do to support your faith or religious commitments?	3.03 (0.94)	(20) 2.37 (0.77)

For patients, the strongest correlation for how comfortable they were in being asked these questions by nurses was related to how important they rated spiritual assessment ($r = 0.757$, $p < 0.001$). There was a strong and significant correlation between how important they found spiritual assessment and self-reported religiosity ($r = 0.502$, $p < 0.001$) and self-reported spirituality ($r = 0.457$, $p < 0.001$). Standard deviations from the mean/average for each question ranged from 1.04 to 0.73 but were fairly even across most questions (0.90 s for nurses and 0.80 s for patients).

3.3. Qualitative Findings

The thematic analysis of the open comments and the open-ended questions from nurses and patients provided us with a diverse picture of what is at stake in the relationship between patients and nurses when it comes to spiritual assessment. Both nurses and patients see trust and communication as key to a comfortable assessment regarding spiritual concerns. Identified themes from nurses and patients are presented below and are compared in the discussion.

Patients comments revealed three themes about patients' attitudes: *"Don't ask me"*, *"May ask me"*, and *"Ask me anything"* (Cone and Giske 2020). Patients who did not want to be asked about spirituality thought of spirituality as very private and saw nurses as professionals who mainly relate to urgent or physical health needs. Spiritual assessment was not seen as the nurse's responsibility by this group of patients, and they discussed such issues only with their family or a priest/chaplain. Patients who kept the possibility open of a spiritual assessment, and those who accepted it or even would love to be assessed spiritually, all focused on the attitude of the nurse and relationship with the nurse. By being respectful, open, and genuine, and through attentive listening and an expressed interest in what was important to the patient, the nurse would be seen as kind and caring. Such a process would build a trustful relationship between the patient and the nurse. The opposite attitudes and actions from the nurse would be experienced as a lack of respect and interest, and thus, would undermine the

patient's desire to share with the nurse what was of importance to the patient in the spiritual domain. The middle group could move in either direction depending on the nurse.

Nurses seemed to have understood some of this process, since they underlined the importance of building a trustful relationship with patients (Giske and Cone 2015). Nurses shared three key elements related to spiritual assessment: *how they gathered information from the patient's surroundings* such as books, pictures, jewellery, or cards; *what the patient talked about* such as deeply important issues, concerns, or resources; and *how they talked about these things*. Tone of voice, facial expressions, and bodily cues denoting peace, unrest, or anxiety were taken into consideration in the process of trying to determine what the patient's concerns could be and what view of life the patient might hold. Nurses provided us with many examples of questions they used in assessing patients, and the most used question was *"Do you want to talk to a priest or chaplain?"* In Norway, with a long tradition of a Lutheran State Church where hospital chaplains are readily available, people are aware that there is a local church with a priest available for counselling. Nurses trust the priest/chaplain and often introduce them as a person you can talk to even though you are not religious. This suggestion might be a good fit for patients, as 48% of the hospitalised patients would prefer to be assessed spiritually by a priest.

In a Norwegian context, faith and spirituality are seen as being very private. Some nurses even said that spirituality is taboo to talk about and is therefore challenging to assess. The fear of intruding on a patient's faith and possibly hurting the patient or destroying the nurse-patient rapport, together with busy work conditions, leads to a lower priority being placed on spiritual assessment for some nurses.

4. Discussion

One of the main findings when comparing nurses' and patients' levels of comfort in assessing/being assessed spiritually was that nurses reported a higher level of comfort than patients did. However, both reported more positive levels than negative ones. This was a surprise, considering the Norwegian context. It would be interesting to see what is true in other cultural contexts around the world, since nurses globally report feeling ill-prepared for spiritual assessment and care (Edwards et al. 2010; McSherry and Jamieson 2013; Batstone et al. 2020), while little has been published on spiritual assessment from the patient perspective.

It was also unexpected for the authors to find that education did not come up as being directly related and highly relevant for the nurses' level of comfort with spiritual assessment, since this is reported in another study (Taylor 2014). The degree of preparedness, the importance nurses placed on spiritual assessment, and nurses' own spirituality were viewed as being highly significant to how comfortable they felt. The degree of preparedness and the importance of spiritual assessment are elements where continued education and shared collegial reflections in clinical practice could be used to increase the nurses' level of comfort, and thus facilitate nurses to fulfil their professional responsibility to integrate spirituality in their nursing care (Paal et al. 2015).

For patients, their view of how important spiritual assessment, together with the degree of self-reported spirituality and religiosity, was what determined their level of comfort with spiritual assessment by nurses. These findings are interesting in a Norwegian context where spirituality is reported to be very personal and is almost taboo to talk about with nurses (Cone and Giske 2017; Ødbehr et al. 2015). Themes from the qualitative findings provided us with some insight into what might determine how nurses can use professional discernment during spiritual assessment so that patients find it relevant and helpful (Minton et al. 2018).

The qualitative analysis of patients' comments and answers revealed that there were three groups of patients. One group of patients did not want to be assessed spiritually because they saw it as too private and not the nurses' responsibility. Another group of patients would love to be assessed, since for them spirituality and/or religion was very important, and to be assessed in this area would provide them with an opportunity to speak with the nurse about what was very important to them. This could change if they sensed that the nurse was neither interested nor caring toward them. In between these

two groups of patients, there was a middle group who said it would be acceptable to be assessed if it was done with respect, if the nurse was non-judgemental, and it was done in a way that built trust.

The challenge for the nurse is to figure out who is in which group when they meet with a new patient. The nurses' comments reveal that they know patients are different and that they know they should be careful and use their professional discernment to respect those who do not want to be assessed and to find those who may or do want to be assessed spiritually. The nurses' comments confirm the findings from a study that explains how nurses work through a process of three phases to assess and address patients spiritually (Giske and Cone 2015) and from Batstone et al. (2020) review reporting that spiritual care competencies among nurses develop from personal spirituality, life experience, and professional experiences.

It is also interesting to see that nurses and patients shared three of the questions they were most comfortable with asking and being asked. If we look at those questions, they are quite open and general and do not use the words spiritual or religious. Such open questions are also supported by Ross and McSherry (2018). Asking patients simple, open questions is seen as more respectful and non-judgmental. Nurses and patients also share three of the five questions they are least comfortable with, and all these questions use spirituality or religion as part of the question. The question Norwegian patients were least comfortable with nurses asking was: *Would you like to explore religious matters with someone?*

Another result worth noticing is that patients rated hospital chaplains as number one for spiritual assessment, before nurses. Moreover, the most frequent question nurses said they used in their clinical practice was: *Do you want to talk to a priest/chaplain*? Nurses feel comfortable referring their patients to the chaplain/priest as a trusted member of the health care team with good communication skills and more time available for patient conversations. Nurses encourage their patients to spend time with the priest, which is supported by another study of Norwegian nurses in which the healing process was to advocate priest care (Giske and Cone 2015). This is also supported by McCormick and Hildebrand (2015).

5. Conclusions

In a Norwegian context, religion and spirituality are seen as private and something that one should be careful addressing in nursing. This article has compared how comfortable nurses are in assessing spiritual issue of patients and how comfortable hospitalised patients are with being assessed spiritually. The findings indicate that both nurses and patients are more comfortable than not, and that broad, open questions are to be preferred. However, the most interesting findings relate to the importance of the process between the nurse and the patient that can build a relationship where such important and private questions are acceptable to be asked by nurses. A strong and positive nurse-patient rapport provides a bridge to personal and important issues of concern that can be shared by the patient and the nurse.

6. Relevance to Clinical Practice

The value of nurses understanding when and how a patient's perspective differs from his/her own view cannot be over emphasised. Nurses need to individually tailor their care to patients' views and preferences. Increased spiritual literacy is helpful for nurses to be more aware of the variety of needs and resources that patients have when hospitalised. Becoming more comfortable with what and how to ask questions in a non-offensive way is also important for nurses to be able to safely address spiritual concerns without destroying nurse/patient rapport. One of the most important issues related to clinical practice is the value of trust building so that nurses have a good rapport that would enable them to address any and every topic that is deeply important to the patient.

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