A MODEL FOR THE INTEGRATION OF SPIRITUAL CARE INTO THE NURSING CURRICULUM IN NIGERIA

Student Name: AFOLAYAN, JOEL ADELEKE

Student Number: 3315247

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Department/School: SCHOOL OF NURSING

Supervisor: PROF. José FRANTZ

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Abstract

Man is a bio-psycho-social-spiritual being, and his needs are informed by all these elements. The need for spiritual care in nursing education and practice is no longer a new concept in developed countries, nor even in some developing countries. However, in Nigeria, there is no consistent evidence of how spirituality is taught within the nursing curriculum nor how it is practised. The literature review also confirms that no existing set of rules or models for integrating spiritual care into the curriculum of nursing exists in the country. If nursing care is to be holistic, concerted attention must be paid to spiritual care, and to the training of nurses so that they can provide spiritual care within the context of holistic care for patients in the healthcare system. The main purpose of this academic work was to develop a model for the integration of spiritual care-giving into the nursing curriculum. This cross-sectional study used adapted modified Intervention Mapping (IM) strategies with a mixed method approach, to collect in-depth information. The study was conducted in two phases:

Phase One utilised situational analysis methodology, using steps one to three of the IM strategies to solve objectives one to three of the study. All the nurse educators, nurse clinicians and nursing students were conveniently and purposively sampled for the study. The study was carried out in selected geo–political zones of Nigeria. Structured questionnaires were used for the quantitative data while focus group discussions, in-depth interviews as well as clinical and classroom observations were conducted with the stakeholders using unstructured question guides. The interviews were recorded through tape recording, script transcription and keynote taking. The current curriculum and lecture notes of both the nurse educators and nursing students, including the nursing process documents of the patients in clinical areas, were carefully scrutinised and observed. This occurred within the context of spiritual care in nursing. Intervention mapping content analysis was used for qualitative data while the quantitative data generated were analysed using the SPSS Version 22 for both

descriptive and inferential statistics. With the aid of Analysis of Variance (ANOVA), Chi-square and multiple regression statistics, the relationship between variables of interest and variation in mean values were established, while for the qualitative study, ATLAS.Ti 7 was used to analyse concepts and competencies for spiritual care. The second phase of the research was the stage of developing the model that incorporates spirituality into the Nigerian nursing syllabus through collaboration with the panel of experts/linkage committee (nurse educators, nurse clinicians, NANNM focal persons, State Committee of Nursing and Midwifery, DNS, DAP, General and Nursing curriculum experts) using the Delphi technique. The Research Ethics Committee of the University of the Western Cape and all other windows used for the study, including all participants involved, gave their full permission for this study. The researcher ensured that participation in this study was voluntary and that the participants were not harmed in any way. Participants were given detailed information about the study. The identity of participants of this study has been protected and their anonymity ensured by using numbers instead of names for the participants. An informed consent form was signed by the participants of the Focus Group Discussion (FGD). Confidentiality binding forms were signed by all who participated in the FGD, including the research assistants employed for the study. Participants were informed of their right to withdraw from the study at any time, notwithstanding them tendering their signature on the consent form. The situation analysis revealed firstly, that there was a lack of understanding on the part of the participants as to the concept of spiritual care. There was also a lack of competence evident in the way spiritual care was practiced and taught which impacted on the areas of knowledge and skill development, which failed to enhance positive attitudes. In addition, there was no existing competence for rendering spiritual care since it was not emphasized in the curriculum. Phase Two produced a model for the effective incorporation of spiritual care-giving into the Nigerian nursing curriculum. The model contained the contents of spiritual

care as well as the competencies, suitability and relevance of spiritual care to nursing education and practice. These elements provided the basic components of the model and answered the questions around the what, when, how, who, where and why of spiritual care integration. It is then recommended that implementation of the model should be urgently done and for greater effectiveness; nurse educators and nurse clinicians should be retrained for proper implementation of the new curriculum. This would be done in order that nursing practitioners acquire the necessary knowledge, attitudes and skills of spiritual care in nursing.

KEYWORDS

Bio-psycho-social-spiritual care

Competence

Curriculum

Holistic nursing care

Integration

Intervention mapping strategies

Model

Nursing

Spiritual nursing care

DECLARATION

I declare that '*A model for the integration of spiritual care into the nursing curriculum in Nigeria'* is my own work. This work has not been submitted before for any degree or examination at any other university. All the sources I have used or quoted have been indicated and acknowledged as complete references.

Joel Adeleke Afolayan Date: 14 December , 2017

Signed

DEDICATION

I dedicate this PhD thesis to every nurse who cares to render spiritual care to his or her clients/ patients and who knows that he or she will give account of his or her life to the Maker.

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I sincerely thank Almighty God, the King of kings and Lord of lords for His faithfulness, love, compassion and mercy over my life and for giving me all the enabling grace, endurance, wisdom, courage and strength to start and end this second doctoral degree programme successfully, despite all negative situations around me. To Him be all glory and honour.

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ACRONYMS AND ABBREVIATIONS

ACNO: Assistant Chief Nursing Officer

CNO: Chief Nursing Officer

DAP: Director of Academic Programmes

DNS: Director of Nursing Services

FGD: Focus Group Discussion

FMOH: Federal Ministry of Health

FRN: Federal Republic of Nigeria

IM: Intervention Mapping

KAS: Knowledge, Skills and Attitudes

N&MCN: Nursing and Midwifery Council of Nigeria

NANNM: National Association of Nigeria Nurses and Midwives

NO: Nursing Officer

PNO: Principal Nursing Officer

SCCS: Spiritual Care Competency Scales

WHO: World Health Organisation

CERTIFICATION

I, Professor José M. Frantz, hereby certify that this thesis was completed by **Joel Adeleke Afolayan**, a doctoral (PhD) student in the School of Nursing, Faculty of Community and Health Sciences, University of the Western Cape, South Africa, under my supervision.

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PROFESSOR JOSÉ M. FRANTZ

SUPERVISOR

TABLE OF CONTENTS

Contents

LIST OF FIGURES

LIST OF TABLES

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background of study

Spiritual care arises from belief systems of communities, and therefore has strong links with cultures and traditions. Spirituality is strong in societies that foster strong bonds, and particularly those that are less scientific than other societies. The transcendental nature of man causes him to place emphasis on the spiritual aspects of his life, even when it comes to matters of health and illness. Spiritual caring is a vital aspect of an all-encompassing nursing care that necessitates nurses to understand the link between the emotional, social, physical, spiritual and cultural domains when caring for their patients (Freshwater & Maslin-Prothero, 2016). Nurses who appreciate the spiritual component demonstrate this in the way they care for their patients (Callister, Bond, Matsumura & Mangum, 2012). Spiritual nursing care-giving is the centre of nursing care that embraces a holistic approach: social, physical and psychological (Koslander & Arvidsson, 2018). Consequently, spiritual nursing care is an esteemed and essential element of quality care for both severely and frequently ill patients (McEwen, 2014).

In the last decade there has been renewed emphasis on spiritual nursing care and the contention that nurses need to espouse a caring-healing concept. Current thinking is that nursing should move beyond high-technology cure and adopt spiritually-based nursing care that meets the needs of patients holistically and assists them to make sense of their circumstances.

Spiritual care is an aspect of holistic care and is therefore designed to reach the deep, but intangible human needs that are important for the promotion of good health, such as inner strength and peace (Hsiao, Chiang & Chien, 2010). Spiritual needs are more apparent when a

person's capacity to handle life situations is reduced by illness and other life crises (Agrimson & Taft, 2017). Wallace, Campbell, Grossman, Shea, Lange, and Quell (2013) argue that spirituality plays a major role in patients' perception of their health and how they either deal with illness or prefer to die. They further assert that spirituality is fundamental when recuperating from a physical illness, but unfortunately nurses are often poorly trained in this aspect of care.

Carron and Cumbie (2011) are of the view that spiritual care is an integral, but often neglected and poorly understood component of holistic nursing practice for adults in primary healthcare settings. They maintain that it is important for nursing care to incorporate the spiritual needs of adult patients. This is demonstrated in the literature, where the connection between spirituality and health is highlighted. However, to ensure the satisfactory provision of spiritual care, nurses should comprehend the meaning and interpretation of spiritual care from an adult patient's point of view. Subsequently, the patient's viewpoint needs to be incorporated with the perceptions that the nurse has about spiritual care. The association between spirituality and religion also needs elucidation. Fundamental questions such as how patients have been able to access their internal spiritual resources and how these resources are used to benefit their health helps to uncover a patient's belief system. Rogers and Love (2012) discuss nurse educators' views about the role of spirituality in curriculum development and teaching. They indicate the need for nurse educators to be vigilant about the education of their patients in the area of spiritual care, taking whatever measures are necessary for the teaching of spiritual caring in nursing practice. Nevertheless, nurse educators consider the evaluation of the affective domain to be challenging; thus they give little or no consideration to this aspect of knowledge. Focusing only on psychomotor and cognitive skills generates nurses who are merely technical experts, but who lack humanistic approaches to healthcare. Hence there is a need for nurse educators to train students to

understand the meaning of spiritual care and how this promotes the nurse-patient relationship in the care situation. Nursing curricula that allows students to appreciate spirituality in a broader context goes beyond religious viewpoints (Wallace et al., 2013).

1.2 Spiritual care as a component of holistic care

According to Sartorius (2016), there are three types of definitions that are commonly used to define health. The first is that 'health is the absence of any disease or impairment.' The second is that 'health is a state that allows the individual to adequately cope with all the demands of daily life (implying also the absence of disease and impairment).' The third definition states that 'health is a state of balance, an equilibrium that an individual has established within himself, and between himself and his social and physical environment.' The author further states that if we are to effectively address health, the third definition implies that we cannot only remove disease and address risk factors, but that we should actively involve the individual whose health we want to improve and do this in a holistic manner. It is this third definition that resonates with this researcher as it is patient-centred and all-encompassing. With the focus on holistic care, the question of spiritual care is introduced. Spiritual or compassionate care involves serving the whole person, which includes the physical, emotional, social and spiritual aspects. It is considered an element of holistic care (Hsiao, Chiang & Chien, 2010) that is structured to meet intangible human needs; which is considered significant for high-quality health since it facilitates a state of mind that promotes inner strength and peace. Unlike physical needs, which are tangible, spiritual and psychosocial needs are intangible in that they are often abstract, complex and more difficult to measure. According to the literature, the effect of spirituality on health can be classified into three major categories, namely mortality, coping and recovery (Puchalski, 2012). Strawbridge, Cohen, Shema and Kaplan, (2011) suggested that people who usually engage in spiritual practices tend to live longer than those who do not. Another revision points to a

possible connection between elevated interleukin (IL)-6levels and frequency of disease. Furthermore, Koenig, Cohen, George, Hays, Larson and Blazer, (2016) in their research study concurred that older adults who attended church regularly were less likely to have elevated levels of IL-6 than those who did not attend church. The authors put forward that religious commitment may improve stress control by giving better coping methods, richer social support, and the strength of personal values and worldview.

Coping: Spiritual patients gain strength from their beliefs, which helps them to cope with illness, pain and the stresses of life. Yates, Chalmer, St. James, Follansbee and McKegney (2015) maintained that those who are spiritual have optimistic view points and enjoy a better quality of life. For example, in patients with advanced stages of cancer, those who were religious were found to be more content and satisfied with their lives, with decreased levels of pain. Spirituality is an integral aspect of the 'existential domain' measured in quality-of-life scores. Optimistic reports on those trials – a significant peculiar reality, fulfilment of life objectives and a sensation that life up to that point, had been meaningful – inter-related with an ideal value of life for patients experiencing advanced ailment (Cohen, Mount, Strobel & Bui, 2017).

Various studies have explored the role of spirituality in relation to pain. One study in particular showed that spiritual well-being was connected to the ability to feel content with life even in the presence of health symptoms, including pain. This suggests that spirituality may be a vital clinical goal (Brady, Peterman, Fitchett, Mo & Cella, 2014). The outcome of a pain questionnaire distributed by the American Pain Society to admitted patients revealed that 76% of the patients turned to personal prayer as the most frequently used non-medication method of controlling pain (McNeill, Sherwood, Starck & Thompson, 2014). Another study reported that prayer is the most frequently used method of pain management compared to the use of intravenous pain medication, pain injections, relaxation, touch and massage. Although

administering medication to combat pain is vital and should be encouraged, it is also important to consider other methods of treating pain. Believing in divinity can help patients deal with illness and come to terms with impending death. When patients with gynaecologic cancer were asked how they cope, 93% of 108 women mentioned their spiritual conviction. Furthermore, 75% of them opined that religious belief had a significant place in their lives, while 49% said they became more in tune with spirituality after they were diagnosed (Roberts, Brown, Elkins & Larson, 2014). Among 90 HIV-positive patients, those who were spiritually active had less fear of death and felt less guilt (Kaldjian, Jekel & Friedland, 2013). People surveyed cited that they would opt for companionship and spiritual comfort over advance directives, economic/financial/social concerns if they were dying. They cited several spiritual hopes that would give them comfort. The most common spiritual reassurances cited were beliefs that they would be in the loving presence of God or a higher power; that death was a passage and not the end, and that they would continue to exist through their children and descendants (George, et al. 2013).

Mourning over the loss of a loved one is one of life's greatest stresses. A study conducted with 145 parents who lost their children to cancer, revealed that 80% of these parents found comfort in their spiritual faith, a year after their children's demise. These parents were able to physiologically and emotionally adapt to the loss compared to parents with no religious beliefs. In addition, 40% of those parents reported a reinforcement of their religious beliefs over the course of the year prior to their child's death (Cook & Wimberly, 2014). These results are not astonishing because fact has shown that when people are faced with personal trauma such as a severe ailment or death, they very often turn to their religious beliefs to help them deal with or understand their ailment or loss.

Recovery: Spirituality and religion aid a patient's recovery from illness and surgery. For example, a study conducted among heart transplant patients showed that those who engaged

themselves in religious practices and rituals and who held their faith in high esteem, recovered when supplementary treatment was administered to them. They also experienced better physical activity at the one -year follow-up visit; had elevated levels of confidence; had reduced apprehension and experienced fewer health issues (Harris, Dew, Lee, Amaya, Buches, Reetz & Coleman, 2017). In general, people who do not fret and brood as much as others, tend to have better health outcomes. This suggests that spirituality enables people to lower their stress levels, to forgo stressful situations and enjoy the moment.

Intertwined with spirituality is the power of courage and positive thinking. Beecher revealed that when patients were told that the placebo was a drug for their condition; between 16% and 60% of those patients – an average of 35% – experienced recovery from ailments, which ranged from headaches, pain, cough, drug-induced mood swings, sea-sickness, or the common cold (Beecher, 2016). Currently placebos are only used in clinical trials, however, even in these trials, 35% of patients respond to them positively. Research of the 'placebo effect' has led to inferences that a person's beliefs are dominant and can affect his/her health for the better. Herbert Benson, a consultant cardiologist at the Harvard School of Medicine, has given another name to the placebo effect, namely 'remembered wellness' (Beecher, 1996). I see this as the capacity to tap into one's inner strength to wellness, and in agreement with Benson and other researchers who view the doctor-patient connection as taking a placebo effect. This means that the connection is a vital aspect of the healing progression. Benson proposes that we have three constituents that add to the placebo effect of the patient-physician bond; these are positive beliefs and expectations on the part of the healthcare professional, positive expectations and belief on the part of the patients and a noble relationship between the two parties (Benson, 2010).

There are also certain spiritual rituals that have been shown to enhance wellness. Benson started research on the effect of spiritual practises on health in the 1960s. People who

practised mystical meditation approached Benson and requested him to ascertain whether meditation had useful health effects. He realised that observing 10 to 20 minutes of meditation two times daily leads to reduced metabolism, lower respiratory rate, slower brain waves and a decreased heart rate. The exercise was beneficial for the treatment of anxiety, chronic pain, insomnia, depression, hostility, infertility and premenstrual syndrome and was a useful aid in the treatment of patients with cancer or HIV. He described this as ‘‘the relaxation response.’’ Benson also stated that ‘any disease is caused or made worse by stress, ’thus, ‘evoking the relaxation response is effective therapy’ (Benson, 2014).

When an individual’s ability to handle the difficulties of life is depleted by sickness and other life challenges; spirituality plays a pivotal role in helping the individual to cope (Agrimson & Taft, 2017). If conveyed outside of a religious agenda, spiritual desires are very likely to be overlooked. Thus, if we are to identify spiritual needs and provide care to meet these needs; it is important to have some understanding of the nature of spirituality and how various people express their spirituality.

The view expressed by Wallace Campbell, Grossman, Shea, Lange and Quell (2013) is that spirituality plays a vital role in how patients perceive their well-being, deal with difficulties, manage illness and decide to die. They further stressed the fact that spirituality is important when recuperating from a physical infirmity, but disappointingly most health professionals, including professional nurses, are often poorly prepared to deal with this area of care-giving. According to Puchalski (2012), doctors need to understand that ‘‘spirituality can be an imperative factor in the way patients face prolonged illness, suffering, and loss’’. This may affect compliance to care and thus doctors need to resolve and pay attention to all the emotional, spiritual, and physical needs of their patients, thus ensuring a well-rounded compassionate care. In view of this, Carron and Cumbie (2011) are of the view that spiritual care is an important, often omitted, and least understood factor of holistic nursing practice for

adults in primary healthcare settings. They argue strongly for the relationship between spirituality and health (Carron & Cumbie, 2011). Certainly, there is a pressing need for nurse practitioners to address the spiritual care needs of adult patients. However, in a bid to provide spiritual care, nurse practitioners need to understand the definition and interpretation of spiritual care from the patient's point of view. The patient's perspective then needs to be unified with the spiritual perceptions that nurse practitioners have about spiritual care. Integrating spirituality as an element of healthcare may also create boundary issues for patients. Those who do not consider themselves to be spiritual may feel uncomfortable by any movement into this realm. This may be, in part, a matter of definition and interpretation, as people have widely differing views about what it means to be spiritual.

Holistic care will thus focus on all the dimensions of the person – biological, psychological, social/relational and spiritual. Hefti (2011), studying the integration of spirituality and religion into psychiatry and psychotherapy, argues that the dimension of the extended biological, psychological and collective model in mental medicine, the model introduced by Engel in 1977, is the prevalent concept in clinical practice and research. It shows that biological, psychological and social factors become intertwined in a complex pattern for both health and disease. In the prolonged biological, psychological and social model (Hefti, 2013), religion and spirituality introduce a fourth element. This all-inclusive and integrative masterpiece is a useful tool to comprehend how spirituality and religion affect physical health and mental wellness. Collaborations with the psychological, social and biological dimensions form the diverse disciplines of the psychology, sociology and biology of religion. The extended bio-psycho-social model demonstrates that a universal method to mental wellness has to add pharmaco-therapeutic, psycho-therapeutic, socio-therapeutic and spiritual elements.

Hefti and Esperando (2016) infer that the lengthy bio-psycho-social model puts into consideration the fact that besides having social, biological and psychological needs patients also have spiritual desires. These are the need for meaning, purpose and hope; to have a sense of connection with self, with other people and the supreme, and the need to be treasured. These spiritual essentials become more pronounced during periods of ailment and grief (Koenig, 2012). Patients' spiritual and religious possessions or resources enable them to deal effectively with illness and other challenges of life. Supportive religious networks are a vital phase of general caring for patients. Also important is the evaluation of spiritual tussles and distress (Monod et al., 2010), which can adversely affect the process of recovery. This is supported by Sulmasy (2016) who used a bio-psychosocial-spiritual model for the care of patients approaching death. Based on Sulmasy's concept, every patient has a spiritual account. This spiritual history is revealed within the framework of an explicit religious ritual for many persons. Not regarding how it is revealed, their past spiritual account informs the patient's personality. When life-threatening ailments surface, this affects the individual in his or her entirety (Ramsey, 2011). This entirety includes, but is not limited to, the biological, social and psychological aspects of the individual, as well as those parts of the person that is spiritual (King, 2013). This bio-psycho-social-spiritual concept is never ''dualism'' where in a ''soul'' inadvertently occupies a body. Instead, the social, biological, spiritual and psychological are separate aspects of the individual, and no single part can be removed from the whole. To this end each aspect interacts with and affects other aspects of the person and in this way the illness and history impacts differently on each aspect.

The basis of holistic nurse caring thus requires nurses to understand the relationship between the social, cultural, physical, psychological/emotional and spiritual influences. This understanding provides useful information to guide their approach to the treatment of their clients (Freshwater &Maslin-Prothero, 2016; Govier, 2012; Meyer, 2010). Nurses who

respect this relationship are more likely to ensure that the spiritual mode is relevant in their patient-care (Callister, Bond, Matsumura & Mangum, 2012). Spiritual nursing care-giving constitutes the core of a care practice that is holistic. This is the essential factor that links the social, physical and psychological care provided by nurses. Koslander and Arvidsson (2018) assert that the primary aim of nursing is to assist patients to accomplish an elevated level of unity between the body, soul and spirit. This brings about self-reverence, self-healing, self-care and self-knowledge. Presently, there is transformed prominence on spiritual nursing care (Draper & McSherry, 2011).

1.1.2 Religion versus Spirituality

Kliewer and Saultz (2017) noted that the incorporation of spirituality in medicine may also cause boundary issues for patients. Those who do not see themselves as being 'spiritual' may feel uncomfortable as a result of any movement into this area. This may, in part, be as a result of differences in understanding what it means to be spiritual. However, this is certainly a significant issue, which is the reason why training in the area is required. If the approach is truly patient-conscious, unwanted interferences can be avoided. There may even be reasons for those who consider themselves to be spiritual to resist movement into the realm of the spirit. The research by Kliewer & Saultz (2017) shows that most patients are open to discovering the spiritual aspects of their treatment, although there are obstacles. Ehman et al. (2011) stated that firstly, many patients may simply prefer spiritual issues to be dealt with only within the context of their faith setting. They want spiritual sustenance but prefer to receive it from their religious heads and through prayer and ritual, which they are familiar with. Secondly, people may find it difficult to examine and confront their inner issues. They may fear that those issues will be uncomfortable or even shaming. Thirdly, some people are afraid that if they address their spiritual issues, the tentative relatedness they feel to the sacred

may be lost. For them their sense of the sacred may be negligible, but helpful (Kliewer & Saultz, 2017).

In addition to the barriers identified above, the relationship between spirituality and religion also need to be elucidated. Religion is a set of practices, rituals and beliefs connected to the Divine (Carson & Koenig, 2010). These practices and beliefs are always highly regarded and are thus thought of as being holy. Religion may also involve beliefs about spirits, angels, demons, or other supernatural powers that are present outside the natural world, yet are thought to interact with it (Koenig, 2011). Religions normally have creeds about life after death and instructions to conduct behaviour during the contemporary life to prepare for the life to come. Religion also provides guidance on how to live within a social group in order to maintain harmony and cooperation, while reducing conflict and harm to self or others. It is usually organized and practiced within a community made up of those who seek to adhere to the doctrines of a particular faith tradition and is often organized and maintained as an institution. It has been argued that spirituality, rather than religion, is viewed more clearly and individually (Koenig, 2011). Spirituality is seen as a comprehensive word that people can define for themselves, which carries a minute fragment of the baggage (authority, divisions, rules and responsibility) associated with structured religion (Carrette, 2018). Spirituality is the principal part of a person's existence and is usually intellectualized as an ''upper'' experience or a wholeness of the self. Frequently these encounters include the feeling of an intimate connection to a sovereign God. Spirituality also consists of thoughts and feelings that give purpose and definition to the human passage of life. Spirituality is also known and felt in relationships (Burkhard & Nagai-Jacobson, 2015). Relationships with other people have been described as a parallel aspect of spirituality that crisis-crosses with a vertical relationship with the creator of the universe (Stoll, 1989). Cognizance needs to be taken of the belief systems of patients and how they have logged into their inner spiritual assets and

resources previously, in order to understand how these assets can benefit or improve their health. Eric et al. (2016) and Clarke (2009) agreed that spirituality is an individual exploration that gives a sense of importance and purpose to life that may or may not be related to religion. However, various authors speculate that spirituality and religion are intertwined and interchangeable (Thornton, 2016; Rieg, Mason & Preston, 2016; Eric et al., 2016; Penman, 2012). Conversely, spirituality is seen by others as a larger concept that surpasses religion and ethnicity (D'Souza, 2016; Lubbe, 2012).

Thus, spirituality involves our respective faiths and beliefs about our habitation in this planet, and our search for meaning in our lives. Religion, on the other hand, might be compared to a container or rite that can be used to show and focus these beliefs (Ojink, 2010). Tokpah (2010) upholds that variation exists between the two paradigms and says that spirituality rather than religion is the right emphasis for the spiritual dimension of the nursing concept. Maier-Lorentz (2014), Barlow (2011) and Sloma (2011) agreed on this variation and all read spirituality to mean a universal theory that entails a relationship with a God, but which doesn't need faith that is religious. Notwithstanding these variations, Deal (2010) and Barlow (2011) commented that the usage of religious possessions provides patients and relatives the strength to cope during turbulent times.

1.3 Spirituality in the nursing curriculum

Healthcare practitioners, of whom nurses are included, must play a prominent role in working hand in hand with the family and chaplain to meet the spiritual needs of patients. Baldacchino asserts that models of all-inclusive care are inadequate as the spiritual measures are frequently ignored by professional workers in the healthcare field (Baldacchino, 2015). Baldacchino further argues that this could be due to feelings of inadequacy as a result of the absence of inter-professional education (IPE), work burden, cultural dissimilarities,

inadequate time, lack of devotion to individual spirituality, the deficiency of education on spiritual care, ethical issues and reluctance to render spiritual care (Baldacchino, 2015).

As nursing students are trained and nurse educators/nurse clinicians are retrained, the aspect of spirituality in the nursing curriculum needs to be considered. Rogers and Love (2012) highlighted that the role of spirituality in curriculum and pedagogy is important and nurse academics need to be aware of the importance of education about spiritual care and to take charge in the teaching of spiritual care in nursing as a field of study. Nevertheless, nurse educators have always observed this new dimension as Herculean to evaluate, thus they pay minimal attention to this area of information (Barnum, 2011). The challenge with concentrating only on intellectual and psychomotor skills is that this yields nurses who may have advanced practical skills, but who do not have a compassionate approach to care. Hence, nurse educators are required to organize students to fully understand the importance of spiritual care and how it aids the nurse-patient relationship. The curriculum of nurses must be developed in a manner that enables students to understand spirituality in a wide context that transcends beyond religious beliefs (Wallace et al., 2017).

Sawatzky and Pesut (2015) also emphasized that paying consideration to the spiritual aspect of health has received substantial acknowledgement in nursing practice in the last twenty years. Progressively, nurses have come to the realization that spiritual deliberations cannot be overlooked when implementing a complete view of the person as the basis of nursing practice. However, spirituality is a concept that is not always clearly understood or accurately measured. Inadvertently, nurses who work in the clinical settings are expected to respond to the spiritual needs of their patients daily, as ignoring these needs may shift them away from getting treated within the customary system of healthcare. The spiritual aspect of holistic nurse caring is lacking within the nursing curriculum and training. However, holistic nursing care needs devotion to the spiritual dimensions of the individual (Shores, 2010) and there is a

need to facilitate students' knowledge about the importance of spirituality to allow the implementation of nursing care system that is holistic. (Baldacchino, 2014b). Holistic nursing care takes into account the well-being of the individual, the family, the community and the population. At the level of individual well-being, the nurse considers biological, psychological, social and spiritual factors. At the family and community levels, the nurse considers individual factors level on a wider scale, bearing in mind that individuals make up the family and the community, but that there are individual differences in perceptions, knowledge and behaviour. However, spiritual factors are not well understood by nursing students, as nursing faculty and students are always reluctant to broach the topic of spirituality, either because it is unknown to students, or because students believe that the provision of spiritual care is beyond their capabilities (Yuan & Porr, 2014). Emerging research highlights the importance of spiritual care in nursing and suggests that there is scope for improving this dimension of care in order to improve the quality of life for patients. However, there is very little evidence about how nurses respond to the spiritual needs of their patients and they are frequently confused about what spiritual care entails (Narayanasamy & Owens, 2015, Narayanasamy et al., 2017).

In the last decade there has been renewed emphasis on spiritual nursing care and a growing conviction that there is a need for nurses to implement a caring-healing model in order to move beyond the current paradigm of high-technology cure, in order to implement a spiritual nursing care focus (Taylor, 2012). In order to meet the holistic needs of patients and to help them make sense of their situations, spiritual nursing care-giving needs to be viewed as essential social, emotional and physical care interventions (Koslander & Arvidsson, 2018). Although the literature asserts that spiritual nurse caring is a worthy and vital component of quality, holistic nursing care for patients suffering from both acute and chronic ailments (McEwen, 2014), this is not strongly reflected in the nursing curricula. The need to

incorporate spiritual care into the teaching, learning and practice of nursing care is vital if holistic care is to be more effectively achieved. The World Health Organization defined health as ‘a state of total mental, social and physical well-being and not just the lack of infirmity’ (WHO, 2018). Ever since, this explanation has been under scrutiny regarding whether or not the spiritual aspect should be added to it (Blok, 2017). Other advancements in the World Health Organization states that spirituality as a factor is connected to a person’s well-being and that palliative caring encompasses the spiritual facets of patient care (WHO, 2018). Spiritual nursing care as a concept is deeply rooted in the history of the nursing practice, but many professional nurses find the integration of the concept into practice difficult to achieve. According to Dudhwala (2016), nurses are daily facing challenges about the place of religion in healthcare. Vexed questions for nurses are whether spirituality is part of a patient’s make-up, and what role nurses play in the delivery of spiritual care. There is also the question of whether the hospital, as a social institution, should ignore spirituality; thus nurses find it difficult to deal with their patients’ religious needs. However, with adequate educational preparation, they could acquire the necessary knowledge, skills and competence to enable them to function in the culturally diverse and multi-faith societies that they find themselves working in. Furthermore, nurses will be able to focus on patient needs and expectations in relation to patients’ beliefs and values, and this will strengthen the important principle of patient-centered care.

1.3.1 The Patient Cantered Model: Homely approach to spiritual care

The term ‘‘patient-centeredness’’ means the pattern of doctor–patient meeting categorized by sensitivity to the patient’s preferences and needs, using the patient’s conscious wishes to directing, communicating and giving of information, as well as joint decision-making (Rogers & Love, 2012). This is regarded as a method of viewing illness and health, which encompasses the individual’s complete health; in an effort to empower the patient by

expanding his or her task in their respective healthcare. It is vital to ensure that the patient is well informed and that reassurance, support, comfort, acceptance, legitimacy and confidence, which are the basic functions of patient-centered care (PCC), are provided (Fulford et al., 2010). The impression of the objectives of patient-centered care has a direct connection with improving healing while reducing injury and suffering (Nelson & Gordon, 2015). The fundamental philosophy of patient-centered care is that the carer needs to see the patient as an individual rather than as a mass of diseases (Epstein et al. 2014). PCC gives care to the patient through an array of activities including consideration of the patient's beliefs and values, engaging the patient, showing sympathy and meeting the physical and emotional needs of the patient (McCormack & McCance, 2010). Working with patients' beliefs and values validates one of the important principles of PCC. This is closely knitted to joint decision-making and facilitating patient participation through giving information and integrating newly formed views into care activities. PCC adopts the view that patients are capable of making decisions about their needs and expectations. The basis for the establishment of patient-centered care is to educate patients about appropriate health advice so that they can make well-rounded decisions. Coulter (2008) defines patient-centered care as ''…health care that meets and responds to patients' wants, needs and preferences and where patients are autonomous and able to decide for themselves." In the literature review, the basic characteristics of PCC were identified as the personalization of patient care and the participation of patients in their care through information and a joint decision-making process (Robinson et al., 2008). Acknowledging and valuing each patient's perception of what is happening to them, is considered to be a vital objective of patient-centered care. The importance of the patient-centered health professional is to be present, giving personal support and practical expertise, expediting the process of the patient and following the way of their own choosing as they deem fit. (McCormack & McCance, 2010). Either overtly or

implicitly, PCC is referred to as meeting the patient's needs in health care (Lutz & Bowers, 2010).

1.3.1.1 Models of patient-centered care

The creation of the concept of patient-centeredness comes from the recognition of the restrictions of the conventional biomedical model, where illnesses are assumed to mean the presence of disease processes (Mead & Bower, 2011). Patient-centered care includes the patient in all areas of their care. This approach moves away from medical practice with decreased communication towards open communication (Shaller, 2010). The idea of PCC makes the patient the focal point of the healthcare system and recognizes the patient as a complete person with social, physical and psychological needs (Flarey, 2010; Pence, 2012). Considering the patient as a whole person and caring with respect is seen as a basic aspect of PCC. Patient-centered care is viewed through two approaches, namely the systems model and the process model.

The systems model consists of a pyramid of constructs that makes a patient-centered environment possible. This is considered to be central to the PCC structure (Robinson, 2008). Emphasis is given to meeting personal patient care needs by bring together staff and services around the needs of the patient (Coulter, 2008; Ponte et al., 2008; Flarey, 2010; Shaller, 2010).

The process model is an approach that deliberately adopts the patient's views. This consists of seven dimensions (Gerteis et al., 2009). It describes a number of activities, including consideration of the patient's beliefs, values and expressed needs, co-ordinating and integrating the care, informing, communicating with and educating the patient on treatment and care, providing physical comfort and emotional support, involving patients and families in decision-making, and ensuring transition and continuity of patient care. Essentially the

systems model lays emphasis on the creation of a patient-centered environment in order to successfully incorporate PCC into the healthcare system; while the process model describes a range of activities essential for patient-centered care (Brown et al., 2012).

Benefits of the patient-centered care model includes placing the patient at the middle of the care delivery and redirecting activities so that the right work is done effectively by the right person at the appropriate time (Pence, 2012). The literature specifies that patient-centered care advances the stability of care and incorporation of health professionals collaborating on behalf of their patients, by reducing the movement of patients via the hospital, providing autonomy to patients and empowering staff members to plan and execute their work in ways that are most responsive to patient needs (Frisch, et al., 2000; Robinson, 2008; Lathrop, et al., 2012). PCC is also known to respond accurately to each patient's needs, wants and preferences (Institute of Medicine, 2016). It affords patients abundant opportunities to be informed and involved in their own care decision-making, thus giving them a sense of importance. Additionally, patient-centered care provides a more holistic care, improves communication skills between relatives, patients and healthcare providers, modifies emphasis from body care to complete care, ensures a team approach, and promotes reflection, learning, allocation of skills and abilities among health professionals (Ellis, et al. 2013).

Pelzang (2010) states that the literature specifies that one of the most important jobs of the health professional in giving PCC is to place the patient in the appropriate environment to ensure adequate recovery. The capability to care for the patient is considered the core of optimal healthcare practice in patient-centered care (Kitson, 2010). The main activities through which this can be achieved are determining, planning and efficiently prioritizing the care required by the patient and family (Broom, 2010). The ability to concentrate on important trials, circumstances or situations affecting the patient is another important skill

that allows the health professional to deliver personalized care in a timely and effective fashion.

1.4 Intervention Mapping Strategy

Intervention Mapping (Bartholomew et al., 2011; 2016; 2017) is a framework for developing and transparently reporting the rationale and content of theory and evidence-based health promotion programmes. The framework is well-matched for creating intricate, multi-level interpolations to enhance health, by changing health activities and environmental conditions, which can be social or physical services and policy. The science of psychological change and the use of behaviour change techniques (Michie et al., 2013) are vital in this process, but intervention developers are skilled at looking far above ordinary meanings of Behaviour Change Techniques (BCTs) while paying attention to details on what theories and evidence they think are the requirements under which the BCTs are likely to be effective (Peters, de Bruin & Crutzen, 2015).

Intervention Mapping combines the design of complex interventions with comprehensive content control on each of these key steps, to take advantage of the possibility that the intervention is realistic, acceptable, effective and justifiable. Intervention mapping has been found to be useful and effective in the development of various important public health programmes, namely HIV/AIDS (Leerlooijer et al., 2014; Wilson et al., 2014) and has also been used effectively in drug abuse studies (Dupont, Lemmens, Adriana, van de Mheen & de Vries, 2015). Although intervention mapping was not found by the researcher in any literature related to curriculum development, the researcher is of the opinion that the processes involved in intervention mapping could be adapted to provide evidence for curriculum development. Intervention mapping helps in building quality interventions that are systematically planned and based on theory and evidence (Bartholomew et al., 2011). It

takes cognizance of the end users and those involved in the implementation of the emergent model, which in this case are the educators and students.

Intervention Mapping Strategy is solely dependent on three factors, namely the ecological approach, active stakeholder participation and the use of theories and evidence. The ecological approach recognizes and constructs the factors within the socio-physical community that might affect the problem realized. This is the absence of considering spirituality in holistic care. The inter-relationship between the individual and his/her environment is noted, as changes in the environment could affect an individual's behaviour. In this case, how educators and students practice and perceive spirituality may influence how they practice it in the nursing environment. An unbiased involvement of stakeholders is seen as mandatory since it ensures that the focus is on challenges identified among the participants as a group (Kreuter, De Rosa, Howze & Baldwin, 2011). Uniting the key stakeholders in the current study, such as nurse educators, nurse clinicians and nursing students, is important when attempting an amendment that affects them. In addition, the use of various theories to solve a problem helps researchers to understand spiritual care as a vital piece of holistic care in nursing (Glanz, Rimer & Viswanath, 2015) and increases the success rate of executing such a planned programme (Kok, Schaalma, Ruiter, Van Empelen & Brug, 2014). Certainly, theories are likely to influence behaviour change and increase the prospect of sustaining behaviour change (Ellis, Speroff, Dittus, Brown, Pichert & Elasy, 2013). The Intervention Mapping Strategy consists of six interrelated steps, namely:

1. The assessment of needs, based on the model
2. The definition of performance and change objectives depending on scientific analyses of health problems and problem causing factors

3. The selection of theory-based intervention methods and practical applications to change health-related behaviour
4. The production of programme components and design
5. The anticipation of programme adoption, implementation and sustainability
6. The processes of anticipation and evaluation

Although Intervention Mapping is presented as a series of steps, the authors see the planning process as iterative rather than linear. Bartholomew et al (2016) state that programme planners move back and forth between tasks and steps. The process is also cumulative: each step is based on previous steps and inattention to a particular step may lead to mistakes and inadequate decisions.

Intervention Mapping guarantees that theoretical models and suggestive evidence guide planners in two areas: (1) the identification of behavioural and environmental determinants related to a target problem, and (2) the selection of the most appropriate theoretical methods and practical applications to address the identified determinants. Although Intervention Mapping is considered a useful approach to design programmes, it is also a complicated and time-wasting process, replicating the effort of changing health behaviours. Intervention Mapping has been described as cumbersome, complicated, intricate, costly and time-consuming (Côté, Godin, Garcia, Gagnon & Rouleau, 2014). Remarkably, despite these censures, the same authors also conclude that Intervention Mapping has helped to bring the development of interventions to a greater level, indicating that the advantages of using the strategy far outweigh the disadvantages. Intervention Mapping has been found useful in the health promotion field but can easily be applied to other fields (Kok, Lo, Peters & Ruiter, 2011). The objective of the initial step was to carry out a needs-based assessment to ascertain how much of the concept of spirituality is clearly understood within the context of holistic care in nursing as one of the cardinal points of holistic care within the curriculum (Epstein et

al., 2014). This step was thus used to explore objective one of the study as stated: ‘‘To describe the extent to which nurse educators, nurse clinicians and nursing students understand the concept of spiritual care within the context of holistic nursing care’.’ The second step of IM was to explain, as directly as possible, what should be modified in the target group and the environment, once a concept for the amalgamation of spiritual care into the nursing curriculum in Nigeria has been created. The objectives of the model would be for nursing service delivery to be truly holistic in nature and for the nurse educators, nurse clinicians and nursing students to acquire adequate knowledge and skill with tested competence, to teach and administer spiritual care with boldness and self-confidence. The objective of the third step is to examine theoretical procedures to cause changes in the behaviour of the nurse educators, nurse clinicians and nursing students in order to guide all stakeholders in developing a model for the assimilation of spiritual care into the nursing curriculum in Nigeria; and to change organizational and societal factors in the environment so that these individuals will acquire the necessary competence to teach their nursing students and provide spiritual care to the clients/patients:

1. Theoretical and empirical literatures have been reviewed for theory-based methods. Techniques have their roots in behavioural and social science philosophies and are general processes for influencing changes in the determination of environmental conditions and behaviour (te Velde et al., 2012). The theories explored included bio-psycho-social-spiritual theories by Engel (1977), modified extended bio-psycho-social-spiritual care by Hefti (2011), the patient-centered care model, inter-professional theories and the middle-range theory of spiritual well-being in illness model developed from O’Brien and Watson’s theory of the Human Caring Model. For example, in trying to reach the change objective when the participants expressed the relevance of spiritual care to meet the holistic care of their patients, Hefti (2011)

further expressed the view that this approach did not typically inform nursing practice, that it had not been taught in the course of training and that since the knowledge had not been acquired; it was to be expected that no-one would practise what they did not know. As a result, the competence to teach and practise spiritual care was neither accessible nor present.

2. Direct exploratory descriptive overt observation through field trips, individual interviews, inspection of lecture notes of both the nurse educators and nursing students was used. Recording sheets and checklists were also used to collect the data and these included observation guides. For the selection and documentation of these methods, content analysis of the curriculum document was done in relation to spiritual care in nursing. Discourse, conversation and multimodal means were adopted with the nursing students, educators, and clinicians on the matter of inclusion/integration of spiritual care into the nursing curriculum in Nigeria.

3. The preferred techniques were deciphered into practical applications. In Step Four of the intervention mapping i.e. producing programme components and materials, chosen presentations of Step Three were united into a programme and used to develop working documents to guide the model production (Verbestel et al., 2011). The researcher then used a qualitative exploratory design by means of a Delphi method. The components of the model for integrating spiritual care into the Nigerian nursing curriculum were developed with a committee of experts. In Step Five, which is the implementation plan, Bartholomew et al. (2011) identified a few steps as identifying adopters and implementers of the programme: re-evaluating of the planning group to ensure representation of potential programme adopters, specifying the contributing factor of programme adoption, application and maintenance, creating a medium of change objectives for programme adoption and mapping out interventions for

programme use, execution and maintenance. A qualitative design was chosen where a focus group was adopted for this step of the intervention mapping. A team of experts and individuals with experience in nursing affairs and curriculum development was constituted. The team was convened in a forum called a linkage group, which met on three occasions, but also communicated through phone calls, text messaging and emails on a regular basis. The team offered consultation on the frequency of programme implementation, the choosing of suitable learning materials, and training opportunities for nurse educators on spiritual care. These included the required competencies for the nurse educators, nurse clinicians and nursing students, which would guarantee self-confidence in the teaching and provision of spiritual care in nursing education and practice. The team concluded their assignment by designing a model for the integration of spiritual care into the nursing curriculum after agreeing that spiritual care in nursing must be accommodated in the current nursing curriculum for now. However, in the near future, it should be a certificate course, post basic training, which all professional nurses must undergo, which should carry its own credit load (minimum of two credit points). This would be compulsory for all nursing students and should constitute a clinical course with practicum hours attached to it.

1.5 Statement of Problem

Nursing education and practice embraces holistic care as the best form of care for the patient. If this is to be achieved effectively, nursing education needs to address patient care in all dimensions of the person and should thus include systematic teaching and supervision of students to prepare them to assist patients spiritually as part of holistic care. However, few role models for spiritual care are seen in clinical practice and limited research identifies the competencies students may need, or how teachers can best facilitate this process (Cone & Giske, 2013).

In accordance with Meyer's health review (2017), the Joint Commission on Accreditation of Healthcare Organization (JCAHO) requires that nurses carry out a spiritual evaluation and provide adequate spiritual care to all their patients. According to the Joint Commission on Accreditation of Healthcare Organization (2018), a spiritual evaluation should be, at least, to find out the patient's church denomination, beliefs and what ritual relating to spirituality are important to the patient. This information would go a long way to assist in quantifying the effect of spirituality, if relevant, on the care/services being provided and would indicate if any further evaluation was required. The criteria required organizations to create valuable contents and scopes of spiritual and other assessments and the qualifications and suitability of the individual(s) performing the evaluation.

The need for inclusion of spiritual care into the teaching, learning and practice of nursing care is very vital if holistic care is to be achieved with better outcome. Since the introduction of the World Health Organization definition of health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO, 1992, 2018), the definition has been under debates as to whether the spiritual domain should be added to it (Blok, 2004). Other advancements within WHO indicate that spirituality is indeed a health-related factor and that palliative care encompasses the spiritual aspects of patient care (WHO, 2017). A search of Nigerian-based literature showed that not much has been done in the field of spiritual care in nursing in Nigeria, nobody is even talking about it, whether the nurse educators are teaching it or not is not known and the way clinicians are handling spiritual care is still shaky. It is uncertain if the nurse educators who should teach the nursing students have the knowledge of spiritual care in nursing or/and competent to teach it or knows what spiritual care in nursing is all about or if there is any barrier preventing teaching-learning process and delivery of spiritual care. If the nurse educators or nurse clinicians are not talking about spirituality then people need to raise questions about it

and yet, patients' impression of illness and underpinning health beliefs is that illness is believed to have its origin in a primary supernatural cause and needs spiritual solutions (Iyalomhe & Iyalomhe 2012). If this aspect is not properly met, there is a tendency for people to seek for the spiritual component outside the health care system which may lead to under-utilisation of modern health care and its resultant effect on chronic disease. The researcher has worked in different institutions of higher learning (both private and public) as a lecturer in the department of nursing, holding various nursing positions and most importantly, the researcher was privileged to work at various levels in curriculum committee to design the curriculum for teaching nursing students both at diploma and undergraduate level. While working as a committee member, a review of the curriculum showed that there is little or no integration of spiritual care into nursing curriculum consequently affecting the practice of spiritual care in nursing which is an integral part of holistic care in nursing practice. This study thus attempted to maximize the level at which nurse educators, nurse clinicians and nursing students easily assimilate the concept of spiritual care within the context of holistic nursing care. In addition, this study attempted to develop a model for the integration of spiritual care, which would be a useful guide for the teaching, learning and practice of spiritual care in nursing.

1.6 Purpose of Study

The main reason for this study was to develop a model for the integration of spiritual care into the nursing education curricula in Nigeria.

1.7 Specific objectives

Specific objectives of the study were to:

1. Determine the extent to which nursing students, nurse educators and nurse clinicians fully understand the concept of spiritual care within the context of holistic nursing care.

2. Establish the competencies required by the nurses for teaching and carrying out spiritual nursing care.
3. Compare the required competencies with the available spiritual care competencies, if any, that exists within the content of the nursing curriculum in Nigeria.
4. Develop a model for integrating spiritual care into the nursing education curriculum in Nigeria.

1.8 Research questions

1. To what extent do the nursing students, nurse educators and nurse clinicians understand the rubrics of spiritual care within the context of holistic nursing care?
2. What are the competencies required for teaching and carrying out spiritual nursing care?
3. Is there any difference between the required competencies and the available spiritual care proficiencies that exist within the context of the nursing curriculum in Nigeria?
4. What model will be required for integration of spiritual care into the Nigerian nursing curriculum?

1.9 Significance of Study

This researcher developed a model to integrate spiritual care into the curriculum of nursing in Nigeria in order to raise awareness and guide the Nursing and Midwifery Council of Nigeria (N.& M.C.N.) in their efforts to advance the necessary knowledge, skills and competence of nurse educators, nurse clinicians and nursing students for providing spiritual care. A compulsory course on spiritual care will help the nursing students in their systematic inquiry into, and understanding of, spirituality and spiritual care. If the model is fully implemented, it will allow students to develop an understanding of spirituality in a wider perspective that goes beyond religious beliefs. The study will also help to build up a knowledge base that will equip nurses to understand the particular spiritual and religious needs of the clients.

Furthermore, nurses will be prepared to provide spiritual care and it will be an added advantage to patients to be cared for by a nurse who is knowledgeable about the spiritual dimensions of care in order to appropriately practice holistic care. The study will also highlight a more comprehensive understanding of spiritual nursing care and assimilate spiritual nursing care without reducing the mental, social and physical care practiced today. The study will further identify the essential proficiencies required for the unswerving provision of spiritual nursing care to patients.

The model will contribute considerably to the current literature and the body of knowledge of professional nursing organizations such as the National Association of Nigeria Nurses and Midwives (NANNM), NANDA-I Nigeria Chapter, the Nursing and Midwifery Council of Nigeria. These organizations will begin to emphasize the need for nurses to give attention to the spiritual needs of their clients and systematic attention will be paid to spiritual aspects of patient functioning in the nursing process. Spirituality is characterized by its multidimensionality; hence, the study assists in the process of bringing together everyone important in the delivery of spiritual care, including religious and community leaders. Nurses' skills will be improved for better service delivery, they will be better trained or retrained to meet their day-to-day demands of spiritual care in nursing, and the nursing profession will promote the provision of spiritual care to patients and families as a fundamental nursing skill. In addition, scientific knowledge in nursing practice will be advanced.

1.10 Definition of terms

Care: The word 'care' denotes providing nurture to a person, either client or patient, to make the best use of all one's personal and spiritual resources when facing challenges, or to provide careful or serious attention, protection or supervisory control (Collins English Dictionary, 2016).

Clinician: A clinician is qualified personnel (such as a doctor or nurse) who work directly with patients rather than in a laboratory or as a researcher (Merriam-Webster, 2018). Nurse clinician is a registered nurse who has well-developed competencies in implementing direct and indirect nursing care and articulating nursing therapies with other planned therapies. In this study, nurse clinicians are nurses working in the selected hospital at the time of the study.

Curriculum: This is a planned interaction of pupils with instructional content, materials, resources and processes for evaluating the attainment of educational objectives or the totality of student experiences that occur in the educational process, or a planned sequence of instruction; or to view the student's experiences in terms of the educator's or school's instructional goals (Braslavsky, 2003; Kelly, 2009).

Holistic care: Freshwater and Maslin-Prothero (2016) acknowledged everything encompassing an individual's socio-physical and mental conditions, not physical symptoms alone, in the effective management of illness to the point of eradication. According to this study, holistic care signifies caring for, or paying attention to, the physical, mental and spiritual needs of patients, whilst placing special importance on spiritual nursing care needs.

Integration: To add and implement the concept of spiritual care in nursing to the study packages of the nursing students, i.e. the curriculum. Integration also connotes to complete by joining of parts. It includes making a whole or combining parts into a whole (The Concise Oxford Dictionary, 2017). It means putting different parts, activities, programmes, plans and services together to form a whole. Integration is aimed at bringing together a collection of different and separate units and programmes, which previously tended to pursue their own objectives, into a cohesive and unified structure (Monekoso, 1994). Based on this context, the term ''integration'' means to incorporate spiritual nursing care into holistic nursing care.

Model: Freshwater and Maslin-Prothero (2016) define a model as a simplified representation of a phenomenon. A model is the manner in which a scientist or researcher views and

presents his or her material within a certain hypothesis (Polit, Beck & Hungler, 2015). According to Polit and Beck (2012), a model is often used in conjunction with symbolic representations of some aspect of reality. A physical or figurative expression of a theory or conceptual framework helps to visualize intellectual ideas in a simple and readily understandable form. Other authors see it as a symbolic representation of theories or variables, and the interrelationships that exist among them (De Vos, Strydom, Fouche & Delport, 2011; Polit & Beck, 2012). For the purpose of this study, a model refers to a diagrammatic representation of the themes, categories and the defining attributes, which integrate spiritual nursing care.

Nurse: A nurse is an individual specially trained and registered to deliver care to both well and ailing individuals, as well as their families and their various communities. Only those whose names appear on the register conserved by the Nursing and Midwifery Council are legally entitled to be called nurses (Freshwater & Maslin-Prothero, 2016). In this study, ‘‘nurse’’ refers to a nurse registered with the Nursing and Midwifery Council of Nigeria who provides care to patients in the wards of a public or registered private hospital.

Nurse Educator: According to the Nursing and Midwifery Council of Nigeria (N&MCN), a nurse educator is a nurse who is registered with the N.& M.C.N. as a nurse educator (NMCN, 2018). For the purpose of this research, a nurse educator includes nurse lecturer or nurse tutor who teach both in the classroom and the demonstration laboratory and accompany the students for clinical practice during their clinical placement. Therefore, lecturer, nurse tutor and nurse educator will be used interchangeably in this study.

Nursing: Nursing can be seen as the responsibility of nurses to assist individuals, sick or well, in carrying out those activities contributing to their health or recovery (or to a peaceful death), that they would perform unaided if they had the necessary strength, capacity or

knowledge. Central to this definition is the nurse's role in assisting patients to achieve their total health potential and spiritual well-being.

Nursing care: Nursing care refers to all activities performed by nurses to help the patient, which involve observing, diagnosing, treating, evaluating, counselling and serving as an advocate for the patient (Freshwater & Maslin- Prothero, 2016).

Spiritual: The Concise Oxford Dictionary (2018) defines spirituality as being of the spirit as opposed to matter, or of the soul proceeding from God, holy, divine and inspired. Spiritual care practices are those actions that are meant to promote spiritual well-being, coping, growth or relationships (Taylor, Amenta & Highfield, 2017).

Spiritual Nursing Care: Spiritual nursing care involves activities that promote a healthy balance between the biological, psychological, social and spiritual aspects of the individual, thus upholding a sense of wholeness and well-being (Taylor, 2012). Applied to this study, spiritual nursing care embraces activities which will provide both nurses and patients with spiritual coping strategies to rise above the present situation, discover meaning and purpose, and experience a relationship with God, self, other human beings and the external environment.

1.11. Overview of the thesis

The thesis has been organized into eight chapters as:

Chapter One: This chapter gives background information about spirituality and spiritual nursing, statement of problem, purpose of the study, specific objectives, research questions and significance of study in developing a model to fully integrate spiritual care into nursing curriculum in Nigeria.

Chapter Two consists of a literature review and theoretical background, which includes a concept of spiritual care together with spirituality in nursing, historical background of spiritual care, theories of spiritual care in nursing, assessment of spiritual care, spiritual

competence, intervention models, educating on strategies of spirituality and spiritual care in nursing education.

Chapter Three is an overview of the research design, which the researcher applied and discussed. The study used an Intervention Mapping (IM) strategy, which incorporated its steps into the two phases adopted for the study.

Chapter Four: This chapter presents the quantitative data that were generated and analysed. The opinion of nurses on the idea of spirituality in nursing practice and competencies required for teaching and practising spiritual care in nursing are analysed and discussed.

Chapter Five focuses onqualitative information that were generated and examined as presented in this chapter. The findings from the data are also discussed.

Chapter Six: This chapter presents experts' review using Delphi technique in both Rounds One and Two. Findings from the Delphi study are discussed.

Chapter Seven focuses on adoption and implementation plan of action. The findings from the expert committee leads to a proposal presented to the expert committee for their deliberation, amendment and adoption for implementation with their resolutions.

Chapter Eight presents a summary, conclusion, scope, limitations of the study, recommendations and implications of the study to nursing development.

1.12. Conclusion

This chapter presented the general background of the study, spiritual care as part of holistic care, religion versus spirituality, spirituality in the nursing curriculum, the patient - centred model, intervention mapping strategy, statement of problem, the purpose of the study, research questions, significance of study and definition of terms. It also gave a brief overview of the objectives of the study.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL BACKGROUND

'Finding spiritual meaning (in a chronic illness) is welcoming my lungs into the wholeness of my individual. My lungs are not 'the other|,' but all is part of the whole. Spiritual meaning is about accepting and loving myself as a whole individual. It's honouring the self and body. Life is a journey'. Mary, living with pulmonary hypertension

2.0 INTRODUCTION

A literature review is a text of scholarly papers, which include current knowledge including substantive findings, as well as theoretical and methodological contributions to a particular topic that follows a sequence of events (Burns & Grove, 2013). The process defines what is already known about the topic and the policies used. It forms the basis of comparison that serves to support and inform the study (Burns & Grove, 2013). The literature review is a summary of the research on a topic of interest, often focused on putting a research problem into writing, thereby qualifying the researcher to constructively criticize previous research (de Vos, Strydom, Fouche & Delport, 2011). This chapter presents the relevant conceptual and empirical review of literature on spirituality and spiritual care, as related to nursing education and nursing practice, as well as the theoretical framework for the study.

2.1 HISTORICAL PERSPECTIVE OF SPIRITUAL CARE

The International Council of Nurses (2018) defines nursing as follows:

'Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well, and in all settings. Nursing includes the promotion of health, prevention of illness and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy, in-patient and health systems management and education are also key nursing roles'.

This definition emphasizes the importance of nurses working collaboratively with the individual to establish the needs of the patient. The definition underlines and reinforces the importance of nursing, adopting the holistic and patient-centered care approach that is at the heart of the American Holistic Nurses Association mission statement (2018).

Florence Nightingale considered that ‘‘the sick body...is something more than a reservoir for storing medicines’’ (Kramer, 2016). This sentiment is still evident in the Royal College of Nursing’s most recent definition of nursing, where nursing is defined in terms of its key functions. These are concerned with promoting, improving and maintaining health and healing, helping people to cope with health problems, in order to achieve the best possible quality of life (Medeiros, Enders & Lira, 2015).

Literature in the early 1950s presented a definition of nursing that incorporates the concept of the patient's spiritual nature, as well as the self-sacrificing occupation of the nurse. Florence Nightingale defined nursing as neither pure science nor true art, but as a combination of both. ‘Nursing, as a profession, will embrace more than an art and a science; it will be a blending of three factors: of art and science, and the spirit of unselfish devotion to a cause primarily concerned with helping those who are physically, mentally or spiritually ill’ (Price, 1954).

Price finally described nursing as ‘‘a service to the individual which helps him to regain, or to keep, a normal state of body and mind; when it cannot accomplish this, it helps him gain relief from physical pain, mental anxiety or spiritual discomfort’ (Price, 1954). Even though this was written about 25 to 30 years before the general approval of the term ‘holistic nursing’. Nightingale envisioned the professional nurse's role to clearly include paying regular responsiveness to the needs of a patient's spirit, as well as the needs of the body and the mind. In their book ‘*Introduction to Nursing*’, written some 40 years ago, after the publication of Price's 1954 text; co-authors Lindberg, Hunter and Kruszewski (2012) argue that, because of the incessant development of the profession, no single

definition of nursing can be acknowledged. The authors present citations of nursing definitions articulated by a team of theorists from Florence Nightingale in 1859 to Martha Rogers in 1970, suggesting that every practicing nurse should create a definition of his or her own. Lindberg and colleagues did, however, make known the hope that, irrespective of one's definition, it will include an emphasis on caring or nurturing as a motivational factor for choosing nursing as a career. Following the suggestions of Price in 1954 and Lindberg, Hunter, and Kruszewski in 2012, a modern working definition of nursing is articulated as follows:

> "Nursing is a sacred ministry of healthcare or health promotion provided to persons both sick and well, who require caregiving, support or education to assist them in achieving, regaining or maintaining a state of wholeness; including wellness of body, mind and spirit. The nurse also serves those in need of comfort and care to strengthen them in coping with the trajectory of a chronic or terminal illness, or with experiencing the dying process."

When we examine nursing education and practice in Nigeria, then the question that should be posed is 'does it really conform to this definition?'

2.2 SPIRITUALITY AND SPIRITUAL CARE IN NURSING PRACTICE

Philosophically, attention to a patient's spirituality is part of holistic nursing practice (McSherry, 2011; O'Brien, 2017; Popoola, 2015). Holism assumes ''that a person is more than the sum of many parts and differs from holism which suggests that persons are a collective of their subsystems or the whole of their component parts'' (Delgado, 2015). Unlike the logical-positivism of science, spirituality is viewed as a metaphysical concept that defies a clear definition (Delgado, 2015; Dyson, Cobb, & Forman, 2012; Koenig, 2012; Miller & Thoresen, 2011). In trying to find clarity in understanding the meaning of spirituality, we see that spirituality is primarily viewed as a metaphysical yet human

phenomenon within the intricacies of mind-body-spirit dualism (Dyson, Cobb, & Forman, 2012; Thoresen & Harris, 2017). Furthermore, the concept of spirituality can be evaluated from an eschatological versus humanistic paradigm. The eschatological aspect of spirituality refers to the sacredness or theistic meaning of life (Miller & Thoresen, 2011). The humanistic aspect of spirituality can be described through art, poetry, self-concept ideals, or relationships with other people (Dyson, Cobb, & Forman, 2012). For others, spirituality can be seen as an intersection between the sacred and the secular fields of humanism (Dyson, Cobb, & Forman, 2012). Nevertheless, spirituality is a source of coping in finding importance and tenacity in one's life. The discourse on the concept of spirituality is broad. According to Ellison (2017), the significance of spirituality may be subjective in nature, affirming religious, social and psychological attributes, and can be described as either intrinsic or extrinsic. As conceptualized by Ellison (2017), intrinsic spirituality is the individual's framework of meaning and purpose regarding life's challenges. Extrinsic spirituality is based on religious rituals and practices such as attending church, prayer, meditation or performing works of charity (Ellison, 2017). Nurse researchers Dyson, Cobb, and Forman (2012) did a meta-analysis of the literature exploring the concept of spirituality and its meaning within the context of God, self, and others. It was found that the ''nature of God may take many forms to be reliant upon an individual's ultimate value in his or her life'' (Dyson, Cobb, & Forman, 2012). As such, spirituality is incorporated as part of the ontological foundation of nursing, which is important in human health and well-being from an intrinsic as well as an extrinsic perspective. In conceptualizing spirituality, there is confusion around its meaning, which is hindered by its relation to religion. One way to distinguish spirituality from religion is as follows: '…religion is more about systems of practice and beliefs while spirituality is an expression of it' (Dyson, Cobb, & Forman, 2012). Research reveals that the dichotomy of

spirituality and religiosity in religious and non-religious communities does not reflect their lived experience (Coyle, 2017; Dyson, Cobb, & Forman, 2012; George et al., 2013).

For them, spirituality and religiosity are interwoven (Dyson, Cobb, & Forman, 2012; Tanyi, 2016). For others, this may not be the case, where spirituality is more defined along the lines of non-theistic beliefs, such as personal values or goals (Tanyi, 2016). Instead, spirituality is a type of altruistic awareness or personal responsibility in matters of social justice, or from an Eastern spiritual perspective, entailing compassion for others (Delgado, 2015). Whether spirituality is interwoven with religiosity or not; in the literature review themes that emerged strongly were purpose and meaning, connection, spiritual well-being, self-transcendence, inner peace and adaptation in health or illness (Coyle, 2017; Delgado, 2015; Gall et al., 2015; O'Brien, 2013; Tanyi, 2016). Sawatzky and Pesut (2015) reported that nurses realized that spiritual contemplations of care cannot be overlooked when implementing as the foundation of nursing practice, a holistic view of the person. In clinical settings, nurses are called to respond to the spiritual needs of their patients on a daily basis. Ignoring these needs may move patients away from treatment within the orthodox healthcare system and inhibit them from depicting a powerful inner source for health and healing. If society is yearning for nursing care that includes spiritual care, nurses who are ill-equipped will not be able to meet these needs in their society, hence the need for a review of the present nursing curriculum in Nigeria. There is also the need to integrate spiritual care so that when the revised curriculum is effectively implemented; all nurses will be trained to provide holistic nursing care for their patients.

Nurses should offer spiritual care simply by their caring presence and empathic approach, irrespective of their own personal spiritual beliefs and faiths. Setting ethics for spiritual care practice will help nurses to not only identify the spiritual needs of their patients, but also to develop the necessary attitude, orientation, knowledge and skills to render spiritual care

whenever and wherever it is needed (Glasper, 2011). Since nurses are in a position to work closely with humans they have access to the most cherished elements of human experience. Many nurses, however, face challenges in addressing spirituality with their patients (Taylor, 2007). The literature review has discovered that research on spirituality in a nursing context is widely spread all over the world with strong attention being paid to holistic patient care (McSherry & Jamieson, 2010; O'Brien, 2011; Koenig, 2012; Taylor, 2018). In contrast, there is a shortage of experimental work on spirituality in nursing within South Africa. After a broad literature search, the researcher was able to find only few South African studies that describe the occurrence of spirituality from the perspective of nurses and patients (Chandramohan & Bhagwan, 2016). This situation applies also in Nigeria, where there is no documented study on spirituality in nursing. This underlines the need for studies such as this one, to interrogate the topic as it is experienced in Nigeria.

The body of studies in countries other than Nigeria and South Africa provides a rich understanding of spirituality in nursing. Mahlungulu and Uys (2011) conclude that spirituality is an exclusive personal pursuit for establishing and maintaining a dynamic relationship with self, others and with God; this means having a belief, trust and hope, inner peace and a meaningful life. Ross (2016) carried out a logical review of 45 articles on spirituality (1983-2005) in nursing practice. These included fourteen articles on nurses' perceptions of spirituality and spiritual care in nursing, twenty-three articles on patients' views on spiritual care in nursing, five articles that compared nurses' and patients' perceptions of the meaning of spirituality and spirituality in nursing, and three articles on spirituality in nursing education. The review identified three areas where nurses can address the spiritual needs of individual patients. These involve the following:

1. Assessing spiritual needs at the end of life.
2. Spiritual environments such as chapels, quiet personal spaces, and multi-faith rooms.

3. Competent agendas to help staff identify and support spiritual needs.
4. Skills, qualities and caring attributes of nurses, such as the use of touch and silence.

The results included learning methods of active and compassionate listening and companionship, where the nurse moves beyond notions of an expert carer, taking a role which includes accompanying the dying person throughout their spiritual episode. Multi-faith spiritual practices such as prayer, contemplation and meditation are techniques that may help nurses boost their patients' sense of peace and well-being. The question then is: 'to what extent is this done by nurses in Nigeria?' No doubt it is a great challenge. The current curriculum is evidence enough that spirituality and spiritual practices in nursing is a neglected area; one can even say that there is no structure in place for spiritual care delivery in Nigeria. Nurses who do not have the knowledge, skills and positive attitude towards spiritual care will definitely lack the competence to offer spiritual care.

Lundberg and Kerdonfag (2010) affirm that spirituality is vital when meeting the needs of patients and their families, which affirms the contention that there is a need to provide competent spiritual care.

Glasper (2011) published an organized review of the literature on spiritual care, which aimed at collating knowledge on spiritual care. The analysis showed the following themes:

1. Identifying the patient's spiritual needs as part of his/her assessment.
2. Showing a humanistic approach whereby psychosocial needs help nurses explore facets of spirituality. These include exploring a person's attitudes, beliefs, ideas, concerns and values about their own life and death issues, including their hopes and fears.
3. Spiritual distress caused by the loneliness of dying.
4. Contemporary practice suggesting that spiritual needs must be evaluated more regularly.

Where spiritual assessment is done regularly by the spiritual therapists, including nurses, the needs of the clients or patients will be identified early and spiritual intervention done appropriately. This will be of tremendous assistance to the clients and families.

2.3 THE CONTEXT OF SPIRITUAL ASSESSMENT

Nurses use the nursing process as a tool for their evidence-based nursing practice, so their knowledge of the components of the nursing process is expected to enhance their spiritual assessment, in order to guide their clinical judgment as well as the decision-making process. However, little or no attention is given to spiritual assessment while assessing the needs of the patients, and this means that in Nigeria especially, the patient's assessment is never holistic. This study will try to close the gap, since the integration of spiritual care into the nursing curriculum will aim to up-skill nurses so that they are better able to carry out holistic assessments of their patients. A key to this pattern of working together is the descriptive interaction between the healer and patient that progresses over the course of several visits. It involves the nurse, physician and other professional health-workers using precise tools that help the patient to say what needs to be said and to help the healer have a clearer understanding of the patient. By expediting this process, the healthcare professional attends to the different aspects of the person's being; focusing on those that may be relative to the patient's problem. This model has been referred to as contextual care. Contextual care is a systematic approach to healthcare that involves a wide search for a 'context for the patient's problem so that both the doctor and patient will have a clear understanding of the problem for its meaning to be explored' (Kliewer & Saultz, 2017). Likely settings according to this model include psychological, biomedical, community and family. The major concept is the individual patient context, which is perceived to involve a wide array of issues:

Any plan to integrate healthcare and spirituality is best understood within a framework that is provided by appropriate care. Before integration can be done, the individual patient's context

must be recognized, and one of the core elements of this context is spirituality. To integrate specific tools, active listening or using the BATHE technique is used to bring to the apex issues that must be considered. If evidence emerges that there are spiritual issues to be deliberated upon, then a process of assessment must occur that will allow the healer to develop the right response, one that is constructed and effected together with the patient. Modern nursing assessment instruments are much more detailed than the medically oriented database model forms used in the past. Then too, cognizance is taken of the fact that some nurses may not be comfortable or prepared to discuss religious or spiritual topics with their patients (Brush & Daly, 2015; Ameling & Povilonis, 2001). In addition to assessing physiological constraints, caregivers also analyze sociological and psychological factors that may affect patients' state of health. A noteworthy weakness, however, of many contemporary nursing assessment tools is the absence of evaluation of a patient's spiritual needs. Regularly, the spiritual assessment is shown in a single question asking for the religious affiliation of the individual. It is usually assumed that the patient's spiritual care can then be directed to a hospital priest entrusted with the task of ministering to persons of that religious tradition. In reality, though there are hospitals with such chaplains, in most hospitals in Nigeria this is not the case. This study expects to improve nurses' skills in spiritual assessment in Nigeria, especially those who have trained through the envisaged new curriculum where spiritual care in nursing is integrated into their training course, with this as a major and compulsory component; with the objective of up-skilling nurses in this area so they are better equipped to deliver care.

In the present-day era of home health care delivery, evaluation of a patient's spiritual needs and beliefs is vital to the creation of a holistic home nursing care plan. At times, the home care patient experiencing or recuperating from illness is secluded from sources of spiritual support. Authors within the discipline continue to expatiate the relevance of assessing the

patients' spiritual needs (Young & Koopsen, 2011) as well as the importance of developing spiritual assessment tools (Power, 2015). The inability of nurses to carry out effective spiritual assessment does not enhance the metamorphosis of nursing care into that which is holistic, but it is expected that the integration of spiritual care into the nursing curriculum will enable the nurses to acquire knowledge, skills and attitudes that will make them professionally competent to deliver holistic nursing care, including effective spiritual assessment.

To Bor, Miller, Latz and Salt (2018) the assessment turns into an evolution that, whether it occurs in one session or spans across a series of sessions, has six stages. At each stage the health professional may be addressing both the physical and the spiritual disease, which work together to create the person's state of illness. The first stage involves bonding with the patient. As far as bonding is concerned, the importance of creating a rapport with the patient or re-establishing a rapport developed in an earlier session cannot be over-emphasized. When dealing with powerful issues such as anger, hopelessness and guilt, trust is critical and this step cannot be discounted. Clinicians should introduce themselves and should seek to establish a connection through effective communication, tone and body language. Information about the healthcare professional, including name and qualifications, should be given.

The second stage involves collecting and giving information. This will happen through the entire session in many ways. Information will be conveyed through words, body language and tone. It may be given openly or discreetly. It may be plain or well-hidden evidences. If the healthcare professional listens carefully and is open, the information provided by the patient will give pointers that will probably suggest one or more contexts as primary concerns. It is possible for the doctor, nurse or healthcare provider to regulate the discussion in a manner that forces the patient to focus on the physical realm only. This mistake is the

commonest in American clinical medicine and results in a reduced assessment of patients' problems. If the counselor, doctor or nurse possesses good listening skills and takes time to carry out this step properly, then shallowness, misinformation and misunderstanding can be avoided. The focus here is to detect those contexts for the patient's problem; this is the clearest way of formulating a management plan. Patients should not be probed or coerced into giving information. Care must be made to proceed at a pace comfortable for the patient.

During the third stage, the original information is reviewed in-depth and concerns and issues are identified and clarified. Again, active listening is very important. Creative questioning, perception checks and other tools are important to aid this process. What is the patient's belief about their illness? What does their illness mean to them? What do they believe is wrong with them? Why do they think they are ill? How is their illness affecting them personally? How is the ailment affecting their emotions and relationships? Is there any spiritual disease present? The fourth stage, which occurs only after these initial steps are taken, involves the duty of assessment. The assessment should be dependent on what has been seen, heard and felt. It should involve the emotional, relational, physical and spiritual facets of the person, and should be well contextualized.

The fifth stage involves making decisions about how to respond or intervene with respect to the most disturbing issues. As part of this process the physician, nurse or counsellor should give a summary of their perception of the issues and priorities that have been discussed. With a deep spiritual encounter, the risk of error is high and it is necessary to check constantly. The sixth and final stage involves establishing follow-up. Will there be a need for another visit? What will the patient do between this session and the next? What will the healthcare professional do between this session and the next? If this is a final visit, at least for the moment, and will there will be any follow-up. Even if there is no need for another visit, patients should be made to realize that help will always be available when needed. The

assessment stage, as practiced by social workers, psychological therapists, counsellors, and religious leaders, has fairly standard components. Normally an assessment addresses the presentation of the patient, a patient's problem description, a spiritual history, a detailed examination of the patient's mental status (addressing cognition, affect and behavior) and an impression of the client's concerns. This process closely matches the assessment process practiced by doctors and nurses when exploring physical cases. The typical medical process includes taking a history of present illness from the patient, a past medical history, social history, family history, review of systems and physical examination; perhaps including a mental status exam allowing the healthcare professional to follow the patient's lead as the story unfolds.

2.3.1 Determining the necessary attributes in spiritual nursing care

Monareng, (2009) in her unpublished study titled "A model for integrating spiritual nursing care in nursing practice: A Christian perspective" extensively discussed the necessary attributes in spiritual nursing care. According to Walker and Avant (2011) in order to determine the defining characteristics, an effort is made to try to show a number of attributes that are most frequently associated with the concept studied. Determining the defining characteristics is also crucial to spiritual assessment. For this reason, it is important to group those characteristics that are most frequently associated with spiritual nursing care together. The characteristics as they are discussed by Walker and Avant (2011) give the researcher a comprehensive insight into the concept. However, the defining attributes are subjected to change as the researcher's understanding and maturity of the concept and its applications to nursing practice is expressed and developed during the process. It is also important to note that an extensive review of existing studies on spiritual nursing care and spirituality allowed the researcher to identify the common major characteristics of ''spiritual nursing care'' as a concept.

2.3.1.1 Caring presence

Caring presence can be defined as a feeling or the state of showing concern, compassion and empathy for others (Dictionary, Encyclopaedia & Thesaurus, 2018). Caring presence comprises of the concepts of being available, listening, touching and providing spiritual support (Kliewer, 2013). Byrne (2011) states that the nurses' ''being'' is more important than their ''doing''. Sawatzky and Pesut (2015) advocated that the role of the nurse is to be available and provide care during the patient's search for meaning and purpose in times of pain and suffering.

Touhy, Brown and Smith (2012) realized that spiritual nursing care involves being available when patients experience a 'personal crisis.' According to Kliewer (2013), the notion of a spiritual caring presence includes showing care when executing activities that demonstrate connection when a cure is possible and also when it is not. In a study conducted by Greasley et al. (2013), the participants defined spiritual nursing care as encompassing loving presence; being available for patients and helping them achieve inner peace and spiritual wellness. It is through this caring presence that the values of care, empathy, compassion, respect, concern, trust and hope are made visible (Touhy et al., 2012). Figure 2.1 depicts the values associated with caring presence.

O'Brien (2011) stated that seven characteristics of caring were identified in a study of 200 nurses' stories to describe patient care such as caring, compassion, spirituality, community outreach, providing comfort, crisis intervention and going the extra distance. However, it is vital to identify the dimensions of caring which entails the features of caring as noted in the healthcare and theological literature and the aim of a healing outcome as clearly understood in nursing's clinical practice in order for spirituality to make its impact in the health sector. For nurses to practice spiritual care efficiently and effectively, some activities may provide approaches for the carrying out this to serve the clients/patients which include; (i) being with the clients/patients in times of pain, suffering and any situations they are going through, (ii) listening to clients/patients and allowing them to express their needs such as apprehension, anger, loneliness, depression which may be affecting their health in words, and (iii) touching the clients/patients holistically to ensure their connectedness with others around them. These acts of being with the clients/patients, listening to, or touching may not connote spiritual care but have a therapeautic impact on the individual client/patient in the time of distress needing supports.

(A) Being: According to Emeth and Greenhut (1991) "Being with a sick person without judgment creates space for meaning to emerge and for the sacred to be revealed." Carers like nurses, must be willing to be with others in their experiences of unanswered questions which they need to live with. The importance of being with clients/patients and families in their periods of sickness when they need to ask several questions that the carer would have no answer to cannot be under estimated. Sometimes, patients/clients need to live the remaining part of their lives with those unanswered questions.

(B) Listening: If a professional nurse is to be an effective spiritual care giver, listening is a therapeutic skill that he/she must exhibit. Active listening with open and sensitive

reaction to the clients/patients is important in giving spiritual care. The ability to listen is both an art and a learned skill which requires that the nurse completely attend to the clients/patients with open ears, eyes and mind. Many clients/patients are seeking for an ear that will listen to their plight in their states so that they can relay their anxiety, anger, despair, depression, feelings, fears, worries, sufferings, sorrow and loneliness.

(C) Touching: "And there was a leper who came to Him, and knelt before Him saying: "Lord, if you choose you can make me clean." He stretched out His hand and touched him saying: "I choose. Be made clean." Immediately, his leprosy was cleansed. As stated in the Holy Bible, according to the gospel of Matthew, chapter eight verses two and three (Matthew 8:2-3), From the interaction between Jesus Christ and the leper man, it was learnt that touching is critical as it shows an identification with each other. A nurse's touch may be verbal i.e. a kind and caring greeting or a gentle word of comfort and support. Touching may be physical such as taking the other person's hand, holding or gently stroking the other person's forehead or laying on of hands. Loving, empathetic, compassionate touch is perhaps the most vital dimension of a nursing theology of caring (O'Brien, 2011).

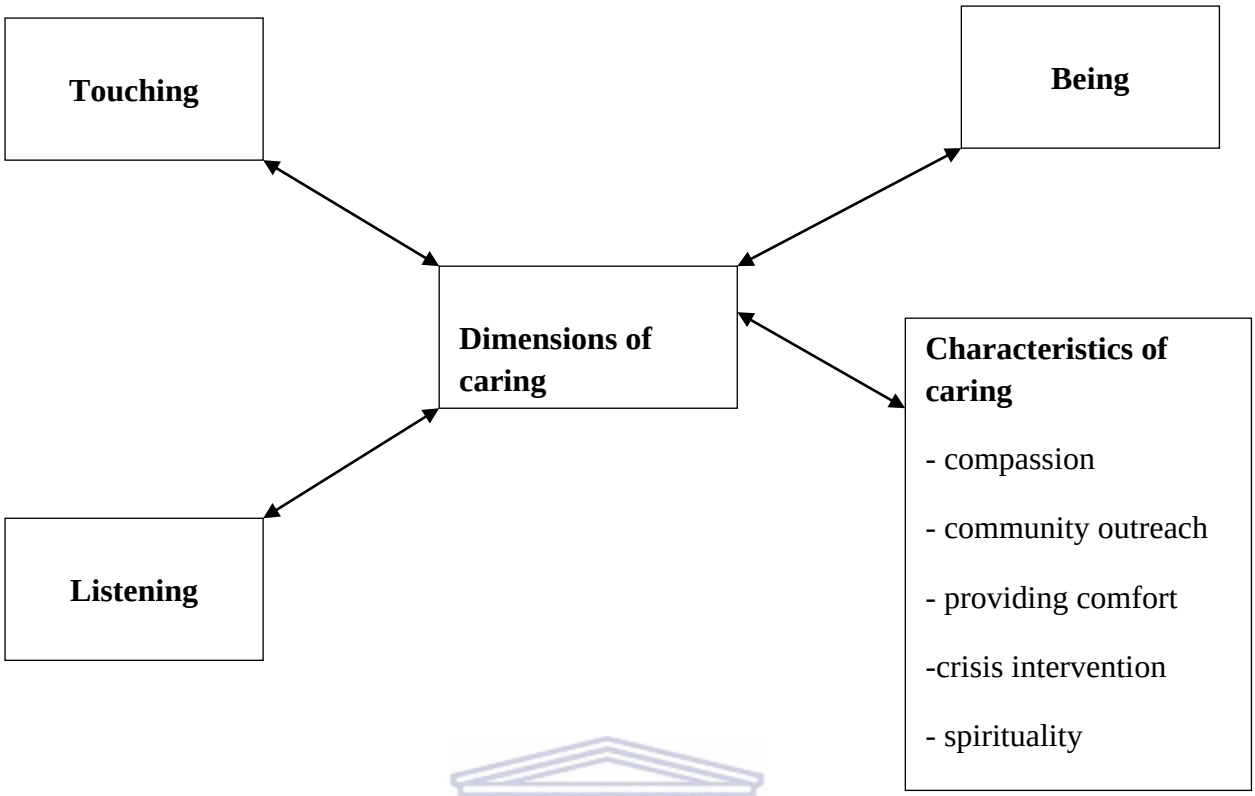


Figure 2.1: Dimensions of Caring

2.4 DELIVERY OF SPIRITUAL CARE

The practice of spiritual care is about meeting people at the point of their deepest need. Values and beliefs are very dear and personal to everyone. This can cause conflict for nurses in their dealings with patients, clients and families, particularly if the latter's life view differs from that of the nurse.

McSherry (2012) provides a useful framework for considering four major challenges that require deliberation by the nursing profession if the practical application of spirituality is to be fully realized. The four broad challenges are:

2.4.1 Conceptual: Consideration must be given to the different ways that people define, perceive and understand the nature of spirituality. Assumptions and generalizations cannot be made by nurses with regard to this personal dimension of human existence. If concepts and theories of spirituality and spiritual care, meaningful and relevant to practice, are to be

developed, then flexibility will be required so that the needs of diverse groups and individuals can be accommodated.

2.4.2 Organizational: All institutions and organizations that are involved in the provision of nursing care, in whatever context, whether this be community, hospital or residential facility; must acknowledge the importance of people, places and processes when seeking to offer or provide any form of spiritual care. Unless these organizations acknowledge the importance of this dimension for the health and well-being of those receiving and providing care, then the provision of spiritual care will be ad hoc, uncoordinated and fragmented.

2.4.3 Practical: This is a broad term that spans any of the practical implications for the delivery of spiritual care. This may include attention to areas such as spiritual assessment, the resources to support nurses in the delivery of spiritual care and the educational preparedness of nurses to be involved in the spiritual dimension of people's lives. The nursing profession has made excellent progress in some of these areas. Cobb, Puckalski and Rumbold (2012) reveal that nursing scholars and practitioners are engaged in a broad range of debates and activities that will develop nursing practice in this area, such as the development of educational competencies and the construction of spiritual assessment tools for use in specific clinical settings. More importantly there is a real desire to ensure that these developments are informed by the voice of patients (Cobb, Puckalski & Rumbold, 2012).

2.4.4 Ethical: The nursing profession must start to engage in a more meaningful way and consider the ethical issues and potential dilemmas raised and encountered when supporting people in the spiritual aspects of human existence. The spiritual dimension of people's lives is affected by a number of elements: personal, social, cultural and political. Therefore, the spiritual dimension, by its very nature, is ''ethically laden''. Until recently little attention has been paid to the ethical issues at play when supporting patients in spiritual aspects of their lives. For example, is it correct to routinely assess all patients for spiritual needs only to find

that there are inadequate resources to support both the individual and the staff involved in this activity? A further consideration may be educational preparedness, i.e., do nurses have the requisite knowledge and understanding to support patients in these deeply personal aspects of human existence?

A way forward for nursing education and practice in Nigeria is to review and evaluate the evidence base developed to date; mapping this activity against the four challenges outlined above (personal, social, cultural and political elements). This exercise would provide a benchmark to assess how far the nursing profession has come in relation to the direction it needs to take moving forward. It would be fair to say that the nursing profession has pioneered understanding and developments in spiritual care. Recent trends in Nigeria show that the nursing profession is not closed and rigid, but flexible and willing to engage in dialogue and further debate in order to advance this important dimension of holistic care, and one of those foci is research which seeks to provide evidence for much-needed dialogue.

2.5 SPIRITUAL NURSING INTERVENTIONS

Spiritual nursing interventions are defined by Rankin and Delashmutt (2015) as tactics that nurses integrate into patient care practices to support the spirit. These include being available, providing care, being empathetic and respecting the spiritual faith of patients; providing spiritually uplifting reading material or soothing music of choice, and engaging in prayer. O'Brien (2017) warns that in an attempt to minister excellently to those who are ailing, two vital ideologies pertaining to spiritual nursing intervention must be remembered. Firstly, the nurse must understand that providing spiritual nursing care cannot be centered on a procedure book or plan of orders because each individual is spiritually unique. Secondly, the nurse must offer spiritual support, identify the need to look beyond spiritual counselling either for personal benefits or for the patient when the situation requires it.

In this study, some of the defining attributes such as the search for meaning, transcendence and self-transcendence and harmonious interconnectedness provide guidance on specific nursing interventions to be employed in the interests of meeting the spiritual needs of patients.

2.5.1. Search for meaning and purpose

Frankl (2018) asserts that meaning can be experienced through engaging in creative activity, which addresses emotions such as pain and guilt and also tough circumstances such as health crises and death. According to Burkhardt (2014) and Coyle (2017), spiritual nursing care is a way of ‘‘unfolding mystery’’ related to one person’s endeavour to help another person understand the purpose and meaning of life while going through suffering and pain. This quest centers on the value of life, makes sense of life conditions and finds resolve in human existence (Burbank, 2014; Frankl, 2018). Hall (2017) argues from the existential point of observation, and states that nurses who give spiritual nursing care help their patients, who may or may not be skillful enough in spiritual matters in the bid to seek answers to their enquiries about the meaning and purpose of their illness or suffering. Burbank (2014) augments this by stating further that such an approach helps nurses to deliver care that comforts patients who are ill or in pain to access appropriate interventions. This type of care is meant for patients who are in search of the meaning and purpose of life in the scope of sickness, pain and suffering. Spiritual nursing care is described as follows:

1. Helping individuals and families to not just deal with illness and suffering, but to find meaning and purpose in these events (McEwan, 2014)
2. Assisting those who are distressed to reflect upon and find meaning and purpose in their experiences (Govier, 2012)

3. Providing individually-tailored assistance which, through confirmation, allows humans to efficiently utilize all their personal and spiritual resources in dealing with the doubts, worries and enquiries arising in healthcare settings, and which very often follows sickness and suffering (Gould, Berridge & Kelly, 2013). Pertinently it should be noted that care entails man's need to find suitable answers to his crucial questions about the significance of life, illness and death (Reed, 2012).

Frequently used strategies, recognized in the literature according to O'Brien (2011), that nurses can use as spiritual nursing interventions when meeting the spiritual needs of patients looking for meaning and purpose in moments of sorrow are spiritual dialogue, spiritual capability, self-consciousness and spiritual sensitivity.

2.5.2 Spiritual dialogue

Monareng, (2009) states that dialogue can be defined as a discussion between representatives of two groups, or an exchange of proposals or a conversation between two or more peoples. According to The Concise Oxford Dictionary (2018) and Mahaffey (2017), the concept 'dialogue' comes from two Greek words *dia* and *logos*. *Dia* means through while *logos* means the mind of God. Dialogue can be viewed as having streams of meaning that are conveyed between two people in a discussion, as a result of which, new understandings unfold. Spiritual dialogue is the means by which patients are helped to identify individual meaning in their states of distress and sorrow; it is this man-to-man discussion about God or spiritual issues that feeds the soul and enhances growth for both the patient and the nurse towards spiritual well-being (Mayer, 2017; McGrath, 2017). Ross (2016) asserts that spiritual nursing care includes being involved in spiritual dialogue with patients who are going through spiritual distress.

However, Tanyi, Recine, Werner and Sperstad (2014) are of the opinion that when patients prefer to be engaged in spiritual dialogue, nurses should be comfortable with addressing the

topic irrespective of religious beliefs. Some nurses, according to Byrne's (2011) findings, were adamant to do so because they view spiritual matters as delicate and intimate matters. Byrne (2011) states that the presence of the nurse and the type of spiritual language used, whether positive or negative, can affect the patients' search for meaning and purpose.

2.5.3 Spiritual competence

According to the Manitoba Civil Service Commission, as cited in the Manitoba Corporate Competency Catalogue (2012),'competencies are considered to be an effective approach to capturing all that employees bring to their jobs. Competencies are being used by many private organizations within the federal government, and by many provincial and municipal organizations. They provide the ability to look beyond acquired knowledge, skills, and abilities and include behaviours. In the past, the focus has to a large extent been on what an individual brings in the way of 'hard' or 'clinical' skills...the competency model builds on past practices by providing a better way to capture both 'hard' and 'soft' or 'transferable criteria''. The Manitoba Corporate Competency Catalogue further stresses that, ''…competencies are the characteristics of an individual that underlie performance or behaviour at work. Competencies may include a person's aptitudes, intelligence, skills, abilities, knowledge, experience, physical competencies, styles, personality, principles, values, attitudes and interests''. Principal competencies or critical competencies are what most individuals working in spiritual health care need to be efficient in helping a healthcare facility to meet its objectives of quality care. These competencies are skills, attitudes and knowledge that are manageable and universal and relate to how work is completed. They can therefore be applied or transferred to various jobs. Hodge (2016) states that spiritual competency is a more precise form of cultural competency. This includes knowledge of one's own spiritual outlook and associated prejudices, a concerned understanding of the client's questions and the ability to answer them, and the ability to brainstorm and create

interventional strategies that are helpful, significant and delicate to the client's spiritual worldview. Van Leeuwen and Cusveller (2012) speculates that nurses need to develop spiritual competencies that will enable them to cope with their own values, principles and perceptions in their professional relationship with clients of various cultures, beliefs and religions. Research from a study by Labun (2015) discovered that most patients who come to the clinical settings for assistance are people with no vast philosophical or religious beliefs. They may, however, still want to explore their feelings, sense of worth and develop an understanding of life. To do this, they require the participation of another person who is spiritually experienced, to discuss these areas of apprehension, answer their different questions concerning the meaning and purpose of their challenging situations and share common experiences. The challenge is to develop spiritually capable nurses who are able to meet the unique spiritual needs of patients and handle their own spiritual concerns and questions with competence (Monareng, 2009).

2.5.3.1 Self-awareness

Self-awareness is the consciousness of one's own individuality, including one's feelings, traits and behaviour (Encyclopaedia & Thesaurus, 2018; Merriam-Webster Online Dictionary, 2018). Nurses who are required to assist patients in their quest for meaning and purpose are required to develop and express the ability to reflect on their own lives, nature, and spirituality (Monareng, 2009). They need to have knowledge about their own spiritual perception and associated principles in order to provide reasonable support to those experiencing suffering, pain and / or who are battling with terminal illness (Sawatzky & Pesut, 2015).

Spiritual self-consciousness is a superior awareness that involves the understanding that individuals have the ability to find and give meaning to their circumstances in a way that empowers them to achieve spiritual independence and wholeness (Sawatzky & Pesut, 2015).

Through spiritual self-consciousness the person's inner resources are heightened and the self is reinforced (Sawatzky & Pesut, 2015). This allows the nurse to give spiritual nursing care from a place of inner strength. Hall (2017) is of the view that self-consciousness is defined as 'self in relation' to others. This transcendent self- awareness is developed within the principle of a relationship with the creator and involves being an effective learner in everything spiritual (Sawatzky & Pesut, 2015). Hall (2017) adds that self-consciousness is developed by loving oneself and being in love, caring and being in touch with others and sharing with others.

2.5.3.2 Spiritual sensitivity

Being sensitive is to be delicately conscious of other people's feelings and attitudes (Merriam Webster Online Dictionary, 2018). Nurses who have this understanding are able to show spiritual sensitivity, which allows them to cope with issues such as suffering, hopelessness and the spiritual dysfunction of others in a competent manner (Burkhardt, 2013).

Spiritual nursing care is given and accepted in a context whereby the recipient is physically or emotionally susceptible and accepting of the spiritual views of the caregiver (Conco, 2017). Spiritual invasiveness during times of patient susceptibility is always an impending risk. This can cause uneasiness and block effective spiritual dialogue with the patients. While intrusiveness during times of patient susceptibility can be unfavorable to spiritual nursing care, not discussing spiritual matters with patients is equally dangerous (McSherry & Draper, 2011; Narayanasamy & Owens, 2015). Nurses should, therefore, be subtle and identify when the spiritual needs of patients should be attended to, and also understand the dangers associated with spiritual intrusiveness.

Narayanasamy and Owens (2015) conducted a study that revealed several approaches with regard to developing spiritual sensitivity. The nurses, who implemented a culturally interactive approach, identified and valued the duties of the different cultures/religions. The

patient's cultural identity gave nurses a vital understanding as to what course of action should be commenced to meet the patient's spiritual needs. A personal approach entailed describing religious needs in non-religious terms. Nurses who adopted this approach were willing to give time and attention to patients and engage in all aspects of patient care. This approach assisted them to advance in structuring a nurse-patient relationship. The counselling approach entailed assisting patients during the dire stages of their illness. Monareng (2009) states that a small number of nurses gave accounts of spiritual care occurrences that could be described as an evangelical approach. In terms of this approach, nurses share the gospel with patients impulsively, reading holy texts and praying for and with those in need of prayer.

2.5.3.3 Transcendence and self-transcendence

According to Monareng (2009), transcendence is the process of going beyond our present restrictions and gaining a broader perspective of ourselves and the world. For human beings, transcendence forms part of how the world is experienced. Spiritual caregivers, as is the case in this study, experience the sensitivity that enables them to be conscious of the inestimable awareness of God's assistance for both themselves and their patients during times of sorrow. McEwan (2014) explains that the significance of spiritual nursing care is reassuring patients to have belief in God, and finding their purpose in life in connection to their illness or disease. Spiritual nursing care enriches a transcendent relationship with divinity. In this relationship, patients become conscious of God's power, help, solace and intervention by faith. This finds expression in the use of transcendent approaches such as scriptural reading, scriptural meditation and prayer. In a study conducted by Coyle (2017), participants emphasized that transcendence and a relationship with God gave their lives meaning in the face of difficulty. This is confirmed by Mayer (2017) and Touhy *et al.* (2012) who accept as true that the loving and spiritually sensitive care by a nurse gives hope to the patient.

Alternatively, self-transcendence is defined as an experience of emerging into one's unfulfilled prospects. It is the process of spreading oneself both inwardly in reflective activities and outwardly in relationships with other people (Reed, 2012). Self-transcendence means being able to reach beyond oneself; to experience a higher being or other human beings in order to find meaning and purpose (Frankl, 2018). Coyle (2017) clarifies that the core of being is self-transcendence, which is the process of surpassing one's current limitations to improve and better oneself, mentally and spiritually and physically. It involves a personal journey of self-discovery. In this spiritual self- transcendence, the nurse helps the patient to practice a form of self- transcendence that leads to achieving true satisfaction. Monareng (2009) states that in the transcendence and self -transcendence process, patients are assisted to reach out to God and others, to grow to reach their potential and overcome difficult circumstances.

2.5.3.4 Assisting patients to reach out to God

Monareng (2009) further states that participants in Coyle's (2017) study believed reading the Bible and praying were essential ways of reaching out to God as they believed that this activity gave patients something to work through in order to control their suffering and illness. They viewed meeting with God in this way and sharing values with those who thought the same as themselves, as intensely significant and providing purpose and healing.

2.5.3.5 Assisting patients in reaching out to others

Transcendence is viewed as an encounter and obligation of a dimension above oneself and that which enlarges self-boundaries (Reed, 2012). In the healthcare community this is seen as assisting patients to go beyond themselves and their limitations by reaching out to others and engaging in important activities to enhance the health and spiritual well-being of others. For example, a patient who is HIV positive and is well-accustomed to treatment and general care

can reach out to newly diagnosed patients to help them cope and experience hope (Monareng, 2009).

2.5.3.6 Assisting patients in their personal growth

Monareng (2009) states that through the transcendence process nurses augment the skill of patients to rise above their drives and develop past themselves. In this respect, humans have an inborn ability to grow. They have a coping mechanism that enables them to overcome demanding difficulties by connecting with God in faith and faith in themselves in a way that helps them to cope beyond what they are capable of achieving (Frankl, 2018). This occurs because humans have the potential to self-transcend, namely to choose their behaviour in the face of adversity, to rise above adverse conditions and circumstances and have a sense of inner-peace (Frankl, 2018).

Growing through difficult times requires personal effort and a strong will to change. At the core of self-transcendence is the spiritual notion that humans have the ability to adjust and grow into a more enlightening nature and gain a broader perspective of the real self. Growing into one's real self refers to when people are able to become what they want to be, to be fully themselves during each moment; to achieve inner stability and knowledge of one's centre and to rise above every limitation of self and self-constructions. These limitations can be due to pain, sickness, disease or injury (Lloyd &O'Connor, 2015). However, challenges experienced by patients such as illnesses or injury are seen as opportunities for spiritual development. Hidden in those times of suffering and pain is spiritual growth and autonomy (Sawatzky & Pesut, 2015). As patients and nurses who possess spiritual integrity engage in honest, healthy relationships with God, others, themselves and the environment, personal growth is inevitable.

2.5.3.7 Assisting patients to overcome their current circumstances

Transcendence means being able to rise above adverse conditions and circumstances. namely suffering. It is the ability to think about and take a stand against suffering and do something about it (Monareng, 2009). Frankl (2018) theorizes that humans are called upon to change themselves when confronted with circumstances that cannot be changed. This requires detachment, being able to laugh at themselves, talking about their fears and wisely choosing their attitudes in the face of adversity. In a research study by Galek, et al. (2016) the importance of 'positive transcendence' for patient was emphasized. Nurses are required to assist patients through positive transcendence to make hopeful connections with possibilities and realities beyond the self; possibilities that will give them a sense of peace, contentment, gratification and a positive perspective regardless of the challenge of sickness (Monareng, 2009).

2.5.3.8 Harmonious interconnectedness

According to Stoll (2013) a person's spirituality consists of a vertical and a horizontal dimension or axis. The vertical dimension is closely related with a person's transcendent relationship with God. The horizontal dimension shows a person's beliefs, values, way of life and those human environmental components and interactions of human existence. Burkhardt (2013) further asserts that harmonious interconnectedness is revealed in healthy relationships with God, one-self, others and the environment. Harmonious interconnectedness based on giving and receiving love brings about meaning and fulfilment in life and provides a reason to live when faced with challenging circumstances (Coyle, 2017; Harrison, 2013; Walton, 2015). Monareng (2009) concludes that this relationship is further discussed as transpersonal, intrapersonal, interpersonal and environmental interconnectedness.

2.5.3.8.1 Transpersonal connectedness

Monareng (2009) states that transpersonal connectedness means to have a meaningful relationship with God. This is possible by developing opportunities for religious practices such as prayer, Bible reading, personal, group and corporate worship. This enables patients to have a feeling of peace or a foundation of strength from their faith, beliefs and values (O'Brien, 2013). Forgiveness, love, hope and trust can be experienced in a transpersonal relationship (Miner-Williams, 2015). The nurse acts as the major person to offer spiritual guidance or refer patients to other people in the faith environment such as pastors, priests, chaplains or recognised spiritual agents, based on the patient's choice (Burkhardt, 2014; Coyle, 2017; Walton, 2015).

2.5.3.8.2 Intrapersonal connectedness

Intrapersonal connectedness centers on 'potentiality of the self.' This is the capacity for inner knowledge and a well-spring of inner strength; a resource that is always available. Intrapersonal connectedness, by definition, involves religious meditation of one's inner self and helps to develop a deeper understanding of the self and others (Coyle, 2017). O'Brien (2013) asserts that religious contemplation is a mental prayer that helps individuals draw intrinsic strength from God. As a result, spiritual nursing care involves helping patients to draw on their inner strength in periods of distress and directs them to spiritual workers, psychologists and social workers when necessary.

2.5.3.8.3 Interpersonal connectedness

To Monareng (2009), Spiritual nursing care involves the promotion of a harmonious relationship between the patient with the nurse and others. Interpersonal bonding is a foundation for social support from family and friends, which gives a sense of relevance. In a qualitative analysis carried out by Narayanasamy and Owens (2015), those who participated concluded that spiritual nursing care consists of a nurse-patient bonding that is attributed by

mutualism and is solely dependent on altruism that causes feelings of trust, security and respect (Narayanasamy & Owens, 2015). Patients are encouraged to express their fears, views and worries as well as to gain new perspectives and consciousness about their conditions when there is a healthy inter-personal relationship between themselves and nurses (Narayanasamy, 2012). Purpose and self-expression are found when people have healthy relationships with others; who could be members of the healthcare team, family, friends, other patients and God (Young et al., 2015). When interrogated, these relationships are described by patients as entailing them being free and open to discuss their spiritual needs without fear of judgment. In this relationship nurses must be conscious of their own spirituality. Both parties can engage in dialogue and also shed light on and deal with spiritual issues in a manner that is healthy (Monareng, 2009). According to a debate by Greasley, et al., (2013) in order to harmoniously have a sense of connection with others, the importance of a good verbal and non-verbal communication skills as well as an attitude seasoned with warmth, respect and empathy cannot be over-emphasized.

2.5.3.8.4 Environmental connectedness

Monareng (2009) states that environment consists of all internal and external components that affect and aid the susceptibility of both nurses and patients in that medium. The factors include, but are not limited to:

1. physical factors such as temperature, food, climate
2. socio-economic factors e.g. having a good support system, culture and available resources
3. biological, spiritual and educational factors such as spiritual language, spiritual objects or people (Young et al., 2015).

Nurses are entrusted with the task of integrating spiritual nursing care so that patients' connectedness with nature and God is enhanced. This is based on Nightingale's philosophy (1957), as stated by Wilkinson, 2015; Kozier and Erb (2014), with the environment in focus. The five environmental factors relating to spiritual nursing care are fresh air, water, sunlight, a good drainage system and cleanliness, which is said to be next to godliness. In the 1800s, relating to their connection with the spiritual health of patients, these factors became important. For example, giving fresh flowers to an ill or recuperating patient gives comfort and aids calmness; a walk in the garden makes it possible to enjoy the happiness that fresh air exudes and cleanliness of one's personal space provides warmth. (Mayer, 2017).

Monareng (2009) states that using religious symbols such as religious soft music, Christian artifacts, religious pictures and music and the cross-use of spiritual language by nurses in the wards during communication with patients, all enhance one's religious connection with God. This promotes innate strength and peace to overcome all challenges. The outcomes of a study carried out by Sun, Long, Boore and Tsao (2015) concerning patients' connection with the psychiatric community, revealed that within the context of spiritual nursing care, using symbols had a spiritual effect that assisted the patients to exhibit calmness; thereby reducing their destructive psychiatric tendencies. Nurses who offer spiritual nursing care need to be sensitive enough in ensuring that a therapeutic environment is provided, where privacy is assured. Environmental measures should be put in place so that the patient experiences comfort in an environment that is free from distress.

2.6 ANTECEDENTS AND CONSEQUENCES OF SPIRITUAL NURSING CARE

Walker and Avant (2011) assert that antecedent and consequences are useful in the definition and refinement of attributes. Monareng (2009) view antecedents are events that must happen before the concept occurs. Moreover, antecedents may give reasonable illumination on the social setting in which the concept is found useful. They assist theorists to recognize hidden

conventions on the studied concept. Incidents or events that happen because of the results of the concept are termed as 'consequence' (Walker & Avant, 2011).

2.6.1 Antecedents

These are incidents that have existed before in the quest to support the search for meaning and purpose (Monareng, 2009). They are significant for spiritual nursing care to be actualized and are explained below. These include self-consciousness or awareness, which is a criterion because nurses require an in-depth knowledge of their own personal spiritual perspective and doubts associated so as to become skilled in attending to the spiritual needs of their patients. Monareng (2009) states in her study that spiritual competence is significant as nurses need confidence, knowledge, skills and insight to deal with the various facets of spiritual nursing care that need to be rendered. Spiritual sensitivity equips nurses with the ability to accurately identify the spiritual needs of the patient while identifying spiritual misery and doing everything possible to offer spiritual nursing care on time, without imposing spiritual views on the patient. To understand the patient's spiritual worldview nurses must have empathy (Sawatzky & Pesut, 2015). Spiritual nursing care to patients going through spiritual discomfort that is beyond physical treatment is crucial. Nurses must develop a relationship of trust with patients so that patients may view them as open, honest and concerned about their general well-being. Patients must feel free to communicate sensitive issues irrespective of spiritual beliefs and still be treated with respect by the nurses (Kozier et al., 2014).

2.6.2 Consequences

According to Monareng (2009) in her study on spiritual nursing care, the consequence of spiritual nursing care is the quality of care given to patients. Even as spiritual nursing care must meet the patient's expectation, so should the end result (Sawatzky & Pesut 2015). Consequences become very helpful in finding commonly ignored concepts and ideas, which give new direction and guidance to research and help develop new theories and hypotheses

(Meraviglia1, 2014). Spiritual health, spiritual integrity and a heightened sense of well-being are consequences that are common (Monareng, 2009).

Spiritual integrity is present as an outcome when a person experiences growth in self-awareness. Labun (2015) refers to spiritual integrity as an individual's feeling of completeness with him/herself, with other people and with God. O'Brien (2013) asserts that feeling complete within oneself, means being in tune with the spirit, mind and body. An increased feeling of wellness is categorized by spiritual well-being. Spiritual well-being is a declaration of a connection with self, God, others, and the environment, in a manner that creates a sense of completeness. People who derive pleasure from spiritual wellness feel alive and happy (Labun, 2015). Hence, appraising nursing care without spiritual care shows nursing care delivery that is not holistic. The pursuit of this research is to integrate spiritual care into the nursing curriculum in Nigeria that is truly holistic, so that the patient can experience wellness and a sense of living that goes beyond the natural (Monareng, 2009).

2.7 SPIRITUAL CARE MODELS

2.7.1 Introduction

Models are deliberately used for complex circumstances in order to have a clearer understanding and in an attempt to grasp them clearly and respond well to them (Cobb, Puchalski & Rumbold, 2014). At times modeling streamlines to focus on a set of possibilities by making a choice from the various options. Complementary models can be useful in identifying the functional areas of model use. A 'horses for courses' method is used where the model that best fits the questions we wish to ask, and answers we wish to obtain is chosen. It is therefore of great significance that spiritual care models must relate not only to the understanding of spirituality, but also to methods of executing the understanding in certain areas. Appropriate models of spiritual care for religious settings are usually not right

for worldly organizations. Another model of practice will be needed even if found, upon the premise of a comparable understanding.

2.7.2 Operational models of spiritual care

Spiritual care models predominantly need to address a health services context where care provision is organized according to a bio-psycho-social model. Spirituality is introduced as a further dimension or domain of care alongside physical, psychological and social domains, and spiritual needs assessments are carried out in the psychosocial assessments. Usually these spiritual assessments are adapted to the style of other assessments carried out in the psycho-social domains. That is, the assessment of spiritual needs and resources adopts a form readily recognisable to the host system with a view to acceptance, and ideally participation, by all healthcare staff.

Frequently this spiritual domain of care is simply juxtaposed with other domains: little attention is given to the effects of expanding the system of care in this way or the compromises involved in adapting spiritual care to the host model.

This study examines some spiritual models in order to show relevance of spiritual care as one of the components of holistic care like the bio-psycho-social-spiritual model of care, inter-professional spiritual care model, O'Brien's theory of spiritual well-being in illness and Watson's theory of human caring. According to Puchalski et al (2012), spiritual care provides a framework for healthcare workers to bond with their patients, calm their anxieties and work with them to provide healing. In this context, healing is a person's capability to find peace of mind, comfort, connection, meaning and purpose in the midst of suffering, disarray and pain. This care is embedded in spirituality using hope, sympathy and the realization that, even if circumstances render a person's life socially unproductive; happiness can still be experienced (O'Connor, 2018).

A model for spiritual care comprises of a setting for healthcare professionals to bond with their patients by being empathetic about their pain, fears and aspirations; co-operating with them by seeing them as helpful partners who have a common goal in care and providing, via a soothing relationship, the privilege to heal and be healed. Caring for patients transcends the physical care and nurture of the nursing profession. Spiritual care is grounded in important theoretical frameworks, one of which is the bio-psycho-social-spiritual model of care. Another is a patient-centered care model in which the focus of care is on the patient and his or her experience of illness as opposed to a sole focus on the disease. Fundamental to both models is the recognition that there is more to the care of the patient than the physical.

2.7.3 Bio-psycho-social - spiritual model of care

A universal approach which states that psychological (which encompasses emotions, behaviours and thoughts), social (cultural and socio-environmental) and biological factors, all carry out an important task to ensure optimum human functions during illness. This is the bio-psycho-social model (BPS). This model postulates that health can be clearly understood when social, psychological and biological factors are combined rather than by analyzing only one factor within this context. This is totally different when compared to the biomedical model of medicine, which states that the process of every disease can be better defined within the context of a deviation from normal functioning, which can be a developmental anomaly, injury or genetic deficiency. This is found useful in clinical fields of family therapy, licensed clinical mental health counselling, psychiatry, physiotherapy, clinical social work, clinical psychology, health psychology, occupational therapy, medicine, nursing and sociological practice. A bio-psycho-social prototype is a term for the theory of the 'body-mind relationship', which solves issues arising from various ethical debates between the bio-medical and bio-psycho-social models; instead of the experimental survey and clinical use.

The model espoused by Engel (1977), a psychiatrist at the University of Rochester, he suggested ‘‘the need for a modern model for medicine’’. In his paper in the American Journal of Psychiatry, he explains this model by discussing a 55-year-old male patient who had two heart attacks, six months apart from each other. Engel points out that the personality of the patient facilitated the interpretation of the patient’s chest pain, even when the patient refused to come to terms with the diagnosis; this after being encouraged to seek help by friends and family. Whereas his heart attack may be clearly explained as a clot in a coronary artery, a broader individualized view can assist in understanding how this patient perceived his health condition.

Consequently, if a patient develops a cardiac arrest as a result of an incompetent arterial puncture not well carried out, systems theory can scrutinize this occurrence within broader standpoints other than a cardiac arrhythmia. The event is viewed as a result of incompetent skill and inadequate monitoring of subordinate medical staff in an emergency room. While there may be no single definitive model published, Engel's sophisticated clarification of his model provides perspective on a broad view of healthcare practice. Engel and White (1977) stated a bio-psycho-social model for care easily incorporated the spiritual. This context is dependent on a philosophical anthropology, the bedrock of which is the principle of the individual as being in a relationship. Life is basically about relationships; relation here means ‘transcendence.’ Disease can be defined as that which disturbs relationships, which make up the elements that form a person. Human beings are by nature spiritual, because everyone is either in relationship with others, God, nature, or themselves. Knowing something entails grasping the difficult clusters of relationship that makes it important regardless of what it is. Recently nurse philosophers, thoughtful to the unique and different periods in a client’s life, have found it worthy to develop middle range hypotheses. To this end, hypotheses that solve major health concerns come into play.

To these hypotheses; a theory of the middle age, which focuses on spiritual wellness even in the face of health problems, was created with the help of O'Brien's varied experience in clinical care nursing (O'Brien, 2011).

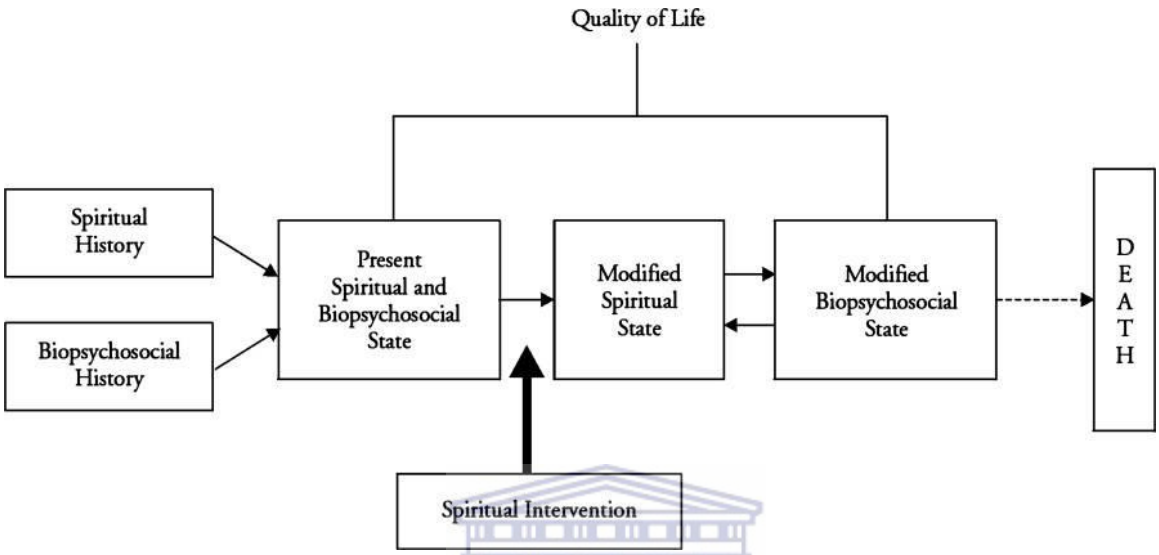


Figure 2.2: Bio-psycho-social- Spiritual model (O'Brien, 2011)

In the 1970s and 1980s especially, both academics and practicing nurses began to incorporate theories of nursing into their research and practice. The majority of these early nursing models fell into the class of 'grand theories' of nursing, or those abstract outlines that seek to understand and define the total scopes of study in clinical nursing. All the models consist of basic investigative concepts such as the environment, the individual, nursing and health. A number of nursing symposiums were organized to deliberate on the significance of these hypotheses in the nursing profession. Major nursing academics such as Betty Neuman, Callista Roy, Dorothea Orem, and Martha Rogers gave presentations at the meeting. The most frequently cited conceptual frameworks were the Neuman systems model, the Roy adaptation model, Orem's self-care model for nursing and Rogers' model of unitary person. Even when the work of the academics was given due consideration as people of that era, nurse theorists, still revered Florence Nightingale as the first nursing theorist. This honor is

because in Nightingale's 1859 nursing book notes, she stresses the significance of having a framework for the nursing profession. Some nurse researchers have tried using nursing theories to make known their findings. Normally, this grand theory is scrutinized by a health investigator as a part of the model being used. Important parameters to allocate and describe professional nursing practice are provided by grand theories of nursing, and as a result theorists have advocated for theories that seek to describe more distinct nursing phenomenon.

In contrast to the striking theories of nursing practice that resolves to impose various principles that define a wide number of concepts in nursing, the theories of the middle range have achieved emergence in literatures of professional origin. Some of these include frameworks addressing matters related to chronic sorrow, control of pain and death. The perception of 'middle-range theory' was first presented in literature of sociological origin, written by Merton (2015). The notion of mid-range theories is that it comprises of encompassing bodies of knowledge beyond limited variables and of utmost significance rather than experimentally tested grand theories. Those previously identified concepts of interest stated above is what middle range nursing theories revolve around, as noted by (Chinn & Kramer, 2013). Middle range theories can be defined in accordance with Meleis (2012) as 'theories that concentrate on certain nursing concepts that express clinical practice'; 'not covering the full range of phenomena that are of concern within the discipline' (Chinn & Kramer, 2016); sharing 'some of the conceptual economy of grand theories but also [providing] the specificity needed for usefulness in research and practice' (Walker & Avant, 2011); and 'made up of a limited number of concepts and propositions that are written at a relatively concrete level' (Fawcett & Downs, 2013). As middle-range theories aim to solve a speculated concept, their objective is to 'describe, explain or predict phenomena' (Fawcett & Downs, 2013). In summary, middle-range theories lie between the

more theoretical or striking theoretical models. Even though, minimal focus is present on spirituality in orthodox nursing theories, midrange theories and grand theories, very pressing issues have been addressed by theorists in healthcare nursing. Examples include, but are not limited to, presentation of an ever-changing framework for maximizing the models of spirituality in nursing (Miner-Williams, 2015) development of a model for advancing spiritual care in nursing and health care (McSherry, 2011); and discussion of the 'construction of spirituality' in nursing theory (Henery, 2015).

2.7.4 Middle-range theory of spiritual well-being in illness

Attention to the needs of body, spirit and soul is vital in order to implement holistic healthcare. This is of major importance in the middle range theory of ensuring spiritual well-being during illness. This theory orientation is highly significant for nurses taking care of patients with varying degrees of life-threatening illness and injuries, which retard people's professional and personal prospects. In this scenario, patients usually struggle to find meaning, being as they are in the midst of disability and sickness. Irrespective of one's religious views, and also in the absence of religious views, patients dealing with life-threatening circumstances struggle to find purpose. However, when finding purpose seems impossible to achieve, patients can develop a feeling of acceptance; accepting the situation as unpalatable as it is. Mid-range theory of spiritual well-being in illness assists both nurse researchers and practitioners who work with patients who are very ill; to assess the spiritual needs of their patients.

McEwen (2014) asserts that 'middle-range theories generally emerge from combining research and practice, and building on the work of others'. The concluding fact is endorsed by nurse theorists who suggest that mid-range theories may result from frameworks of conceptual origins (Ruland & Moore, 2014*)* or from clinically established rules (Good, 2010). The midrange nursing theory of spiritual wellbeing during illness was grown from

previous reforms in the field of spiritual wellness and through the model of nursing developed by Travelbee (2010), in which a major view point of the context is the principle of discovering meaning during an illness (Travelbee, 2010). The basic constituent of the nursing theory of spiritual health in sickness is the concept of deriving spiritual meaning when sickness sets in. Although the importance of spiritual concerns was introduced by Travelbee (2010) who states that 'the spiritual values a person holds will determine to a great extent his [sic] perception of illness'. The author didn't clearly describe 'spiritual wellbeing' as a concept in her model. Instead, she enhanced an interactive masterpiece on 'man-to-man', 'nurse-to-patient relationships', seeing the role of nurses as supporting 'patients that are ailing to derive hope as a way of dealing with suffering and sickness' (Chinn & Kramer, 2016). Chinn & Kramer, (2016) postulated that illness was projected as a 'physical, emotional and spiritual' experience that may be described both 'objectively and subjectively.' Travelbee (2010) emphasized that a person's meaning of illness is dependent on 'the symbolic meaning attached to these concepts by the individual' (Thibodeau, 2016); furthermore, she argued that 'one's attitude toward suffering ultimately determines how effectively he [sic] copes with illness' (Meleis, 2012). In conclusion, Travelbee (2010) imparted that 'the professional nurse practitioner must be prepared to assist individuals and families not just to cope with illness and suffering but to find meaning in these experiences.' 'This is the difficult task of professional nursing,' she agreed, (but) 'it must not be evaded'. A distinguished psychiatric nurse practitioner and educator of high repute, Joyce Travelbee died at the age of 47 at the onset of her doctoral study; thus, we do not know how much of her beginning conceptual model for nursing practice was enlarged. Although Joyce Travelbee never lived long enough to expatiate and authenticate her model of interaction her astonishing analysis, based on the context of an ill person deriving purpose and meaning in the event of ailment and pain, gives a scholastic and well-grounded foundation for the expansion of a

midrange-level theory maximizing and recounting what illness and suffering means spiritually: a nursing theory of spiritual well-being during illness. As stated, the middle-range theory of spiritual well-being during illness was also derived inductively and firmly rooted through nursing research aimed at discovering the significance of spiritual wellness in dealing with disability and long-lasting ailment. Between spiritual well-being and quality of life, overpowering associations of positive values, both qualitatively and quantitatively, were discovered. Certainly patients attested to having a greater level of personal belief and spiritual gratification. Furthermore through spiritual exercise they showed more positivity and satisfaction within different areas of their lives and they had greater futuristic aspirations, irrespective of experiencing incapacitating and painful ailments at times.

2.7.4.1 Philosophy and Key Concepts

All theories have a foundation that is philosophical, which acts as a foundation for other theories and associations uttered in the context. The middle-range theory of spiritual wellness in illness is based in the credence that humans, in addition to being influenced by a psychosocial nature, are spiritual and have the ability to accept experiences such as pain and suffering in the illuminative view of the creator. Clinical nurses have experienced illness and disability in patients over and over again and have witnessed patient's astonishing transformation in their rise above psychosocial discrepancies to a life that is productive. Embracing and accepting suffering and illness is essentially due to the spiritual resources of the individual. Supporting, identifying and strengthening the impact of these spiritual assets as they relate to illness, is the foundation on which the theory of nurses on the spiritual well-being in sickness has been established.

The concept of the middle-range theory of spiritual well-being in illness that is most important is the concept of spiritual well-being. Based on the conceptual model (Figure 2.3), a sick person having the gift of discovering spiritual purpose in the midst of an illness, can

reach a state of spiritual wellness. The ability of finding spiritual purpose in an episode of illness is inclined by various factors. Firstly, a person's notion of the spiritual purpose or meaning of an illness is caused by spiritual, personal and religious behaviours and attitudes. These behaviours and attitudes consists of factors relating to having faith in God and finding peace in one's spiritual and religious beliefs, as well as having a strong assurance in God's power and feeling secured in God's love. There is a sense of empowerment derived from personal beliefs and having faith in God's wisdom. In this way patients do not entertain fear, but instead derive a sense of pleasure in faith, a feeling of closeness to God, faithfulness; spiritual contentment and religious practice. Being supported by a community of faithful people encourages spiritual companionship through which people find consolation in prayers and communicating with God through religious rituals.

The evidence that these spiritual activities facilitate spiritual meaning during illness can be reconciled by intervening factors such as severity of illness, level of functional impairment caused by disease or injury; as well as moral support given by family, friends and/or health workers during stressful situations.

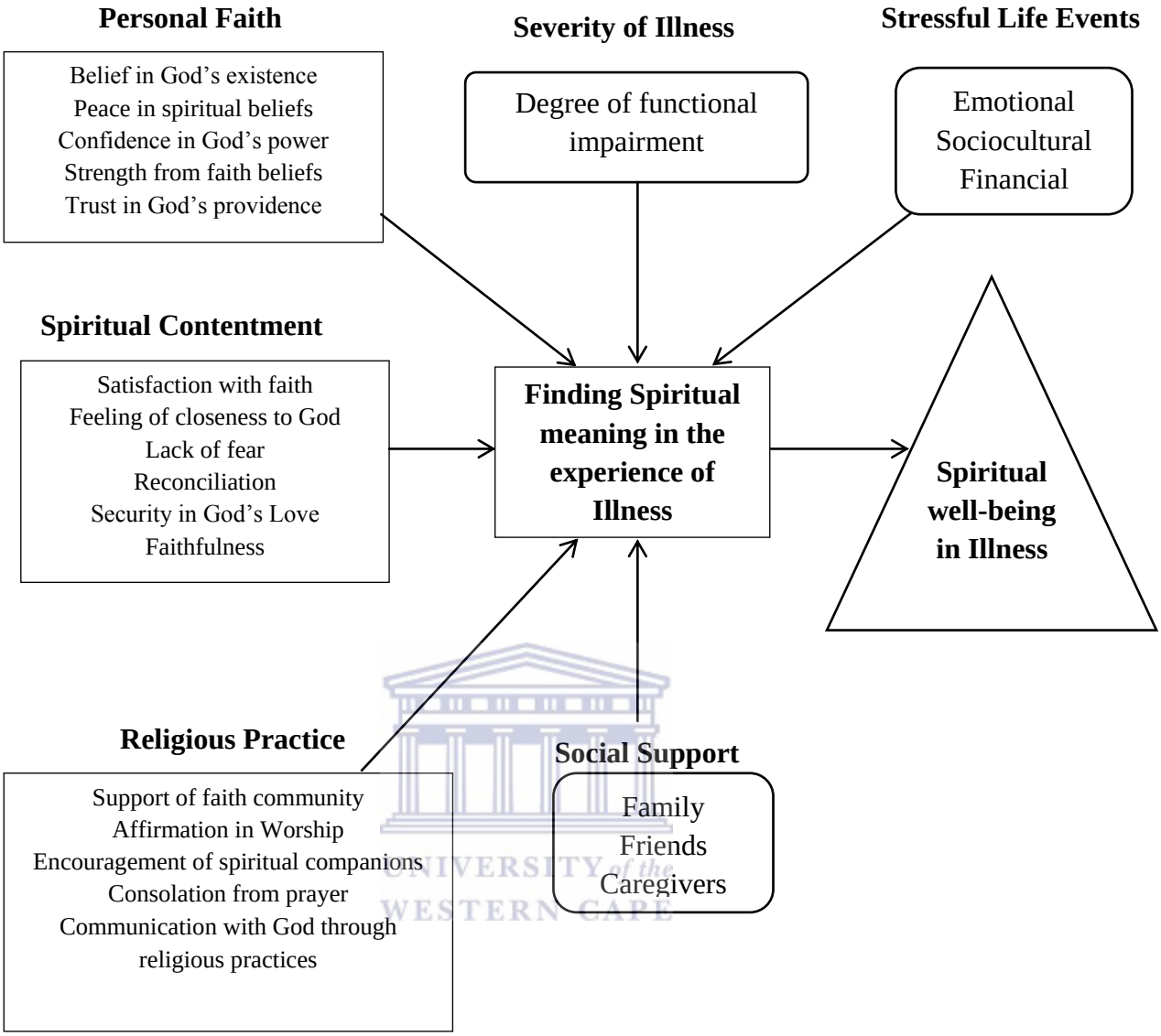


Figure 2.3: A conceptual model of spiritual well-being during illness (O' Brien, 2011 adapted)

To develop a middle-range theory, the first step is to carry out an analysis of the crucial concepts of the model. Walker and Avant (2015) assert that a nurse theorist identifies a number of 'phases' in a 'concept analysis,' which define the objectives of the analysis, 'through identifying 'uses of the concept,' and 'defining empirical referents'. The basis of spiritual wellness is identifying and describing this in respect to modern functionality, especially as it relates to experiencing illness. The usage and practical referents of the concept are inspected from the existing literature as well as nursing research and practice. O'Brien (2011) states that the concept of spiritual well-being was discovered in the nursing

and sociological literature in the course of increasing the Spiritual Evaluation Scale based on previous nursing research and practice. The concept of spiritual well-being was envisioned as comprising two dimensions, namely: dimensions of personal spirituality or the transcendent; and dimensions of religiousness, which is the expression a person exhibits while practicing his faith. Often times this does not entail attending and involving oneself in an organized religious ritual. As a result, experimental referential of spiritual well-being is hypothesized in relation to a person's individual faith and spiritual gratification and religion.

2.7.4.2 Theory Synthesis

Walker and Avant (2015) defined theory synthesis as 'a strategy aimed at constructing theory, an interrelated system of ideas, from empirical evidence'. They go on to say 'a theorist pulls together available information about a phenomenon in theory synthesis. Concepts and statements are organized into a network or whole, a synthesized theory'. A graphic model of the theory of spiritual well-being in illness was presented earlier (Figure 2.3) for identification of connections amid core concepts and hypothetically facilitating factors significant to this analysis. A sick or disabled individual's ability to seek spiritual purpose in the incident of suffering is understood as being affected by that individual's religious beliefs and rituals, encompassing those replicating the perceptions of personal conviction, spiritual contentment and religious ritual. A sick person's belief must be regarded whether he or she believes in God or not, but also the person's faith in the goodness of God's kindness, peace of mind concerning those beliefs, courage and strength derived from them-is critical to whether the individual will be able to distinguish and/or acknowledge an illness experience as having a spiritual dimension. If a person believes in God's existence and yet not personally feel close to God; his or her faith may be based on a relationship that incorporates fear of God's judgment rather than security in His love. In such a situation, it may be very difficult for the individual to perceive an experience of illness or suffering as anything more

than a possible retaliation or punishment for past sins. While religious practice, in the formal sense of attending church services, may not be required for one to find a spiritual meaning in illness or disability; coping with illness can be greatly facilitated by the encouragement of a faith community with whom an individual shares worship or whose members pray for sick parishioners during communal worship services and/or the guidance of a pastor or spiritual companion. This can be very comforting in times of illness and suffering. A nurse who is registered and practicing may give vital healthcare intrusions in assisting the ailing person. Very often, as seen in the many practical examples mentioned in this study, nurses fall back on religious rituals previously abandoned by the patient at the beginning of an illness. As verified in the illustrative model presented in Figure 2.2, there are numbers of theoretically baffling variables that affect an ill person's ability to accomplish a sense of spiritual wellness during an episode of distress. A nurse is in the best position to address and to deliberate variables obstructing the patient's effort in the quest to find meaning during illness. To this end, a nurse can assume the role of a transfer agent by supporting patients who are functionally impaired. For example, if a patient has difficulty hearing, an audiology test may be recommended by the nurse, which would be vital in assisting the patient to obtain a Hearing Aid. A nurse can also act as a 'bridge' between family and friends when the relationship between them is strained because of the disability or illness of a loved one. Certainly through the innumerable tasks they perform, being that of educationalists, transfer agents, advisor and patient advocate; nurses are well-equipped to teach; advise; guide and support an ill person. This they do while regarding a number of financial, emotional and socio-cultural concerns that may prevent the patient from reaching a state of spiritual wellness while experiencing illness.

2.7.5. The theory of spiritual well-being during illness

Attention to the needs of body, spirit and soul is vital in orienting nursing care in order to implement holistic healthcare. This is of major importance in the middle range theory of spiritual well-being during illness. This theory orientation is highly significant for nurses taking care of patients with varying degrees of life-threatening illness and injuries, which slow down people's professional and personal prospect. In this scenario, patients usually struggle to find meaning in the midst of disability and illness. Irrespective of one's religious views, or particularly in view of its absence, people dealing with life-threatening circumstances struggle to find purpose in the condition they are faced with. If finding purpose seems impossible to achieve, patients can develop a feeling of acceptance; accepting the situation unpalatable as it is. A mid-range theory of spiritual well-being during illness assists both nurse researchers and practitioners who work with patients who are very ill, in assessing the spiritual needs of their patients. Appropriate spiritual care interventions can be instituted by nurse educators and researchers whilst working with seriously ill patients in order to achieve a speedy recovery.

2.7.6 The inter-professional spiritual care model

The spiritual care model is a relational model in which the patient and clinicians work together through a process of discovery, mutual dialogue, treatment, ongoing assessment and follow-up. In the spiritual care model, everyone involved has the potential to be changed by relating with other people. Centered on illustrations (O'Brien, 2011), the nurse must take the required spiritual history from patients when admitted in the hospital. Clinicians can identify the presence of a spiritual issue (including spiritual discomfort) and can call on the priest in the in-patient setting, or to other spiritual care providers deemed as appropriate in an out-patient setting; from the information offered in the spiritual history taken. Health workers can differentiate between spiritual, psychosocial or emotional matters and make the referral that

is right and in time for any of, or a combination of these issues. This premise focuses on a specialist-generalist model of care where chaplains who are board certified are recognised as highly trained spiritual care specialists. These chaplains, who are available to patients at any time patients are in need of spiritual care providers, should be regarded as an asset worthy of note.

2.7.7 Watson's theory of human caring

Jean Watson is a leader in the development of caring theory in nursing. While teaching at the University of Colorado between 1975 and 1979, she developed the Theory of Human Caring. As Watson has argued, the quality of the nurse-patient relationship is important when providing spiritual care, as this may be an uncharted area for both nurse and patient. Therefore, it is essential to establish a relationship that is based on caring. Watson describes her Theory of Human Caring thus:

> I tried to make explicit that nursing values, knowledge, and practices of human caring were geared toward subjective inner healing processes and the life world of the experiencing persons, requiring unique caring-healing arts and a framework called 'carative factors,' which complemented conventional medicine, but stood in stark contrast to 'curative factors' (Parker, 2012).

Watson defines transpersonal caring as caring that 'seeks to connect with and embrace the spirit or soul of the other, through the processes of caring and healing and being in authentic relation, in the moment' (Parker, 2012). Transpersonal nursing, through the use of Watson's curative factors, involves touching the spirit or soul of the nurse and patient. This can also be called spiritual healthcare. Spirituality is frequently mentioned in Watson's curative factors. The ten curative factors or clinical caritas processes are:

1. Embrace altruistic values and practice loving kindness with self and others.
2. Instil faith and hope and honour others.

3. Be sensitive to self and others by nurturing individual beliefs and practices.
4. Develop helping-trusting-caring relationships.
5. Promote and accept positive and negative feelings as you authentically listen to another's story.
6. Use creative scientific problem-solving methods for caring decision making.
7. Share teaching and learning that addresses the individual needs and comprehension styles.
8. Create a healing environment for the physical and spiritual self which respects human dignity.
9. Assist with basic physical, emotional, and spiritual human needs.
10. Open to mystery and allow miracles to enter.

This includes being open and attentive to spiritual mysteries and coming to terms with one's own death, caring for both ones-self and the person being cared for (Parker, 2012).

In a transpersonal nurse-patient caring relationship, Watson noted that the emphasis is not on the disease state. Instead the nurse will 'center consciousness and intentionality on caring, healing, and wholeness, rather than on disease, illness, and pathology' (Parker, 2012). Both patient and nurse are bonded into a relationship through which both the nurse and patient develop and grow. Watson (2014) noted that nurses enter into transpersonal relationships through caring acts such as gestures, facial expressions, touch, sound, verbal expressions, procedures and other forms of communication and nursing caring-healing modalities. Furthermore, caring relationships occur within caring moments. Watson wrote, 'if the caring moment is transpersonal, each feels a connection at the spirit level; thus, the moment transcends time and space, opening up new possibilities for healing and human connection at a deeper level than that of physical interaction.'

In her article titled 'Intentionality and Caring-Healing Consciousness: A practice of Transpersonal Nursing', Watson (2011) noted, 'in translating the transpersonal theory into authentic practice, the mindset becomes one of creating spirit-filled sacredness and reverence around our work ….consistent with timeless nursing and our Nightingale roots, we acknowledge that nursing is ultimately a spiritual practice'. Watson's Theory of Human Caring intertwines with Nightingale's beliefs regarding nursing care. Recognizing as well as relating with an individual's spirit can encourage a relationship which is 'caring-healing' focused. Through nurturing relationship places the patient in the most optimal state of wholeness, which enables healing and/or wellness to occur and be maintained. As with Nightingale, Watson's approach to patient care involves spiritual nursing care. All aspects of holistic nursing care: physical, mental, and spiritual, need to be incorporated into a plan of action to achieve optimum well-being for individuals, their families and significant others.

The theoretical framework is also germane to this study as outlined in the framework of Watson. This framework defines spirituality as being most significant. Watson maintains that the spirit of humans is a force most powerful in the existence of humans and also the cause of ruthlessly struggling for wholeness via spiritual changes and the attainment of tranquility. Nurses working within this framework were described by Watson as helping the body, spirit and soul; irrespective of age, life circumstances or health problems encountered. According to Watson, the theory of caring is pertinent in accepting the significance of optimism and spirituality to a person's wellness (Touhy, 2014).

Watson (2017) ascertained nursing practice as an art that is not based on task, but instituting a relational connection graced with warmth, care and empathy, that involves nurses being conscious of their patients' religious beliefs. In accordance with findings conducted by Hoffert, Henshaw and Mvududu (2012), knowledge of patients' needs and religious beliefs contribute to the advancement of an aiding relationship and enhancement of the patients'

holistic care will be achieved by the nurses. Watson (2016) and Meyer (2010) stressed the significance of nurses rendering spiritual sustenance in a caring community. Nursing is a science of human nature, caring for humans who are often vulnerable and delicate. Caring involves a social, moral, spiritual and emotional engagement on the part of nurse and a pledge to others as well as to themselves. In nursing, caring is not just an attitude, concern, benevolent desire or emotion. Caring is the moral code of nursing and it demands a moral obligation to protect human dignity and conserve mankind (Watson, 2011). The most important component of spiritual care is the gift of one's presence. In a positive manner, love and compassion consistent with Christianity can be displayed by nurses through meeting a patient's small request within the boundaries of professional contexts. This could be achieved through giving a reassuring squeeze while holding patient's hand and providing attentive physical care (Meyer, 2017).

The 'end point' was defined as that objective which each person endeavours to reach. This is encapsulated by Watson's (1988) theory as follows:

One plain endeavor of the person is the actualization of one's true personality hereby evolving the spiritual purpose of one's personality, and to be more like God in the greatest sense. Furthermore, every individual wants a harmonized body, spirit and soul hence, integrating, actualizing, and enhancing one's true personality. As one experiences one's self the more, the body, spirit and health will optimally be at its peak.

Watson (1988, 2014) in the *Philosophy and Science of Caring* postulates that health, healing and a sense of well-being allows for advanced mindfulness of oneself, peace, ability to rise above the rigours of crisis and fear are all promoted by caring. The effective demonstration of care happens on a personal level. This involves a person-to-person relationship that is said to be 'healthogenic'. This theory projects a substitute to technologically driven care, diseased condition and healing rules. Watson adds as the main rudiments of these findings, an original

and thoughtful awareness that allows an abysmal faith of the supplementary; refinement of one's spiritual life; and the nurse on her own part always showing care and the provision of an environment that aids healing. Caring reactions accommodates a person's personality, which encompasses what they may likely become now and in the distant future. When a relationship is based on caring, the other person's spirit is enlivened.

Watsons's theory reveres that period where care is given within the context of a nurse and client relationship. This relationship is vital because the nurse is the major support system of the client's health so that the client progresses towards optimum health via the caritas principle of Watson's theory. Because of this reason, the major components of the connection existing between the nurse and client within the context of spiritual care and exchange of energy that flows around the health community is comprehensively explained by Watson.

Spiritual care is particularly essential to GNP practice, where long-drawn-out realization and discernments expanded by the GNP may be streamlined in nursing practice to help patients develop their awareness in relation to healthcare.

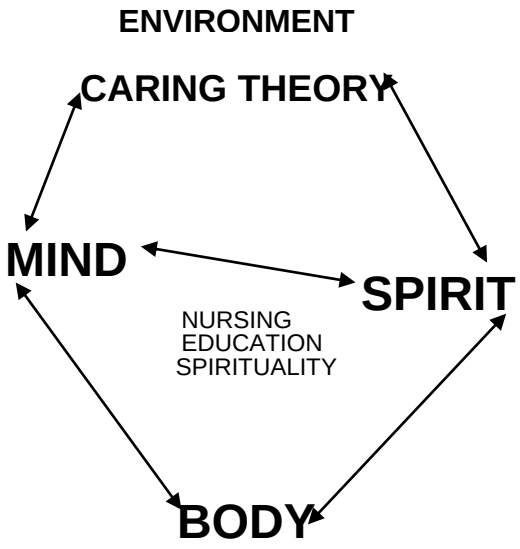


Figure 2.4: Elements involved when addressing the patient's spiritual needs

Adaptation from Rankin and DeLashmutt (2011) model titled, *Elements Involved in Experiencing Spirituality and Presence in the Nurse-Patient Relationship.*

2.8 SPIRITUALITY AND NURSING EDUCATION

2.8.1 Introduction

To what extent are nurses being educated to address spiritual issues and provide spiritual care? Lemmer (2012) states that numerous other nurse researchers continue to report that nursing education is woefully inadequate in preparing nurses to address the spiritual needs of patients, with many nurses feeling unprepared to do this. There is some evidence that instruction in spiritual assessment and providing spiritual care, improves nursing education. In a study conducted by Lemmer, questionnaires were sent to two hundred and fifty randomly selected nursing baccalaureate programmes in the United States, of which one hundred and thirty-two questionnaires were completed and returned (Lemmer, 2012). This aim of the study was to discover whether these programmes included spirituality in their curricula. The results, however, most likely to represented a 'best case scenario,' since 39% of the programmes that responded were sponsored by religious organizations. Nursing schools that did not address spirituality were probably less likely to return the questionnaire due to lack of interest. In any case, 97% of the programmes noted that they included spirituality in the curriculum, while 71% said they included the spiritual dimension in their programme's philosophy.

Even outside the United States, the data on nursing education in countries other than the U.S.A. is limited. However, the following information was gleaned:

In a 1993 study of British nurses, 60% expressed a desire to have more education in spiritual care (Narayanasamy, 2013). In a survey of twenty-nine Canadian undergraduate nursing schools reported in 2003, eighteen schools responded with thirty-nine faculties responding from those eighteen schools). The results indicated that spirituality was often not included in curricular objectives. Two thirds (67%) said that the term 'spiritual dimension' was not

defined in their educational programme; close to 40% said they did not have course objectives addressing the spiritual dimension; and 44% said that no specific method was used to evaluate student learning in this area (Oslon, et al., 2011). In an on-line survey of members of the Royal College of Nursing in 2010; most nurses (nearly 80%) either agreed or strongly agreed that nurses do not receive sufficient education and training in spirituality (McSherry & Jamieson, 2010).

In the 2003 survey of oncology nurses in Sweden, when asked whether they had received education about spiritual care, only 6% said they had (Lundmark, 2016). In the study conducted in Taiwan in 2011, surprisingly over half (45%) of the three hundred and forty nine clinical nurses said that they had received spiritual care lessons during nursing training, and about the same number (59%) reported that they had received continuing education following graduation, that involved spiritual care. However, their definition of spirituality was very broad and the response rate in this study was low (only 23%, suggesting that this is a best-case scenario) (Sodestrom & Martinson, 2011). Thus, while the situation appears to be improving; for the majority of hospital nurses today either in or outside of the United States of America, particularly at the level of nursing education, spiritual assessments and provision of spiritual care are not routine practices.

There are many reasons why nurses are not assessing or addressing spiritual issues more regularly. They include lack of time, lack of education about spiritual assessment or care, confusion about what spirituality is (i.e. how it's defined), fear of being intrusive or offending patients, feeling the area is too personal to inquire about in situations where privacy is lacking, discomfort about assessing spirituality and an over-sensitive temperament on the part of the nurse (McSherry, 2011). Sodestrom and Martinson (2011) asserted that they could only find a couple of systematic studies that addressed barriers that nurses face when assessing or providing spiritual care. In a study conducted over twenty-five years ago, three-quarters

(76%) of oncology nurses indicated that lack of time was a factor preventing routine spiritual assessments. In a 2010 qualitative study of seven oncology nurses in the United Kingdom, lack of time was again cited as the main barriers to addressing patients' spiritual needs, particularly given the priorities and practicalities of the job (Noble & Jones, 2010). Nurses said they tended to focus on the physical side of things, leaving little time for the spiritual. Clearly, a lack of emphasis on assessing and addressing spiritual needs during nurses' training is another pertinent reason why many nurses who trained in the 1970s, 1980s, and 1990s do not routinely ask about spiritual issues. Several educational courses for nurses, however, have now been developed and tested, including a two-hour and a one-hour continuing education for nurses in clinical practice (Lind et al., 2011).

It is imperative that a nurse has a vast knowledge of the multi-faceted doctrines of a belief system; most especially, tenets that have an impact on illness and well-being, in order to meet the various spiritual needs of patients. To deal with the complication of rendering nursing care in a society that exudes diversity, nurses must be well prepared. Nursing entails meeting the patient's needs holistically. When holistic care is provided, quality care that is the core of the nursing profession is achieved (Myers, 2017).

One of the six indispensable characteristics of the nursing profession is the creation of a compassionate relationship to aid patients' progression to smooth recovery and optimum health (ANA 2018). Nagai-Jacobson and Burkhart (2013) defined spirituality as the 'foundation of holistic nursing practice.' He further described spirituality as 'the integrating aspect of human wholeness integral to quality care' (Clark, Cross, Deane & Lowry, 2017). The paramount nursing analysis allied to spiritual distress and spirituality in the North American Nursing Diagnosis Association (NANDA) was founded in the year 1978 and remains today (NANDA, 2018). Professional nursing in the United States of America has a Code of Ethics that is acquainted to the relevance of health and spirituality, proven by the

code's first provision, that 'nurses in every professional relationship must practice with respect and sympathy for the intrinsic self-worth, value and distinctiveness of each person; unhindered by deliberations of socio-economic prestige, peculiar traits or the nature of health problems' (ANA, 2018). Interpretive statements for this provision of the code is further interpreted as 'the procedures nurses [under] take in order to take care of patients so that patients can live in a state of social, spiritual, social and psychological wellness as much as possible.' The ICN Nurses' Code states that 'The nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected' (ICN, 2018).

Even though nursing educationists teach spirituality as an essential component unique to each person, little to no academic advancement of nursing practice relating to this idea to make it a yardstick in nursing has been achieved. There is no generally accepted standard procedure to plan, evaluate, intervene and assess spiritual care as far as nursing is concerned. In the year 2004, a survey of one hundred and thirty-two baccalaureate nursing programmes in the USA found that few defined spirituality or spiritual nursing care (Callister, Bond, Matsumura & Mangum, 2012). However, in the most recent iteration of the Essentials of Baccalaureate Education for Professional Nursing Practice, developed and published by the American Association of Colleges of Nursing in 2008, spirituality was integrated throughout the document (American Association of Colleges of Nursing, 2008). As a result, current nursing schools are integrating spirituality more fully in their curricula.

As cited in Amoah (2011), Firth cautioned against ethnically stereotyping patients. Firth suggested respecting each person's spiritual encounter, molded by each person's world view and cultural background.

Matters arising as a result of a person's view of the world and taking on spiritual matters may be due to mode of dress, diet, views on healing and use of medications, body touch, religious

rituals, celebration of festivals, sacred books, modes of expressing emotions and rituals performed in respect of the dead. Hence nurses are acquaintances-in-voyage to prompt hopefulness and ease recovery when faced with the pains of life. Nurses must see themselves as spiritual givers of care (Gordon & Mitchell, 2012).

An in-hospital educational programme on the religious and spiritual patterns of care was created and implemented by Caramanzana and Wilches (2012). The programme objectives included the spiritual beliefs of Christians, Muslims and Jews as part of its goals in a bid to prepare nurses for spiritual care-giving. The aim was to prepare nurses for the provision of holistic caring. Forty teaching sessions with an attendance of five hundred and sixty one nurses was recorded over a period of three months, at a teaching hospital in New York. Almost all the nurses who attended stated that they felt empowered, regardless of their individual spiritual beliefs. They also noted that they were better prepared to handle situations of diversity more effectively. This reinforces the importance of incorporating spirituality into the education of health professionals.

In the face of evidence showing the need for incorporating spiritual care giving into the nursing profession, literature on spirituality in nursing education is sparse (Chism & Magnan, 2013); (Callister et al., 2012). In 2008, Kiley asserted that American Catholic nursing school deaneries were perturbed by how much importance was being placed on practical expertise and logical intelligence that has the tendency to render useless the spiritual importance of nursing patients with compassion. As a result of this, efforts have been made to integrate spirituality into the curriculum used in nursing schools and colleges. The American Association of Colleges of Nursing in collaboration with the George Washington Institute for Spirituality and Health at the George Washington University; are planning to develop curriculums on spirituality and spiritual care into the syllabus of health professions (Kiley, 2013).

Greater training and professional expansion in spiritual care for nurses working in therapeutic environments is essential. These consist of ensuring that spiritual care materials are easily accessible to both ailing and recovering patients (Hanson & Andrew, 2012). It is a great injury to both the code of ethics and the nursing profession in general, to abandon a patient's spiritual needs. It is still being deliberated upon by health professional whether paying little or no attention to patients' spiritual needs should carry the same punishment as that of neglecting the physical needs of the patient.

Pedrão and Beresin (2010) conducted a quantitative study with Brazilian nurses (n=30) to assess the state of their spiritual wellness and to determine their views concerning the significance of offering patients' spiritual assistance. This study also tested whether the health workers (nurses) had previously received any professional training on giving patients spiritual care. Of the nurses, 83% (n=25) answered in the affirmative on the significance of giving spiritual assistance to patients. Of the five nurses who responded negatively, 60% vindicated their negative responses by stating that nurses have no jurisdiction in interfering with this matter. Some 67% of nurses said they had had no professional training in spiritual assistance throughout their undergraduate study in nursing. Some 93% of nurses who took part in this study had had no training in spiritual assistance during postgraduate training and 87% had had no professional training in other nursing courses on giving patients spiritual assistance (Pedrão & Beresin, 2010).

Seymour (2017) conducted a study involving three groups of nursing students (n=49) to find out how well they understood the concept of spirituality and spiritual care; and to assess the effect of academic interpolations on their knowledge of spirituality and spiritual care. The first group used slogans such as 'to love and be loved, a feeling of belonging to someone and being understood'. The second group emphasized 'love, family and friendship, and the need to belong and be accepted.' The third group agreed by buttressing the previous group's notion

of ‘friendship and love, and supportive relationships as key spiritual needs’. These findings showed that the nursing students could recognize spiritual needs and together had a universal understanding of spiritual patterns and what spirituality entails. Many enquiries arose on whether spiritual care had been incorporated into nursing curriculum.

McSherry and Jamieson (2010) carried out a survey in the United Kingdom involving nurses’ consciousness on the provision of spiritual care and found out that nurses had a clear understanding that providing spiritual care enhanced the overall wellbeing of patients. Four thousand and fifty-four nurses took part in this survey. However, they felt that their knowledge on the provision of spiritual care was inadequate. The need to integrate spirituality and spiritual care into nursing practice has also been asserted by other studies (Koren et al., 2013; Dhamani, Paul & Olson 2011). If nurses acknowledged the importance of linking spirituality to nursing, this would be easy to accomplish.

A cross-sectional descriptive survey was used by Wong, Lee and Lee (2011) to investigate the opinions of nurses about spirituality and spiritual care in Hong Kong. Three hundred and nine one nurses concluded McSherry’s (2012) Spirituality and Spiritual Care Rating Scale (SSCRS). The results showed that a reasonable amount of difference in the mean score of the finding, generality and discernment of spirituality amid the focuses with various academic stages existed. The group that had attained a degree was the highest performing group. Those who had no proper educational training on spirituality scored badly as compared to those who had more training. Hence, the nurses’ educational level appeared to have a positive impact on their perception of spirituality and provision of spiritual care.

Irrespective of these facts, nursing education provides few opportunities to discuss spirituality and spiritual care (Molzahn & Shields, 2011). Sloma (2011) and Barlow (2011) conclusively stated that having no formal training in spiritual issues throughout undergraduate nursing education compromises the nurse’s ability to provide therapeutic spiritual care for patients.

This finding was supported by Lubbe (2012) who emphasized the need for such knowledge to be included into the nursing curriculum, while Dunn (2012) requested precise knowledge about spiritual care and evaluation.

2.8.2 Teaching methods on spirituality and spiritual caring in nursing education

Nathan (2010) and Clarke (2013) state that nurses face major challenges which are primarily rooted in a lack of knowledge about what spirituality entails and the different measures to cope with challenging situations. Nathan (2010) is of the opinion that nurses are better equipped at carrying out monotonous tasks like inculcating healthy dietary plans for patients, and normal day to day nursing tasks, but are ill equipped in solving spiritually confusing issues such as 'why is this happening to me?' and 'how will I cope?' Thus, knowledge on how to identify and give spiritual care should be at the centre of nursing practice. Nurses who have difficulties in providing spiritual care stated the following reasons:

1. Inadequate knowledge about what spiritual care is.
2. Confusion about what is expected of the nurse as far as spiritual care is concerned.
3. Either not being in tune with their own spirituality or a fear of imposing their own religious preference on patients.

With the aid of a sample of eighty-six nurses in the state of Illinois, findings revealed that nurses' level of spiritual wellbeing was in the mid-range and that there was more to learn on spirituality. When Tanzanian student nurses (n=15) were interviewed by Dhamani, Olson and Paul (2011) the student nurses described a longing to give patients spiritual care and expressed a desire to expand their knowledge base on this subject. Shin et al (2014) carried out a study in Taiwan, which yielded similar results. Following a survey of nurses (n=64), nurse professionals were interviewed. According to the results of the analysis, 92% of nurses

believed that spirituality classes would be helpful for their profession. The educational needs identified are listed as follows:

1. To illuminate spiritual care in the curriculum or nursing training.
2. The need to facilitate nurses' disclosure of spiritual beliefs.
3. The need to learn more about the provision of spiritual care.

The use of spiritual assessment tools such as listening, silence and touch were advocated by Ojink (2010) and Barlow (2011). However, notwithstanding the fact that a nurse has a spiritual foundation, it cannot be taken for granted that the nurse will give adequate spiritual care. Spiritual assessment/care must be incorporated into the nursing curriculum by nurse educators. Spiritual contents of models, frameworks and guidelines will make sure those graduating from nursing schools will have essential knowledge of the inter-relatedness between health and spirituality, and would be better privileged in being spiritually aware (Dunn, 2012). With the aid of interviews with pre-registration nursing diploma students (n=16) in Singapore, Tiew, Drury and Creedy (2011) investigated their attitudes and perception on the essence of spirituality in nursing practice. This investigation revealed that nursing students saw spirituality as an in-born attribute of a person's state of awareness on spirituality, which cuts across the individual's lifetime and which constitutes a basic requirement for spiritual wellness. Nurses who participated discovered that there must be a unique connection between themselves and patients in order for spiritual care-giving to be effective. Professional development and education for an efficient spiritual care delivery needs to be offered to nurses. When mid-western nurses were surveyed by Callister et al (2012), only 15% were confident that they were given enough information on spiritual intervention during their nursing training. American baccalaureate nursing programmes carried out additional surveys, which exposed the fact that even where spirituality had been integrated into healthcare education, definitions of spiritual care were lacking. Strategies of

teaching involved the lecture room activities (91.5%) and prayers that are content covered; use of scriptural books and meeting the spiritual needs of people who don't believe in God's existence. From this survey, it was apparent that spirituality was not well addressed. Graham (2018) using a co-joined method, carried out an examination to ascertain the perception of nursing students on how well, proficient and vast they were in tapping into needs that are spiritual. Before and after they took part in a four-hour spirituality seminar quantitative data was collected. In addition, a qualitative approach examined senior nursing students (n=12) through interview sessions. Findings from this analysis recognized five themes worthy of noting:

1. The personal spiritual belief of the nursing students.
2. Spiritual interventions.
3. The needs-based assessment of patients.
4. Individual beliefs.
5. Integration of spirituality in nursing.

Certainly, the findings of this study reveal that more emphasis should be placed on the spiritual aspect of nursing education. During a spiritual education programme for nurses (n=37) conducted at a Minneapolis hospital, to estimate the effects the programme has on satisfaction derived on patient care; nurses were questioned regarding resources they may require to meet patient's spiritual needs, at a follow up review. A patient satisfaction survey evaluated the primary outcome of patient satisfaction. Conclusively the findings showed that patients see nurses as better placed to meet their spiritual needs if adequate tutoring is given in the area of spiritual nursing care (Sendelbach, Lind & Steen, 2011). In addition to the absence of adequate training and education; lack of privacy, lack of time and resources, personal attitudes/sensitivities on the nurse's part and feelings of discomfort felt by nurses in dealing with such private issues are other reasons that nurses gave for not providing adequate

care. A mock test on spirituality and a nursing care training course was undertaken by Vlasblom et al. (2010) for nurses at the three hundred and thirty bed Rotterdam Christian Hospital.

On two occasions the first before this training and the second six weeks after the training, one hundred and eighty-seven patients and forty-nine nurses completed assessments that evaluated attributes of patients. These attributes covered issues such as quality of life, views on well-being and hospital experiences. The findings / outcomes were that patients admitted into the interventional wards got adequate care and information on finding purpose in the face of ailing conditions. Nurses' attitudes in clinical practice also evolved for the best as the hospital's chaplaincy unit experienced more patronage. In this way training in spiritual care for nurses has a positive effect on the general well-being of patients. An expository study by Wehmer et al. (2010) surveying two hundred and forty-one nursing students who answered questions concerning 'what their spiritual experiences are, what the level of their spirituality is and what their spiritual practices are.' From their answers, it became apparent that for these nursing students, the highest spiritual routine on a daily basis was being thankful for everyday blessings. The other daily spiritual routines they described included the following:

1. Selfless caring for others.
2. Finding comfort in religion and spirituality.
3. Accepting others.
4. A desire to be close to God.
5. Asking for God's help.

Most of the nursing students affirmed that these spiritual encounters occurred daily. Playing or listening to music (n=125) followed by helping others (n=120), exercise (n=117), family activities (n=112) and praying alone (n = 110) were the most reported spiritual practices. On the other hand, meditation (n=40) and yoga (n=40) were the least often used spiritual

practices. The most often used spiritual practices were listening to music (n=80), exercise such as walking (n=58) and praying alone (n=54) (Wehmer et al., 2010). In the survey conducted by Lovanio and Wallace (2007) it was discovered that using interventional spiritual practices such as visiting the chapel and praying boosted the spiritual behaviour of the students. A latter study that was aimed at streamlining nursing curriculum and spirituality together, asserted that spiritual characteristics and behaviour improve after adequate academic training is given. Following the introduction of a specific educational programme on spiritual care, similar changes were discovered in spiritual experiences (Wehmeret al., 2010).

2.8.2.1 The challenge faced by spirituality and spiritual care in nursing education

Nurses' effectiveness and skill, as well as the spiritual support experienced by clients, increase after receiving training in spiritual care (Narayanasamy & Owen, 2015; Ross, 2010, Vlasblom et al., 2010). In order to deliver spiritual care effectively, patients' needs must be given the highest priority in spiritual care nursing (Baldacchino, 2014). Baldacchino (2014) further stated that nurses perceived themselves as ill-equipped due to not having received training on spirituality in undergraduate and postgraduate nursing education. Accordingly, to perfect their spiritual dimension skills in nursing care, nurses recommend further academic training. In order to render a holistic care, undergraduate and postgraduate nursing education must give comprehensive information on the art of developing spirituality. Spirituality and spiritual care become an essential component of nursing because of this reason. An in-depth understanding on spiritual care-giving brings up matters of what nurses should be taught and the mode of teaching (Swinton & Patterson, 2010).

Including a wide range of content and experiential learning in the basic nursing curriculum is one of the challenges facing nursing educators (Deal, 2010). Basic understanding of one's own spirituality and spiritual aspects of patient care are very much ignored because the

nursing curriculum has given priority to the integration of the latest technology into healthcare. Since the new millennium, increased attention has given to teaching nursing students about spiritual care.

2.9 THE EPISTOMOLOGY AND PARADIGM GUIDING THE STUDY

2.9.1 Paradigmatic Perspective

A research paradigm is a set of fundamental assumptions and beliefs as to how the world is perceived, which then serves as a thinking framework that guides the behaviour of the researcher. Weaver and Olson (2006) view research paradigms as "patterns of beliefs and practices that regulate inquiry within a discipline by providing lenses, frames and processes through which investigation is accomplished". The paradigmatic perspective is thus the collection of meta theoretical, theoretical and methodological assumptions that guide the research process.

According to Scotland (2012), "every paradigm is based upon its own ontological and epistemological assumptions" and this can be seen in the methodology and methods that underpin a particular research. In view of this, he further states that any methodology a researcher decides to use is determined by the reason for the data, where the data will come from and when the data will come, and how the data is collected and analysed. (Ritchie, Lewis, Nicholls & Ormston, 2013). Grix (2010) states that two researchers working on the same phenomenon can have a different research approach because they have differing epistemological and ontological positions.

2.9.2 Meta-theoretical assumptions

Meta-theoretical assumptions are concerned with the reality that guides the researcher to understand how things are and how things work (Scotland, 2012). The researcher's worldview in this study is that of pragmatism. The proponents of pragmatism are "not

committed to any one system of philosophy and reality" but advocate the use of "pluralistic approaches to drive knowledge about the problem" (Creswell, 2017). Within this worldview, objective and subjective perspectives are not mutually exclusive and therefore a mixture of approaches is acceptable to understand social phenomena (Wahyni, 2012).

Pragmatism advocates for the mixture of objectivist and subjectivist ontology and epistemology to understand a social phenomenon and give the researcher the freedom to choose methods techniques and procedures that suit the study's needs and purposes (Creswell, 2014; Wahyni, 2012). The ontological assumption of subjectivists is that the problem of reality is constructed by the researcher's involvement in the research circumstances which implies that the researcher, those individuals being researched and the reader interpret information differently (Creswell, 2016). In contrast, the objectivist advocates that the researcher adopts a distanced, detached, neutral and non-initiative position from the researched. However, in this study the researcher believed that the combination of the two world views would create room for better understanding and explanation of the phenomena in this study.

2.9.3 Theoretical assumptions

Based on the pragmatic world view, the researcher adopted spiritual model of care theories as the theoretical foundation in this study. This model postulates that health can be clearly understood when social, psychological and biological factors are combined rather than by analyzing only one factor within this context. This is totally different when compared to the biomedical model of medicine, which states that the process of every disease can be better defined within the context of a deviation from normal functioning, which can be a developmental anomaly, injury or genetic deficiency. This is found useful in clinical fields of family therapy, licensed clinical mental health counselling, psychiatry, physiotherapy,

clinical social work, clinical psychology, health psychology, occupational therapy, medicine, nursing and sociological practice.

2.10 SUMMARY OF LITERATURE REVIEW

The literature was reviewed through three methodological approaches; namely conceptual discourse, empirical review and theoretical framework. Basic concepts such as spirituality, religion, spiritual care in nursing, assessment of spiritual care/ nursing assessment, spiritual care in nursing practice, spirituality and nursing, spiritual care interventions, spiritual competence, teaching strategies on spiritual issues and challenges encountered in spiritual nursing education were evaluated. The empirical aspect reviewed studies on spirituality and the challenges faced while integrating or practicing spiritual care in nursing. Spiritual care models were also reviewed including the intervention model used for the study i.e. intervention mapping strategy. The spiritual care models reviewed for this study included the bio-psycho-social-spiritual care model, middle-range theory of spiritual well-being during illness, Watson's theory of human caring model and inter-professional spiritual care model.

CHAPTER THREE

OVERVIEW OF THE RESEARCH DESIGN/INTERVENTION MAPPING

3.0 INTRODUCTION

This chapter describes the theoretical framework and methodology used for this study, which is presented in three sections. The first section provides a theoretical presentation of the Intervention Mapping Framework (IMF) in its six steps. The second section describes the adoption of the intervention mapping strategy for developing a model to fully integrate spiritual care into the nursing curriculum in Nigeria. The second section is divided into two phases. Phase One of the framework focused on situational analysis of the teaching-learning status regarding spiritual care, as it affects the nursing curriculum in Nigeria. In Phase One steps one to three were adapted to explore research objectives one to three, while Phase Two focused on the fourth research objective, i.e. developing a model that integrates spiritual care-giving in Nigeria in collaboration with the stakeholders /expert committee, using the Delphi technique. This phase also described the activities of steps four and five of the intervention mapping strategy.

3.1 RESEARCH SETTING

The research sites are the exact locations where this survey was carried out or the place of data collection. This consists of studies conducted in natural settings such as a real life environment or situation. Carrying out a survey in the natural environment signifies that the research scientist has no influence or control over that environment. The environment may be work area or the home (Burns & Grove, 2016; Polit & Beck, 2013). The research setting was quite diverse in nature considering the fact that the study was both qualitative and quantitative in nature. The settings included the classrooms and offices of the nurse educators/clinicians as well as hospital conference halls. The healthcare environment includes a number of sections such as medical, surgical, accident and emergency, paediatric,

continuing education, nutrition, theatre, out-patient unit, orthopaedic as well as special and gynaecological units in the hospitals where the nursing students receive training. The study was carried out in the Federal Republic of Nigeria, a federal constitutional republic comprising 36 states and its Federal Capital Territory, Abuja. The country is located in West Africa and is 923,768 square kilometres. Nigeria is bordered by Chad (87 kilometres) in the North-East, Cameroon (1,690 kilometres) in the East, Benin (773 kilometres) in the West and Niger (1,497 kilometres) in the North. There are more than 500 ethnic groups in Nigeria, of which the three largest are the Hausa, Igbo and Yoruba (Nigeria Demographic Profile, 2014). According to the National Population Commission (2013) the population of Nigeria is estimated to be 170,123,740, distributed as 50.0% rural and 50.0% urban, with a population density of 173.6 million people (CIA World Fact book, 2014).

Nigeria is divided into six geo-political zones and there are 23 accredited Departments of Nursing Science in the country as indicated below:

1. North Central Area: Niger, Benue, Kogi, Kwara, Plateau, Nasarawa, and Abuja the Federal Capital Territory (two accredited Departments of Nursing Science).
2. North-East Region: Borno, Taraba, Bauchi, Gombe, Adamawa, and Yobe States (two accredited Departments of Nursing Science).
3. North-West Region: Kebbi, Zamfara, Sokoto, Kano, Jigawa, Katsina and Kaduna States (two accredited Departments of Nursing Science).
4. South-East Area: Imo, Enugu, Abia, Anambra and Ebonyi (five accredited Departments of Nursing Science).
5. South-South Region: Bayelsa, Edo, Cross River, Akwa Ibom, Delta and Rivers States (six accredited Departments of Nursing Science).
6. South-West Area: Ekiti, Oyo, Ogun, Lagos, Ondo and Osun State (six accredited Departments of Nursing Science).

The researcher used a university offering a nursing degree programme in a state per geopolitical zone for quantitative study, except in the North-Eastern zone which could not be used, because the only Department of Nursing Science in the zone is located in Borno State, a State that is security restricted.

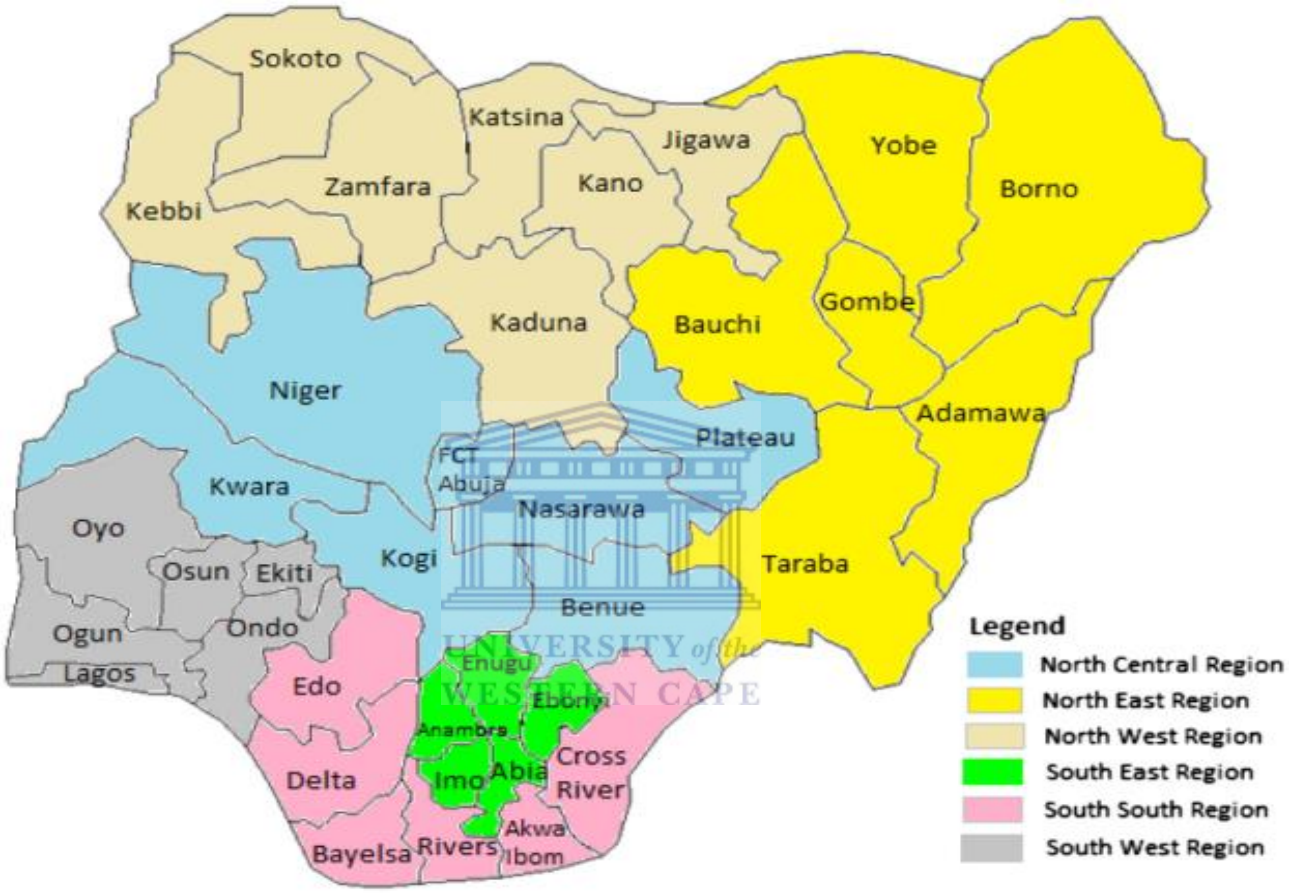


Figure 3.1: Nigeria Geopolitical Zones (Olawale, 2018)

3.2 RESEARCH DESIGN

Burns and Grove (2017) define a research design as a blueprint for conducting a study, with maximum control over factors that may interfere with the validity of the findings. This study used a cross-sectional explanatory mixed method approach in order to answer the research questions and meet the objectives of the study. Creswell (2014) states that mixed methods research is an approach to inquiry involving collecting both quantitative and qualitative data, integration of the two forms of data and using distinct designs that may involve philosophical assumptions and theoretical frameworks. The basic notion of this type of inquiry is that the integration of both qualitative and quantitative methods gives a clearer understanding of the research problem as opposed to using either one of these methods only. The survey was systematic and sequential in nature, which according to Johnson, Onwuegbuzie and Turner (2016), involves the collection of both qualitative and quantitative data in response to research questions. The researcher first collected quantitative data and analysed them, which was then followed by collection of qualitative data, which was also analysed. The two forms of data were integrated into the design analysis through merging of the data. The information derived from the merged data was used to develop the questionnaire for the Delphi Technique, which eventually became the document used to create a model that integrates spiritual care into nursing education.

As noted by Vos et al. (2011), the mixed-methods research is the adopted model for this study for the following reasons:

1. It provides opportunities for diverse views and perspectives, making researchers aware of the fact that issues are more multifaceted than they may at first appear to be.
2. It eliminates different kinds of predisposition, explains the genuineness of a phenomenon under investigation and proves various forms of validity or quality criteria.

3. Mixed methods research, being ‘practical,’ allows the researchers the freedom to use all methods possible to address a research problem, as well as combining inductive and deductive reasoning processes.
4. It enables researchers to address a range of confirmatory and explanatory questions using quantitative and qualitative approaches simultaneously.
5. It provides strengths that offset the weaknesses of both strands (quantitative and qualitative) of the research, thus has the potential to provide stronger conclusions.

This approach gives a full understanding of the investigated subject, and the survey therefore has a wider range than studies conducted before. For this study in correspondence with the explanation and definition of this study, as expatiated by Creswell and Clark, the mixed methods research design was employed. The approach entails incorporating qualitative (FGDs + in-depth interviews) and quantitative (surveys) data analysis and collection into one survey. From both strands, collection of data was sequentially done with the quantitative data model and then qualitative (De Vos et al., 2011; Van Griensven et al., 2014).

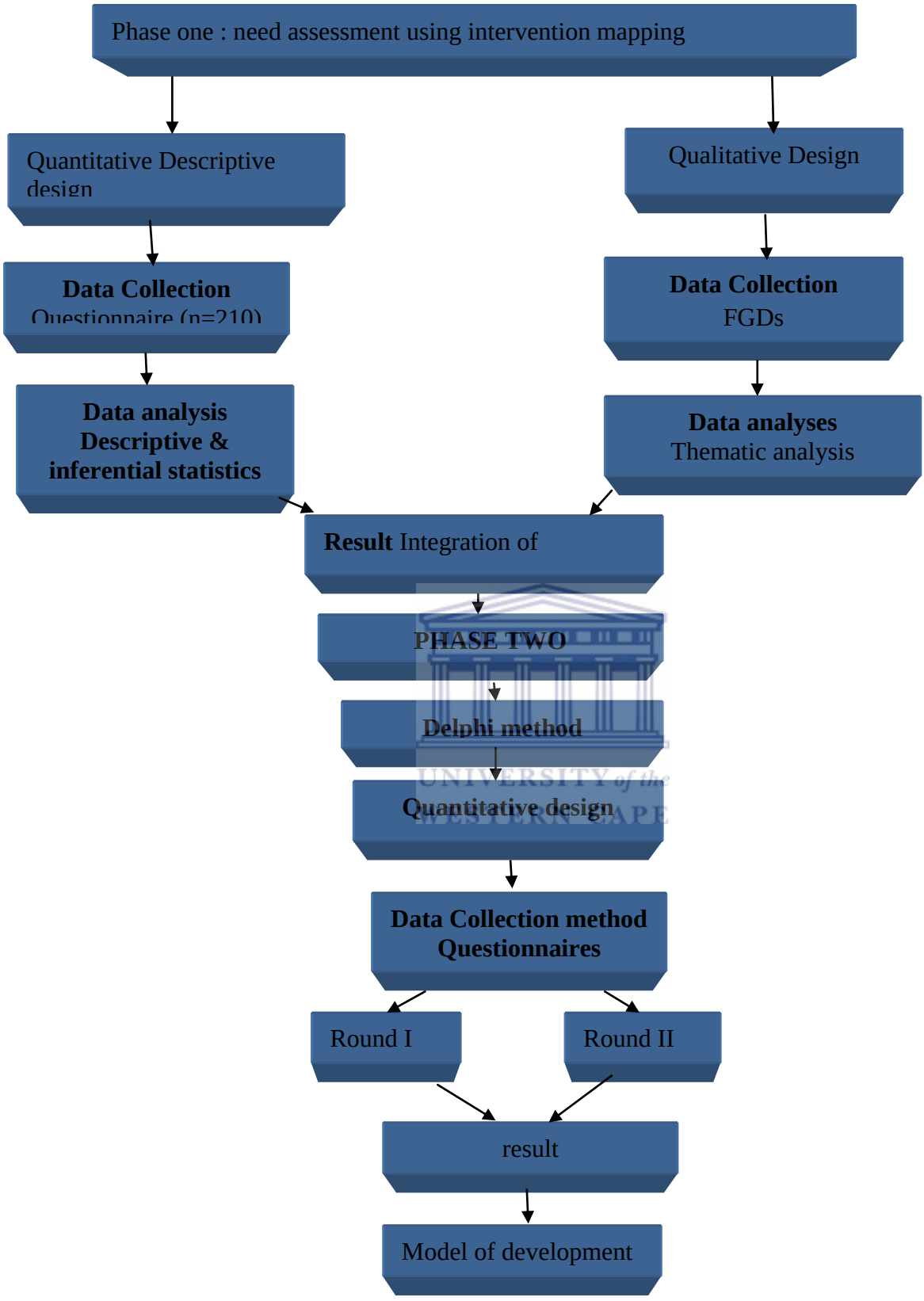


Figure 3.2: Process and various steps of the research

3.3 FRAMEWORK OF THE STUDY

This study employed an adapted version of the Intervention Mapping protocol (IM).

3.3.1 Explaining the Intervention Mapping Strategy

Intervention Mapping ensures that theoretical models and empirical evidence guide planners in two areas:

1. The identification of behavioural and environmental determinants related to a target problem.
2. The selection of the most appropriate theoretical methods and practical applications to address the identified determinants.

Although Intervention Mapping is considered a helpful tool in design programmes, it is true that it is a complicated and time-consuming process, reflecting the difficulty of changing health approaches. Intervention Mapping is explained as complicated, elaborate, tiring, costly and time-wasting (Tortolero et al., 2010). Interestingly, despite these criticisms, the same authors concluded that Intervention Mapping helped to bring the development of interventions to a higher level (Fernández et al., 2017); indicating that the advantages outweighed the disadvantages. Intervention Mapping is developed in the health promotion field, but can easily be applied to other fields, such as promoting energy conservation (Kok et al., 2011). Intervention Mapping was first developed and introduced in 1998 by Bartholomew, Parcel and Kok. It has six main steps which are:

1. Needs-based evaluation
2. Mapping of programme objectives and their behavioural determinants in a detailed format.
3. A careful selection of techniques and strategies to alter the determinants of behaviour.
4. Producing intervention components and materials.
5. Planning for adoption, implementation and sustainability and
6. Creating evaluation plans and instruments

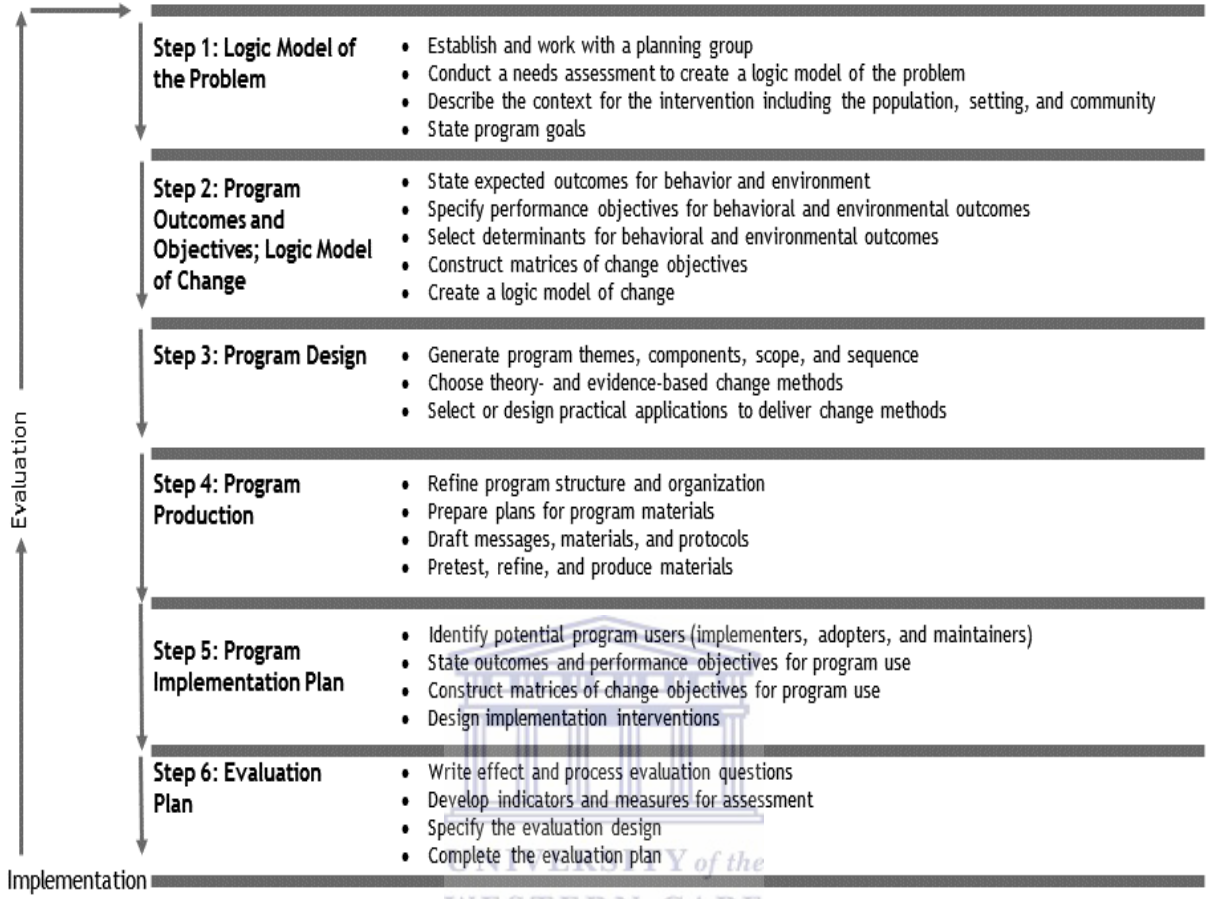


Fig. 3.2 Steps in Intervention Mapping/Plotting Strategies (Bartholomew et al. 2011)

3.3.2 STEPS IN INTERVENTION MAPPING APPLICABLE TO THE CURRENT STUDY

This study employed Intervention Mapping protocol (IM) as its framework in the integration of spiritual care into the nursing curriculum in Nigeria. Table 3.2 below indicates how it is applied.

Table 3.1 Intervention Mapping Strategy and its relation to this study

Phases	Steps	Relevance to this study	Explanations
I: Situational Analysis	**Step 1: Needs Assessment** Obj.1: To describe the depth at which nurse students, clinicians and understand the concept of spiritual care within the perspective of holistic nurse caring.	Needs assessment provides the foundation information regarding the stakeholders' concept of spiritual care. An analysis of the teaching-learning process regarding spiritual care as it affects the nursing curriculum was done. Assess the understanding of the participatory group, of the concept of spiritual care.	Key stakeholders as a participatory planning group were recruited. These were potential programme users and implementers. Carrying out of needs assessment Programme objectives specified for developing a course component that incorporates spiritual care-giving into the syllabus of nursing. Feasibility in developing a model for the integration of spiritual care into the nursing curriculum. Assessment of the facilities, personnel and materials available for the new curriculum. Determining the concept of spiritual care in nursing elements, curriculum contents. Quantitative design was used with 210 as sample size
	Step 2: Programme Outcomes and Objectives Obj. 2: To explore the competencies required by the nurses for teaching and carrying out spiritual care in nursing.	Identify intervention outcomes, performance objectives and change objective on the participants and their environment.	Programme outcome stated based on the needs assessment in Step 1. The basic competencies to acquire before teaching or practicing spiritual care were identified, such as knowledge of spiritual care, skills, attitudes, assessment of spiritual needs of the clients/patients, and ability to teach and provide spiritual care. Nurse clinicians, Nurse educators and nursing students building self-confidence, proficiency and ability. ''Spiritual Care Competence Scale'' protocol was used to collect needed data. FGD and in-depth

			individual interviews were also used for qualitative data collection with recording equipment.
	Obj. 3: To compare the required competencies, if any, which exist within the content of the nursing curriculum in Nigeria. Step 3: Theoretical foundations and empirically evaluated methods and strategies for behaviour change are assessed.	Theoretical and empirical literatures were searched for theory-based method. These included the bio-psycho-social-spiritual model of care, extended bio-psycho-social-spiritual care, the patient-centered care model, the middle-range theory of spiritual well-being in illness model, the inter-professional spiritual care model and Watson's Theory of Human Caring model.	Reviewed hypothetical systems to cause modifications in the behaviour of the nursing students, tutors and clinicians. Change in the structural and social factors to affect the community so that the nurse educators, nurse clinicians and nursing students can acquire necessary competencies to teach and provide spiritual care to clients/patients. Direct explorative descriptive, overt observation, field trips, individual interviews, inspection of lecture notes of both the students and nurse educators using recordings and checklists. Content analysis of the curriculum document in relation to spiritual care was also done.
Phase II	Steps 4 and 5 were utilized for this phase.		Identification of expert committee

	Obj. 4: To develop a model that fully incorporates spiritual care into the Nigerian nursing curriculum. Step 4: Producing programme components and materials.	All the data collected in the previous steps were collated and triangulated. Information produced became the subject for designing the model for integrating spiritual care into the nursing undergraduate course in Nigeria, as contained in Objective 4 of the study.	membership (panel of experts). Determining the willingness of the participants. Completion of consent forms by all the expert committee members. Review of available working materials. Qualitative exploratory design adopted using a Delphi technique. Programme themes, sub-themes, scope and sequence were created such as: Conceptual definition of spiritual care, components of spiritual care, competencies of spiritual care, relevance of spiritual care to holistic nursing care, barriers to teaching and rendering spiritual care and strategies to overcome pitfalls.
	Step 5: Adoption and implementation of the intervention plan.	The model is approved and implemented while the aims and results of performances are measured in this step.	Use the above to prepare the protocol for Delphi study. Administration of Delphi technique to the expert members. Collation of responses from the expert members. Achieving consensus at the second administration of Delphi to the expert committee members. Drafting the model for integration of spiritual care into nursing curriculum. Identification of adopters and implementers of the model. Re-evaluation of planning, maintenance, adoption and implementation.

			Creating a matrix of change objectives for model adoption. A team of Lineage group i.e. experts and experienced individuals constituted for the adoption and implementation plan for the model of integration of spiritual care into nursing curriculum. The consultative forum called a Linkage Board is in place to adopt the model and serve in advisory roles. This advisory committee looked at: -timing of model implementations -selection of suitable teaching and learning materials -training and re-training of nurse educators and nurse clinicians on spiritual care in nursing -competencies required to teach and practice spiritual care in nursing. -contents of spiritual care attractiveness, completeness, suitability, and relevance of

	Step 6: Evaluation Plan	This sixth step is not part of this research work, but the researcher has proposed that this be used for a postdoctoral programme in the near future.	spiritual care to nursing education and practice.

3.4 POPULATION AND SAMPLING

3.4.1 Step 1: Needs assessment:

The estimated population for this phase was 160,423, which included all the nurse educators in all accredited departments of nursing in Nigeria; all nurse clinicians and all Year Four and Five nursing students in all accredited departments of nursing (N&MCN, 2014). Stoker's (2013) table is the basis for the sample size of the survey, titled 'sampling in the quantitative paradigm' as it was discovered to be practical and easy to adjust for survey analysis (Strydom, 2011). The percentage illustration recommended for ranges of population was used for selection of appropriate sample size for the nurse educators, nurse clinicians and nursing students (Table 3.2).

Sample size calculation: The intervals of the sample is calculated for each population by using principles and formula of statistics: K = N/n. Where N = Sample frame Total population; n = sample size and K = Interval of Sample. The sample size (SS) is obtained by applying the standard sample size calculating formula by Strydom (2011).

$$n=\frac{Z^2Pq}{d^2}$$

Where: n = sample size when population is greater than (>) 10,000

Z = Z value (e.g. 1.96 for 95% confidence level)

P = prevalence from previous studies = 0.5

q = 1-P (1- 0.5) = 0.5

d = 0.05

Substituting in the above formula, one obtains the following sample size

$$n = \frac{1.96^2 \times 0.5 \times 0.5}{(0.05)^2}$$

$$n = \frac{0.9604}{0.0025}$$

= 384.16

= 384

$$nf = \frac{n}{1+\frac{n}{N}}$$

Where: nf = sample size when population is < 10,000

n = sample size when population is > 10,000

N = Study population

$$nf = \frac{384}{1 + \frac{384}{398}}$$

$$nf = \frac{384}{1 + 0.9648}$$

$$nf = \frac{384}{1.9648}$$

nf = 195.4

Sample size = 195

Attrition = 10% of 195= 20

Questionnaires to be administered = sample size + attrition

= 195 + 20

= 215

Table 3.2: Proportionate sample for the study

POPULATION GROUP	**ESTIMATED NO.**	**PERCENTAGE= (Estimated No. x 100) / 164,560**	**SAMPLE**
Nurse Clinicians	159076	159,076/164,566=96.7%	207
Nurse Educators	3368	3368/164,560=2.0%	6
Nursing students (4^{th}& 5^{th} years)	2116	2116/164,560=1.3%	2
TOTAL	**164560**	**100**	**215**

The study utilized a convenience sampling technique to pick a nursing science department with a valid accreditation for each geopolitical area. One geopolitical zone was not covered due to security restrictions.

3.4.1.1 Inclusion criteria

All nurse educators and nurse clinicians, regardless of their qualifications, age limit of years 18 and above, years of experience, gender, religion, ethnicity and place of primary assignment, were eligible for inclusion in the study. Every participating nurse educator and administrator was expected to have a current practicing nursing licence and all the nursing students were required to be enrolled in the various departments of nursing science in Nigeria. All the students had to be bonafide students of their institutions and needed to have official school identification cards indexed by the board of the Nursing and Midwifery Council of Nigeria.

3.4.1.2. Exclusion criteria

All other health care professionals or educators who were not nurses were excluded from the study. This included workers at the schools and Nursing and Midwifery Council of Nigeria, who are not registered nurses and all participants below 18 years of age.

Any nurse educator or nursing student who willingly withdrew, or who did not give informed consent, was excluded. Anyone who did not want to participate in the study, and individuals who refused to complete consent forms, were excluded. Also excluded were the nurse educators and/or nurses registered with the State Committee of the Nursing and Midwifery Council, but who do not have a current practicing license, as well as the students without valid identity cards, not indexed by the body of the Nigerian Nursing and Midwifery Council, or not registered in either the fourth or fifth year of their course.

3.4.2 Step 2: Identifying performance objectives

The population for this phase included the nurse clinicians, nurse academics and nursing students of the departments of nursing in Nigeria, as for the previous phase. A non-probability sampling frame was used to select the participants, as the populace has no equal selection probabilities (Babbie & Mouton, 2016). The objective of this phase of the study was not to have a generalized sample, but to enable the mode of sampling frame to be affected by other factors like logistics and availability. This was done to ensure a high level of participation and precise inclusion for samples (Babbie & Mouton, 2016). Purposive sampling frame, also referred to as judgemental sampling frame by Rubin and Babbie (2016), is based entirely on the judgement of the researcher in order to satisfy predetermined criteria (Vos et al. 2012). This sampling technique was used to ensure that productive members were employed for participation, those whose contribution would be regarded as high quality. It was hoped that this would therefore add value to the study (Babbie, 2016). Focus group discussions were held to document the high-quality inputs of the participants, with thirty-six participants selected for the study i.e. twelve nurse clinicians, twelve nurse educators and twelve nursing students in their 4th and 5th years of training.

3.4.3 Step 3: Methods and strategies

The nursing clinicians, educators and students of the department of nursing science in Nigeria formed the population used for the study here – thirty-six participants purposively selected for this phase, who met the inclusion criteria as outlined in Step 1.

3.4.4 Step 4: Programme development

A panel of experts was constituted in this phase of the study, to produce programme components and materials, and also to espouse and implement the model that completely integrates spiritual care into Nigerian nursing curriculum. The population consisted of nurse educators, nurse clinicians as well as experts in nursing and general curriculum development.

Organisations, bodies, experts and agencies consulted were as follows: The professional nursing association (National Association of Nigerian Nurses and Midwives [NANNM]), the Director of Academic Planning at the University of Ilorin, Ilorin, Kwara State Nigeria, the Nigerian Nursing and Midwifery Council (N&MCN), the State Director of Nursing services, and finally, the Director of Nursing Affairs in the State Ministry of Tertiary Education and Religious Leaders.

Creswell and Plano Clark (2014) assert that the purposive sampling technique is employed to ensure that the right individual experts who are well-informed about, or experienced in, the target of interest and topic area are identified and selected. This ensured that participants were consciously selected for inclusion in this study. The expert committee members were considered to be knowledgeable about or experienced in the subject matter. Keeney et al. (2017); Adler and Ziglio (2017) outlined the following criteria as pertinent for participants in such a study. These are:

1. Knowledge of and experience in the issues under investigation.
2. Capacity and willingness to participate.
3. Sufficient time to participate.
4. Effective communication skills.

The eligibility of the panel of experts for this study was based on these criteria. There are no clear guidelines for the members to be included in terms of panel size in the study, applying the Delphi study technique. This is because the nature of the problem being investigated determines inclusion and panel size (Hasson, Keeney & McKenna, 2014). Thus, purposive sampling was also used to select a sample size of twenty expert committee members from among the population stated above i.e. nurse educators/DNS: six, nurse clinicians: two, nurse clinicians/administrators: two, religious leaders: two, experts in nursing curriculum

development: two, experts in curriculum development [General]: four, DAP: one and professional designer: one. Although thirty -five experts were invited, only twenty responded to the invitation and consented to participate in the study.

3.5 DATA COLLECTION METHODS

Methods used for data collection varied depending on the phases and steps of the research process.

TABLE 3.3: Summary of research procedure

	OBJECTIVES	**METHODOLOGY** **DATA COLLECTION**	**DATA** **ANALYSIS**	**REASONING** **STRATEGY**
Phase One:	Obj. 1: To describe the level of understanding at which nurse tutors, nurse clinicians and students understand the concept of spiritual care within the scope of holistic care.	**Steps 1, 2 & 3**	**Intervention** **Mapping**	**Framework**
		Population: 1.Nursing Students 2. Nurse educators **Sampling:** Purposive sampling **Instrument:** Questionnaire	Quantitative -Descriptive and inferential statistics	Deductive reasoning
	Obj. 2: To explore the competencies required by the nurses for teaching and carrying out spiritual nursing care.	**Population**: Nurse educators, nurse clinicians and nursing students **Sampling:** Purposive **Design:** 1.Qualitative explorative 2. Quantitative **Instrument:** 1. Questionnaire 2. Focus Group Discussion (FGD) - Field notes - Interview guide - Observation - Tape recording - Transcription	1. Quantitative -Descriptive and inferential statistics 2.Qualitative - Thematic/Content analysis	1. Deductive reasoning 2. Inductive reasoning

	Obj 3: To compare the required competencies with the available spiritual care competencies, if any, which exist within the content of the nursing curriculum in Nigeria.	**Population:** 1. Nurse Educators 2. Nurse Clinicians 3. Nurse administrators 4. Nursing students **Sampling:** 1.Purposive 2.Systematic review **Instrument:** FGD - Field notes - Observation - Tape recording - Transcription	1.Qualitative - Thematic/Content analysis 2.Qualitative -Descriptive and inferential statistics	1.Inductive reasoning 2.Deductive reasoning
Phase Two	Obj 4: To develop a model for the incorporation of spiritual care into the nursing curriculum.	**Steps 4 & 5 of Intervention**	**Mapping Framework**	
		Population:1.Expert committee such as nurse educators, nurse clinicians, DAP, experts in curriculum development, NANNM focal person, N&MCN Registrar/Rep., religious leaders, curriculum designer, State Committee of N&MCN, DNS **Sampling:** Purposive **Instrument:** 1.Delphi Technique 2.Focus Group Discussion (FGD) - Tape recording - Transcription	1.Quantitative Descriptive and inferential statistics 2. Qualitative - Thematic/Content analysis	1. Deductive reasoning 2. Inductive reasoning

3.5.1 Step 1: Needs assessment or logic model of the problem

A quantitative approach was used in this step. Two adapted structured standardized instruments were used to collect data from the participants i.e. 'The Role of Spirituality in Nursing Practice' and 'Spirituality and Spiritual Care Scale', which has thirty-five items to examine the participants' understanding on the scope of spiritual caring within the rubrics of all-inclusive nursing, as previously discussed in this chapter. To be reliable is to be consistent

and dependable, hence the reliability of an instrument is the rate with which that instrument measures something (Polit & Beck, 2010; Kobus & Jacque, 2011). In order to make sure that a research instrument is reliable, it was pre-tested with five (5) nurse educators, five (5) nurse clinicians and six (6) nursing students (i.e. 3 from 400 level & 3 from 500 level). Testing was done at fortnightly intervals using a test-retest method with reliability co-efficient of 0.80. Cronbach's alpha co-efficient test, a specific statistical test designed to provide internal consistency measures for questionnaires, was used (Bunk, Walt & Rensburg, 2012). The participants used for the pre-testing were not part of the actual study to test the understanding of the participants on the questions, and to ascertain whether their responses properly relate to the questions asked. For validity of the instrument, it was sent to the supervisor for both content and validity, in order to be vetted and evaluated. Even though the instruments were already standardized, environmental factors had to be checked for the context in which they were now administered, as they were adapted instruments. Questions that were lengthy were reduced, likely ambiguous languages were reframed to suit the local environment, complex questions and abbreviations were reviewed. The questionnaires were presented as an addendum to the proposal, through the supervisor, and they were considered by the Ethics Committee. Suggestions were made and the questionnaire was corrected and resubmitted before approval was given.

3.5.2 Step 2: Identifying performance objectives: Both quantitative and qualitative methods were adopted in this step, with the use of the one adapted standardized questionnaire for the quantitative data collection i.e. 'Spiritual Care Competence Scale [SCCS]' which contained twenty-seven items. To Polit and Beck (2010) and Kobus and Jacque (2011), validity is the extent to which an instrument measures what it is meant to measure. The validity of content centres on the point to which the materials in a tool adequately embodies the whole concept that was measured, while face validity involves

biased conclusions by professionals about the rate to which the relevant variable was measured by the instrument. In order to ensure content and face validity, the literature was reviewed to ensure that the instrument covers the full content of a construct that it sets out to measure. The opinions of the supervisor, experts and senior colleagues in the field of study were sought and modifications done, before submitting to the Ethics Committee for approval. For reliability of the instrument, pilot testing was also done using Cronbach's alpha co-efficient, test which was intended to provide processes of internal constancy for the questionnaire. The results of the 'Spiritual Care Competency Scale' had six main spheres of spiritual care-linked proficiencies of nursing.

These were:

1. Professionalization and enhancing spiritual care quality (Cronbach's alpha 0.82).
2. Evaluation and application of spiritual care-giving (Cronbach's alpha 0.82).
3. Individualized care and patient counselling (Cronbach's alpha 0.81).
4. Referral to professionals (Cronbach's alpha 0.79).
5. Attitude towards patient's spirituality (Cronbach's alpha 0.56).
6. Communication (Cronbach's alpha 0.71).

These sub-scales showed good internal consistency, sufficient average inter-item correlations and a good test-retest reliability (van Leeuwen, Tiesinga, Middel, Jochemsen & Post, 2011). Data were also collected using focus group discussions that lasted for between forty-five and sixty minutes, with the proceedings recorded using a tape recorder. A transcription was made of the recorded materials of the recorded materials using content analysis.

3.5.3 Step 3: Methods and strategies: Qualitative means were employed in this phase, using exploratory description, focus group discussion, participant observation in the classrooms and clinical areas, overt observation and record review. Systematic review of

previous research projects and publications were carried out, together with content analysis of the curriculum document in relation to spiritual care in nursing. Interviews were just formalized discussions with a purpose. These were vocal interactions between two or more people who ideally had a common viewpoint (Greef, 2011 & Holloway, 2016), and the most reliable method to find out how people feel, think or behave is by asking them about it (Limb, 2011). Interviews were in-depth, suggesting that substantial data were obtained. This enabled the research scientist to glean values, attitudes, opinions and belief systems of the participants, as was the case in this study. Unstructured and semi-structured interview guides were used by the researcher to conduct data collection interviews. Focus group discussion is a semi-structured group session, moderated by a group leader, held in an informal setting with the purpose of collecting information on a designated topic of interest. The researcher and the research assistants guided the participants in the discussions (Polit & Beck, 2010; Kobus & Jacque, 2011). The fact that group dynamics can encourage people to express and clarify their views in ways that are less likely to occur in a one-to-one interview, is one of the assumptions underlying the use of focus groups. The groups, by virtue of their training, were professional nurses and nursing students. They were familiar with one another, a factor that offered a sense of security to people who may have felt vulnerable during interview sessions. After obtaining permission for its use, an audio tape was used to capture all information during the discussions. This tool became handy for concentrating on the issues discussed as there is always the possibility that vital information may be left out in the course of writing down details. Focus group discussions were very helpful to the researcher because the investigation was centered on the delicate subject of religion, faith and spiritual issues, especially in the workplace. Using focus group discussions had the added advantage of being less expensive, more flexible, more stimulating, cumulative and elaborative.

The focus group discussions also provided rich data on the provision of spiritual care in nursing education and practice. Field notes were used by the researcher both during and after the interviews. According to Langford (2001), field notes are written accounts of what the researcher sees, hears, experiences and thinks during the process of collecting data. In the survey conducted, field notes were used to record observations made in the field and interpret those observations. The participants' non-verbal behaviours, gestures, facial expressions and body language as they responded to the probing questions, as well as other non-verbal responses, which were later clarified in discussion with them all summed up these observations. The participants were each asked to sign a form of consent after the initial briefing and introduction. Two separate interview guides were constructed by the researcher and used for the focus group discussions. The first one was compiled for both the nurse educators and the nursing students while the second one was compiled for the nurse clinicians only. Each of the guides focused on key issues directed at the research objectives and questions, and the data were collected over the course of seven months, from September 2015 to April 2016 (see Appendix IV and V).

3.5.4 Step 4: Programme development: The Delphi technique was adopted for this phase of the study. The outcome of the mixed method research was used to produce programme components and materials that were in turn used by the expert committee members along with the researcher, to produce a model that incorporates spiritual caring into the Nigerian curriculum of nursing education. Focus group discussion, tape recording, transcription, text messaging and email messaging were used in this phase to gather all the required data necessary to produce a model that integrates spiritual care into the Nigerian nursing curriculum.

3.6 DATA ANALYSIS

This section explained the process of data analysis adopted for the study, as follows:

3.6.1 Data triangulation

Triangulation mixed methods design was adopted in this study. Triangulation is defined as "the use of multiple sources or referents to draw conclusions about what constitutes the truth" (Polit & Beck, 2014).. Employing the different methods of data collection will not only compensate for the specific limitations in the different methods chosen (Mouton, 2012) but will further add value to data required for a study of this nature. Therefore, in order to overcome these weaknesses, the researcher used triangulation as a method of data collection in which questionnaires and focus group discussions were used. A combination of data collection methods was used.

Triangulation mixed method research was used in agreement with the set rule by Creswell and Plano Clark (2014); Vos et al (2012). The criteria are as follows:

1. The design should match the research problem that a researcher wants to study.
2. The expertise of the researcher should not be in question.
3. Resources such as time and funding have to be available to complete the study.
4. The relative weight of the quantitative and qualitative approaches, and the approach to mixing the two datasets, have to be carefully considered, i.e. how the quantitative and qualitative datasets will be merged.

The design of the mixed method research pattern was implemented for the first segment and this centred on analysing qualitative and quantitative components of the information. The

study adopted a concurrent mixed sampling method which refers to the implementation sequence of the qualitative and quantitative strands of the study. Concurrent implementation occurs when the quantitative and qualitative components are implemented at the same time or within close proximity and are independent in terms of collection and analysis. Integration of data obtained from both samples occurs at the data interpretation of one component e.g. quantitative follows by the other component i.e. qualitative, and the relationship between the two components is dependent. Dependency occurs when the decisions made within the first phase e.g. quantitative phase influenced the decisions made in the subsequent phase e.g. qualitative phase (Tashakkori & Teddlie, 2010). Qualitative and quantitative methods were used in analysing and understanding the topic area using equal measures at the same time. Data obtained both quantitatively and qualitatively were collected concurrently, they were analysed separately with the results used to plan the qualitative follow-up in order to harmonize and differentiate the findings.

3.6.1.1 Step 1: Needs assessment:

A Statistical Package for the Social Sciences (SPSS) Version 22 was used to analyse the data collected from the quantitative means. Frequency distribution and multiple regressions were both descriptive statistics used. While frequency distribution gave a summary of respondents' bio-data, multiple regression helped to determine the inter-relatedness between a participant's attitudes towards patient communication, spirituality, referral, personal support, patient counselling, professionalization implementation and assessment of spiritual care; increasing of the quality of spiritual care and their professional years of experience. Pearson's link became a useful tool used in examining the connection between participants' spirituality and their years of qualifications and experience. A Chi-square test was carried out to gauge significant differences among the variables.

3.6.1.2 Step 2: Identifying performance objectives:

Thematic analysis such as content from the focus group discussion and interview transcripts were done. Recurrent themes that emerged from the transcripts were identified. The themes were collated into the following categories:

*Thematic category one: Understanding spiritual care.

*Thematic category two: Challenges to and facilitation of spiritual care in the nursing curriculum.

*Thematic category three: Competencies of nurse educators/nurse clinicians/nursing students.

* Thematic category four: Possible limitations that may be encountered

* Thematic category five: Solutions to challenges as suggested by participants.

3.6.1.3 Step 3: Methods and Strategies

In order to carry out a qualitative analysis, information was collected in a well-structured format from which it could be easily accessed and retrieved. The data were managed by transforming descriptive information into smaller segments. Word-perfect recordings of audio-taped discussions were completed for analysis of data. Each audio-taped interview was recorded and transcribed by the information experts, the originality of each translated audio records was verified by the research scientist (Burns & Grove, 2014; Polit & Beck, 2010; Streubert-Speziale & Carpenter, 2011). Morse and Field's (2012) instructions for transcribing tape-recorded interviews were followed. The tapes were objectively listened to by the researcher and his own personal interviewing style was critiqued by himself. Discrepancies were identified as subsequent interactions experienced improvements as recommended by Morse and Field (2012). These translations were then typed and streamlined into a theory constructor that is code-based, which is the Qualitative Research Solutions Non-numerical Unstructured Data method of Indexing, Searching and Theorising computer software. This is known as the NUD*IST power version, revision 4.0 and is used to set the pace for the

process of analysis (Creswell & Plano Clark (2014). This software helped the information analyst handle and manage complex non-arithmetical data (Burns & Grove, 2013). Content analysis was utilized for studying the information in the curriculum, in relation to spiritual care competencies, using a checklist and observation guide developed to identify differences and similarities.

3.6.1.4 Step 4: Programme development

The Delphi technique was used here. The quantitative data obtained were presented in means and modes. A remarkable feature of this pattern is that it is designed for groups with the objective of unifying perceptions which is designed as a group communication process, which aims to achieve a convergence of opinion on explicit world issues. The Delphi technique is well suited as a method for consensus-building, because it makes use of different questionnaires conveyed by many recapitulations to gather information. The main statistics used in the Delphi study are measures of central tendency such as mean, median and mode, and level of dispersion such as standard deviation and inter-quartile range in order to present information concerning the collective judgements of respondents, but only mean and mode were used in this study. Jacobs (2010) concluded that, in view of the anticipated judgement and the lop-sided expectancy of responses as they emerged, the median is the variable that best reflects the unity of various opinions.

3.7 TRUSTWORTHINESS

This is concerned with accuracy and truthfulness of scientific findings, hence, research techniques best suited to ensure trustworthiness of the qualitative aspect of the data collection in this study were put in place. According to Polit and Beck (2010), there are criteria for supporting and substantiating qualitative studies. These are credibility, transferability, dependability and conformability. They will be employed in this study through an extensive

collection of information from the participants and detailed description of the methodology used. A model was developed by Lincoln and Guba (2011) for evaluating qualitative information with respect to its authenticity, based on its trustworthiness. The information is assessed for applicability, consistency, neutrality and credibility. These will be maintained in the course of data collection for this study. **Credibility** refers to confidence in the truth of the data and interpretations thereof (Polit & Beck, 2012). The researcher ensured the integrity of this feature by going back to the participants to verify the information when required. **Dependability** refers to the provision of evidence such that if it were to be repeated with the same or similar participants in the same or similar context, its findings would be similar (Brink, Walt & Rensburg, 2016). Dependability means the constancy or permanency of data over time. Klopper & Knobloch, (2010) assert that the measures used to ensure credibility have an indirect impact on the dependability of the research findings. In this study, dependability was achieved through an inquiry audit; reviewers played the role of auditor by examining the documentation of critical incidents through presentations and interviews to ensure that the findings, interpretations and recommendations were supported by data. In addition, various discussions with the supervisors on the processes of data collection and data analysis to ensure continuous scrutiny of the data as well as the processes applied for collection, analysis and reporting. **Confirmability** is about ascertaining objectivity, that is, the potential for congruence between two or more independent people about the data's accuracy. The researcher documented the procedures for checking and re-checking the data throughout the study. **Transferability** was also enhanced by the researcher thorough description of the research context and the assumptions that were central to the study. **Saturation** is the process whereby the researcher continued data collection through all the phases of the study until the key informants did not produce any new information, i.e. when any further information was found to be redundant. Inter-coder reliability was then

established by sending a set of data with the coding rules to another coder to determine whether there was agreement regarding the categories and themes that had emerged.

3.8 ETHICAL CONSIDERATIONS

The participants' rights were secured by gaining their informed authorization. At the onset of this survey, participants were given detailed explanation about the requirements and significance of the study. By doing this, the participants' rights were protected. Private information given by the participants was never divulged to unauthorized persons without the prior knowledge and agreement (Burns & Grove, 2011; Polit & Beck, 2010). Participants were also informed that withdrawing their participation at any phase of the study would have no negative consequences to themselves. Human dignity was respected as questions were asked in a way that ensured that participants were comfortable, and able to express themselves without interruptions. Complicated questions were simplified so that participants could clearly understand the questions asked without feeling embarrassed or humiliated. The protocols were submitted to the supervisor for his scrutiny and necessary corrections, and then submitted to the Ethics committee of the University of Western Cape for approval with **approval number 15/3/19**. Official permission to conduct the study was obtained from the Ethical Committees of all the study settings used for the study with all necessary rules for conducting research studies obeyed.

The researcher also ensured that research assistants completed confidentiality forms, which guided their conduct during the study. The research-scientist made sure that participants were not in any way harmed as the researcher prevented any situation that would have caused the respondents to recall emotionally painful memories, asking questions in a group setting that would have caused any of the respondents to be embarrassed before other participants, creating situations where a participant's future prospects may be harmed, conducting focus group in such a way that some participants feel their contributions are less intelligent,

relevant or valuable than those of other participants or affected by their participation in the study, whether physically, emotionally, spiritually or economically. They were also given the freedom to participate without coercion. In addition, Focus Group confidentiality binding forms were signed by each member of the group after full explanation.

3.9 CONCLUSION

Chapter Three focused on the theoretical framework used for the study i.e. the intervention mapping strategy and the research methodology. The intervention mapping strategy, which has six steps, was adapted for the study, but only the first five steps were used in this study. The researcher intends to use Step Six, which is an evaluation step, for postdoctoral study in the near future. The next chapter presents and discusses te quantitative findings of the study.

CHAPTER FOUR

QUANTITATIVE STUDY FINDINGS AND DISCUSSION

4.0 INTRODUCTION

The quantitative survey results are reported in this chapter. They give information for the first three goals of this analysis (i.e. Objectives 1 to 3). Research findings are represented by charts, text and in tabular form. During the study 215 questionnaires were distributed but only 210 were found suitable for analysis indicating a response rate of 97.7%.

Figure 4.1 below shows the demographic representations of the participants according to the identified variables.

Table 4.1 Biodata of the Respondents (n=210)

Variable	***F***	***%***
Gender		
Male	58	27.6
Female	152	72.4
Age range in years		
18 – 27	70	33.3
28 – 37	63	30.0
38 – 47	26	12.4
48 – 57	51	24.3
Religion		
Christianity	142	67.6
Islam	65	31.0
Others	3	1.4
Tribe		
Yoruba	105	50.0
Igbo	54	25.7
Nupe	9	4.3
Hausa	22	10.5
Fulani	4	1.9
Others	16	7.6
Marital Status		
Single	70	33.3
Married	131	62.4
Divorced	5	2.4
Widowed	4	1.9

The biodata in Table 4.1 above showed that the majority 152 (72.4%) were females and 70 (33.30%) of the participants were aged between 18 and 27 years. 142 (67.6%) were Christians. Participants were from different ethnic groups within Nigeria, with the majority being from Yoruba, 105 (50.0%).

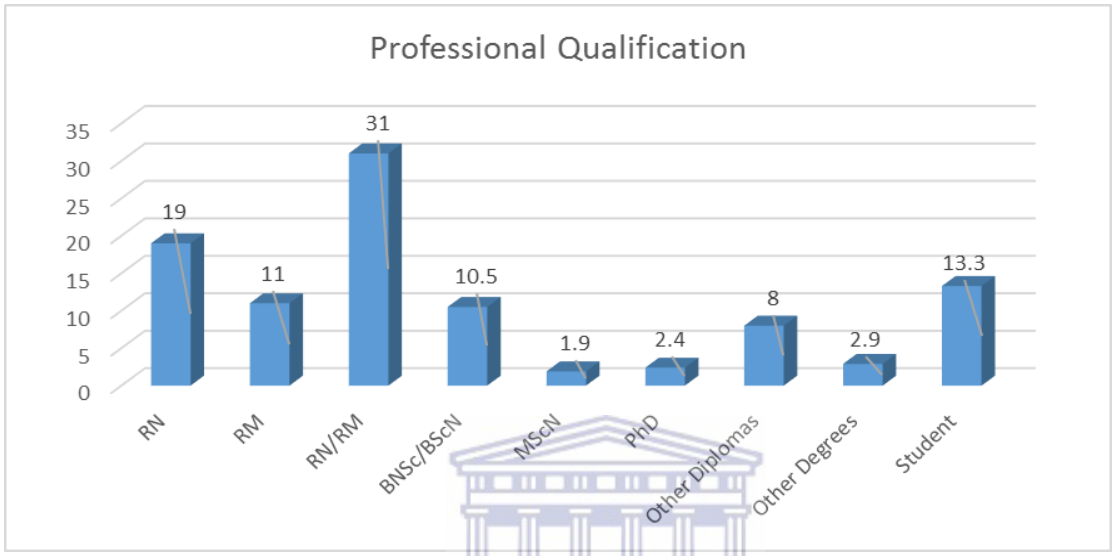


Figure 4.1: Distribution of participants by professional qualification

The professional qualification distribution of the participants showed that the majority (31%) had registered nurse/midwife certificates with the lowest unit of 1.9% having Masters degrees in Nursing Science.

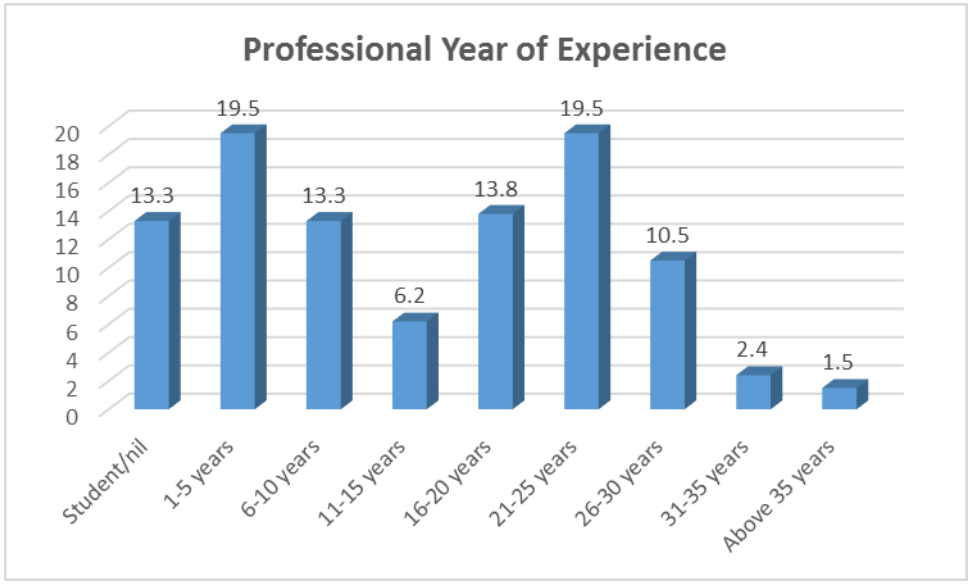


Figure 4.2: Professional years of experience of participants

The figure above shows the distribution of participants in terms of professional years of experience. The majority of participants 19.5% had 1-5 years and 21-25 years of experience respectively, while only 1.5% had more than 35 years of experience.

The next table (Table 4.2) presents the opinions of the participants concerning the model of spiritual care-giving, in frequecy and percentages. Likert Scale was used to elicit the needed information from the respondents. Likert Scale is used in research in which respondents express attitudes or other responses in terms of ordinal-level categories (e.g. agree,disagree) that are ranked along a continuum (Vos et al. 2012; Brink et al. 2016). It is a summated rating scale in that item scores were added to obtain the final result. The values obtained were treated as interval data. This study used the ordinal-level categories of disagree completely, disagree, neither disagree nor agree, agree and agree fully and as in Table 4.2, the scores on each item generally ranged from 1 to 5. The table shows that 69% of the participants were of the opinion that the basic aspect of being human is spirituality and that incorporating spiritual components into nursing practice stood a better chance at empowering clients as opposed to practice without a spiritual component.

Table 4.2: The opinion of nurses on the concept of spirituality in nursing practice

Variable	Disagree Completely	Disagree	Neither Disagree nor agree	Agree	Agree Fully	Mean (SD)	Standard Deviation
The basic aspect of being human is spirituality.	2 (0.9%)	4 (1.9%)	17 (8.0%)	85 (40.5%)	100 (47.6%)	4.38	.753
Nurses need to have more knowledge about spiritual care in nursing.	0 (0.0%)	5 (2.4%)	11 (5.2%)	100 (47.6%)	93 (44.3%)	4.35	.663

(n=210)

Knowledge about different religious faiths and traditions is essential for nursing care.	4 (1.9%)	11 (5.2%)	23 (11.0%)	101 (48.1%)	71 (33.8%)	4.16	.880
Religious matters are not a part of the scope of nursing practice.	53 (25.2%)	106 (50.4%)	26 (12.4%)	23 (11.0%)	1 (0.5%)	2.01	1.024
Spiritual issues are out of context of practical nursing.	60 (28.6%)	104 (49.5%)	22 (10.5%)	22 (10.5%)	1 (0.5%)	2.00	1.002
Nursing with a spiritual content has a better-edge at empowering patients than a practice without such content.	6 (2.9%)	16 (7.6%)	25 (11.9%)	100 (47.6%)	61 (29.1%)	3.90	.926
For effective nursing practice knowledge of patient's spiritual beliefs is important.	2 (0.9%)	7 (3.3%)	6 (2.9%)	100 (47.6%)	93 (44.3%)	4.31	.729
Nurses should be capable of evaluating the beneficial	0 (0.0%)	10 (4.8%)	17 (8.0%)	111 (52.9%)	71 (33.8%)	4.16	.715

significance of spiritual rituals and practices in their clients' lives.							
Nurses should be capable of evaluating harmful effects of spiritual practices in the lives of their patients.	2 (0.9%)	13 (6.2%)	25 (11.9%)	105 (50.0%)	64 (30.5%)	4.05	.812
It is inappropriate to use spiritual language and concepts in nursing practice.	38 (18.1%)	77 (36.7%)	40 (19.1%)	42 (20.0%)	13 (6.2%)	2.78	1.187
Patients spiritual backgrounds do not influence nursing practice.	45 (21.4%)	96 (45.7%)	33 (15.7%)	25 (11.9%)	11 (5.2)	2.55	1.165
The use of spiritual texts and passages by a nurse during nursing practice is inappropriate.	18 (8.6%)	35 (16.7%)	41 (19.5%)	84 (40.0%)	31 (14.8%)	3.22	1.159
Praying with patients is against the ethics of	78 (37.1%)	79 (37.6%)	23 (11.0%)	24 (11.4%)	4 (1.9%)	2.10	1.121

nursing.							
Using spiritual concepts in nursing practice is inappropriate.	52 (24.8%)	90 (42.9%)	33 (15.7%)	30 (14.3%)	5 (2.4%)	2.18	1.063
Sharing spiritual beliefs with a patient is sometimes appropriate.	27 (12.9%)	30 (14.3%)	25 (11.9%)	100 (47.6%)	28 (13.3%)	3.24	1.203
For holistic nursing care addressing a patient's spiritual beliefs is necessary.	3 (1.4%)	20 (9.5%)	20 (9.5%)	95 (45.2%)	72 (34.3%)	4.04	.907
Contents related to spiritual diversity should be included in nursing education.	9 (4.3%)	12 (5.7%)	27 (12.9%)	100 (47.6%)	58 (27.6%)	3.92	.931
Content on how to deal with spiritual issues in nursing should be included in nursing education.	9 (4.3%)	15 (7.1%)	17 (8.1%)	95 (45.2%)	74 (35.2%)	3.99	.974

If nursing education is to include spiritual care in nursing and be effective and efficient in both nursing education and practice, nurses should acquire sound knowledge of spirituality in order to assist patients in diverse spiritual care needs and also to address the spiritual needs of patients as a component of holistic nursing care. In addition, one hundred and fifty nine (75.5%) of the participants disagreed with the view that religious concerns are outside the scope of nursing practice, as with spirituality, with one hundred and sixty four (78.1%) of the participants expressing this view. Many participants felt that using spiritual language and concepts in nursing practice is not right, more especially, that praying with a patient is against nursing ethics. This means that the participants generally agreed that spirituality/religion is a concern in nursing practice and education. The next table i.e. Table 4.3 below, presents the responses of the participants to their knowledge of spirituality and spiritual caring in nursing practice.

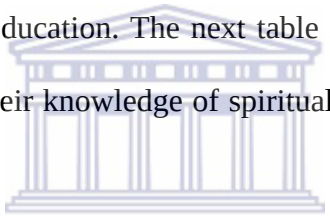


Table 4.3: Understanding spiritual care in nursing practice among nurses (n=210)

	FREQUENCY/PERCENTAGE							
Variable	Completely Disagree	Disagree	Neither agree nor disagree	Agree	Fully Agree	Missing	Mean	SD
Spiritual care can be provided by nurses through arranging a visit by the patient's spiritual/religious leader.	10 (4.8%)	26 (12.4%)	20 (9.5%)	100 (47.6%)	54 (25.7%)	0 (0.0%)	3.70	.758
Spiritual care can be provided by nurses through showing kindness, genuine concern and cheerfulness when giving care.	0 (0.0%)	5 (2.4%)	11 (5.2%)	103 (49.0%)	91 (43.3%)	0 (0.0%)	4.26	.700

	FREQUENCY/PERCENTAGE							
Variable	Completely Disagree	Disagree	Neither agree nor disagree	Agree	Fully Agree	Missing	Mean	SD
A need to forgive and a need to be forgiven is the concern of spirituality.	3 (1.4%)	13 (6.2%)	34 (16.2%)	104 (49.5%)	56 (26.7%)	0 (0.0%)	3.60	1.004
Going to church/place of worship alone is what spirituality entails.	93 (44.3%)	80 (38.1%)	21 (10.0%)	8 (3.8%)	5 (2.4%)	3 (1.4%)	3.62	1.116
Spirituality is not about a faith in a Supreme Being.	87 (41.4%)	71 (33.8%)	23 (11.0%)	25 (11.9%)	3 (1.4%)	1 (0.5%)	3.82	1.160
Finding meaning in the good and bad events of life is what spirituality is all about.	31 (14.8%)	20 (9.5%)	45 (21.4%)	94 (44.8%)	20 (9.5%)	0 (0.0%)	3.71	.700
Spiritual care can be provided by nurses through enabling patients to find meaning and purpose in their illness.	13 (6.2%)	17 (8.1%)	34 (16.2%)	103 (49.1%)	42 (20.0%)	1 (0.5%)	3.58	1.130
Having a sense of hope in life is what spirituality is about.	10 (4.8%)	17 (8.1%)	33 (15.7%)	100 (47.6%)	50 (23.8%)	0 (0.0%)	3.63	1.120
The way one conducts one's life here and now is what spirituality is about.	7 (3.3%)	17 (8.1%)	40 (19.1%)	106 (50.5%)	40 (19.1%)	0 (0.0%)	4.40	1.118

	FREQUENCY/PERCENTAGE							
Variable	Completely Disagree	Disagree	Neither agree nor disagree	Agree	Fully Agree	Missing	Mean	SD
By spending time with a patient and giving support, nurses can provide spiritual care and reassurance in time of need.	3 (1.4%)	21 (10.0%)	14 (6.7%)	119 (56.7%)	52 (24.8%)	1 (0.5%)	3.88	1.224
Nurses can give care spiritually by listening to the patient and allowing the patient time to discuss and explore their fears, worries and difficulties.	2 (0.9%)	4 (1.9%)	13 (6.2%)	109 (51.9%)	81 (38.8%)	1 (0.5%)	3.71	.884
Spirituality is a unifying force that enables one to be at peace with oneself and the world.	3 (1.4%)	14 (6.7%)	33 (15.7%)	98 (46.7%)	61 (29.1%)	1 (0.5%)	3.65	.874
Art, creativity and self-expression are not a part of spirituality.	29 (13.8%)	74 (35.2%)	52 (24.8%)	49 (23.3%)	4 (1.9%)	2 (0.9%)	3.72	.983
Nurses can provide spiritual care by respecting the privacy, dignity, and the religious and cultural beliefs of a patient.	4 (1.9%)	9 (4.3%)	16 (7.6%)	99 (47.1%)	82 (39.1%)	0 (0.0%)	3.44	1.004
Personal friendships and relationships are vital aspects of spirituality.	15 (7.1%)	30 (14.3%)	41 (19.5%)	89 (42.4%)	32 (15.2%)	3 (1.4%)	4.26	1.178

	FREQUENCY/PERCENTAGE							
Variable	Completely Disagree	Disagree	Neither agree nor disagree	Agree	Fully Agree	Missing	Mean	SD
Those who are unsure of God or who do not believe in God, have no business with spirituality.	47 (22.4%)	56 (26.7%)	45 (21.4%)	42 (20.0%)	20 (9.5%)	0 (0.0%)	4.20	.890
Spirituality includes people's morals.	13 (6.2%)	10 (4.8%)	41 (19.5%)	100 (47.6%)	45 (21.4%)	1 (0.5%)	4.02	.874

The table above shows that an average of 65% of the participants agreed that nurses can provide spiritual care to the patients because to them, spiritual care enables patients to find meaning and purpose in their illness and gives them a sense of hope in life. They also felt that nurses should spend time with their patients; giving support and reassurance in times of need. Most of the participants (85%) were of the view that spirituality should be a unifying force that enables people to be at peace; that it involves personal friendships and relationships and also includes morals. However, a significant 21.5% of the participants were of the opinion that spirituality only involves going to church or a place of worship and does not apply to those who are unsure of God or who do not believe in God.

Table 4.4: Spirituality in nursing practice in relation to respondents' socio-demographic characteristics

Variables (dependent)	Participants' socio-demographic characteristics					
	Gender	Religion	Tribe	Marital Status	Years of Experience	Professional Qualifications
The role of spirituality in nursing practice.	0.463	0.938	0.932	0. 116	*0.000	*0.000
Spirituality and spiritual care.	0.634	0.098	0.038*	0.877	*0.036	*0.002

*Significant at p<0.05

The professional qualifications and years of experience of those who participated were found to be significantly related to spirituality and spiritual care in nursing practice, with p-value <0.05 (Table 4.4). This implies that professional qualifications and their years of experience are key factors in providing spirituality and spiritual caring in nursing practice.

4.2 COMPETENCIES REQUIRED FOR TEACHING AND PRACTISING SPIRITUAL CARE IN NURSING

In this section, six components of competencies required for teaching and practising spiritual care in nursing were looked into at a time to ascertain the level of competency of participants. The components were divided into six categories:

1. Assessment and implementation of spiritual care.
2. Attitude toward patient spirituality.
3. Communication.
4. Referral.
5. Personal support and patient counselling.
6. Professionalization and improving the quality of spiritual care as indicated in the various tables (Tables 4.5 – 4.10).

Table 4.5 shows the responses of the participants to the items included in the category number 2, being ‘‘attitude toward patient spirituality’’.

Table 4.5: Attitude towards patient spirituality (n=210)

S/N	ITEMS	Variables	Frequency	Percentage	Mean Score	SD
1	I show fair reverence for the spiritual/religious	Completely disagree Disagree Neither agree nor disagree	26 15 12	12.4 7.1 5.7	4.01	1.189

S/N	ITEMS	Variables	Frequency	Percentage	Mean Score	SD
	beliefs of patients.	Agree Fully agree	55 102	26.2 48.6		
2	I am open to patients' religious faith, even if they are different from my own.	Completely disagree Disagree Neither agree nor disagree Agree Fully agree	6 8 13 120 63	2.9 3.8 6.2 57.1 30.0		.795
3	I don't enforce my own personal spiritual beliefs on a patient or client.	Completely disagree Disagree Neither agree nor disagree Agree Fully agree	12 5 10 73 110	5.7 2.4 4.8 34.8 52.4	4.39	.998
4	I have an attitude that accepts patients for who they are in my dealings with them.	Disagree totally Disagree Neither disagree nor agree Agree Totally agree	4 3 17 94 92	1.9 1.4 8.0 44.8 43.8	4.41	.730
5	I listen actively to a patient's life history in relation to his or her illness and handicap.	Disagree completely Disagree Neither disagree nor agree Agree Agreed fully	3 1 9 104 93	1.4 0.5 4.3 49.5 44.3	4.45	.700

In Table 4.5 above, on attitude towards patient spirituality, it is evident that more than half of the respondents were open to patients' spiritual/religious beliefs and would not enforce their own spiritual/religious beliefs on a patient. Approximately half of participants affirmed that they can actively listen to a patient's life story in relation to his illness and ninety-four (44.8%) indicated that they have an attitude of acceptance in their relationships with patients.

Table 4.6: Assessment and implementation of spiritual care (n=210)

S/N	ITEMS	Variables	Frequency	Percentage	Mean Score	SD
1	I can report in words and/or in writing on a patient's spiritual needs.	Completely disagree Disagree Neither agree nor disagree Agree Fully agree	6 29 43 84 48	2.9 13.8 20.5 40.0 22.9	3.72	.983

S/N	ITEMS	Variables	Frequency	Percentage	Mean Score	SD
2	In consultation with the patient I can tailor care to patients' spiritual needs.	Completely disagree Disagree Neither agree nor disagree Agree Fully agree	12 10 42 101 45	5.7 4.8 20.0 48.1 21.4	3.83	.874
3	Through multi-disciplinary consultation I can tailor care to a patient's spiritual needs.	Completely disagree Disagree Neither agree nor disagree Agree Fully agree	5 27 22 113 43	2.4 12.9 10.5 53.8 20.5	3.69	1.051
4	I can record the nursing element of a patient's spiritual care needs in the nursing plan.	Completely disagree Disagree Neither agree nor disagree Agree Fully agree	22 27 34 65 62	10.5 12.9 16.2 31.0 29.5	3.64	1.181
5	I can report via writing on a patient's spiritual functioning.	Completely disagree Disagree Neither agree nor disagree Agree Fully agree	8 31 40 100 31	3.8 14.8 19.1 47.6 14.8	3.60	1.010
6	I can report orally on the spiritual functioning of a patient.	Completely disagree Disagree Neither agree nor disagree Agree Fully agree	10 23 33 102 42	4.8 11.0 15.7 48.6 20.0	3.71	.983
7	I can effectively care for a patient's spiritual needs to another care provider or care-giver.	Completely disagree Disagree Neither agree nor disagree Agree Fully agree	13 27 22 100 48	6.2 12.9 10.5 47.6 22.9	3.62	1.119

In Table 4.6 above it is evident that approximately 47.6% (i.e. less than half) of the respondents agreed that they can report either orally and / or in writing on a patient's spiritual needs and can tailor care to the patient's spiritual needs/problems in consultation with the patients. However, only about one-third agreed that they can record the nursing component of

a patient's spiritual care in the nursing plan. Furthermore, less than half of the respondents agreed that they can timeously and effectively refer patients with spiritual needs to another care provider/care discipline.

Table 4.7: Personal support and patient counselling (n=210)

S/N	ITEMS	Variables	Frequency	Percentage	Mean Score	SD
1	I can give spiritual care to a patient.	Completely disagree Disagree Neither agree nor disagree Agree Fully agree	9 32 42 100 27	4.3 15.2 20.0 47.6 12.9	4.02	1.016
2	I can carry out an assessment of the spiritual care needs that I have provided in consultation with the patient and in the disciplinary team.	Completely disagree Disagree Neither agree nor disagree Agree Fully agree	10 21 34 109 36	4.8 10.0 16.2 51.9 17.1	3.44	1.130
3	I can provide the patient with information about spiritual facilities within the institution of care (including spiritual care, meditation centre, and religious services).	Completely disagree Disagree Neither agree nor disagree Agree Fully agree	10 22 40 103 35	4.8 10.5 19.0 49.1 16.7	3.58	1.031
4	I can assist a patient to continue day to day spiritual activity (including providing opportunities for rituals, prayer, meditation, reading Bible/ Koran, listening to music).	Completely disagree Disagree Neither agree nor disagree Agree Fully agree	24 23 24 92 47	11.4 11.0 11.4 43.8 22.4	3.49	1.062
5	During the daily care I can attend to a patient's spiritual needs.	Completely disagree Disagree Neither agree nor disagree	18 32 25	8.6 15.2 11.9	3.73	.966

		Agree Fully agree	84 51	40.0 24.3		
6	Members of a patient's family can be referred to a spiritual advisor upon request.	Completely disagree Disagree Neither agree nor disagree Agree Fully agree	18 23 28 76 65	8.6 11.0 13.3 36.2 31.0	3.44	1.224

The table above shows that one hundred respondents (47.6%) agreed that they can provide a patient with spiritual care and one hundred and nine respondents (51.9%) agreed that they can evaluate the spiritual care that they have provided in consultation with the patient and within the disciplinary/multidisciplinary team. One hundred and three, i.e. less than half of the respondents (49.1%) agreed that they can give the patient information about spiritual facilities within the care institution (including spiritual care, meditation centres and religious services), while seventy-six (36.2%) agreed that they can refer members of a patient's family to a spiritual advisor/pastor if they expressed spiritual needs.

Table 4.8 below showed the respondents' views to the items on professionalism and increasing the spiritual care quality. A total of 48.1% agreed that within the department, they can add to quality assertion while 53.3% agreed that they can add to the professional advancement in the area of spiritual care. A total of 49.3% agreed that they can identify challenges that relate to spiritual care in group discussion sessions and can tutor other healthcare professionals in the aspect of delivery of spiritual care to patients, as well as make recommendations of policy on areas of spiritual care-giving to the nursing ward management.

Table 4.8: Professionalization and improving the quality of spiritual care (n=210)

S/N	ITEMS	Variables	Frequency	Percentage	Mean Score	SD
1	I can add to quality assurance in the aspect	Completely disagree Disagree	5 11	2.4 5.2	3.62	1.112

	of spiritual care-giving.	Neither agree nor disagree Agree Fully agree	42 101 51	20.0 48.1 24.3		
2	I can add to professional advancement in the aspect of spiritual caring.	Completely disagree Disagree Neither agree nor disagree Agree Fully agree	7 13 32 112 46	3.3 6.2 15.2 53.3 21.9	3.71	1.178
3	I can identify challenges that relate to spiritual care during group discussion sessions.	Completely disagree Disagree Neither agree nor disagree Agree Fully agree	9 21 34 101 45	4.3 10.0 16.2 48.1 21.4	3.83	.884
4	I can tutor other healthcare professionals in the field of spiritual care-giving to patients.	Completely disagree Disagree Neither agree nor disagree Agree Fully agree	12 33 32 96 37	5.7 15.7 15.2 45.7 17.6	3.52	1.039
5	I can formulate policy recommendations on areas of spiritual care to the management of nursing ward	Completely disagree Disagree Neither agree nor disagree Agree Fully agree	11 32 42 100 25	5.2 15.2 20.0 47.6 11.9	3.45	.985
6	I can implement a spiritual care enhancement project in the nursing ward.	Completely disagree Disagree Neither agree nor disagree Agree Fully agree	1 52 35 100 22	0.5 24.8 16.7 47.6 10.5	3.52	.954

Table 4.9: Referral to professionals (n=210)

The table below represents the respondents' views to referral to professionals on spirituality:

FREQUENCY (%)									
Variable	Completely Disagree	Disagree	Neither agree nor disagree	Agree	Fully Agree	Missing	Total	Mean Score	SD
I can effectively assign care for a patient's spiritual needs to another care giver.	12 (5.7%)	37 (17.6%)	17 (8.1%)	110 (52.4%)	33 (17.7%)	1 (0.5%)	210 100	3.99	1.031
I can, in a timely and effective manner, refer a patient to another care worker upon request by the patient.	8 (3.8%)	17 (8.1%)	27 (12.9%)	88 (41.9%)	70 (33.3%)	0 (0.0%)	210 100	4.32	.865
I know the appropriate moment to consult a spiritual advisor concerning a patient's spiritual care.	16 (7.6%)	29 (13.8%)	41 (19.5%)	81 (38.8%)	39 (18.8%)	4 (1.9%)	210 100	3.19	.988

Table 4.9 above showed that the majority of the respondents agreed that they can effectively assign adequate care for the spiritual needs of a patient to another care provider.

Table 4.10: Communication skills (n=210)

The table below shows the respondents' views to the question of communication skills in spiritual competency.

FREQUENCY (%)								
Variable	Completely Disagree	Disagree	Neither agree nor disagree	Agree	Fully Agree	Missing	Mean Score	SD
I pay attention, through careful listening, to a patient's life story in connection with his or her ailment.	3 (1.4%)	1 (0.5%)	9 (4.3%)	84 (40.0%)	113 (53.8%)	0 (0.0%)	4.45	.700
In my dealings with a patient I have an accepting attitude.	1 (0.5%)	3 (1.4%)	17 (8.1%)	114 (54.3%)	72 (34.3%)	3 (1.4%)	4.27	.676

The above table (4.10) showed that one hundred and ninety seven respondents, who constitute the majority, 197 (93.8%) of the respondents fully agreed that they listen attentively to the story of the patient's life in relation to his or her disability One hundred and eighty six respondents, who also constitute the majority (88.6%) agreed that they had an accepting attitude in their dealings with patients (concerned, sympathetic, inspiring trust and confidence, empathetic, genuine, sensitive, sincere and personal).

Table 4.11: Participants' socio-demographic characteristics and the competencies required for teaching and practicing spiritual care in nursing

Variable	**Participants' socio-demographic characteristics**					
	Gender	Religion	Tribe	Marital	Years of	Professional

				Status	Experience	Qualifications
Attitude toward patient's spirituality.	0.561	0.002*	0.024 *	0.501	0.05 *	0.032*
Communication.	0.957	0. 000*	0.072	0. 181	0.025*	0.040*
Evaluation and deliberate implementation of spiritual caring.	0.180	0.045*	0.015 *	0.445	0.033*	0.045*
Referral of patient/client.	0.130	0.001*	0.000 *	0.614	0.003	0.000*
Personal support and patient counselling.	0.271	0.253	0.000 *	0.271	0.023*	0.001*
Professionalism and improving the quality of spiritual care.	0.29	0.001*	0.001 *	0.215	0.000*	0.000*

*Significant at $p<0.05$

Table 4.11 above shows the association between participants' socio-demographic characteristics and the competencies required for teaching and practising spiritual care in nursing. All of the characteristics of respondents except gender and marital status were found to be significantly associated at various levels with competencies required for teaching and practicing spiritual care in nursing with $p<0.05$. This implies that cultural background, professional qualifications and years of experience influence the competencies required for teaching and practising spiritual care in nursing. Thus, the better qualified a nurse educator, nurse clinician or nursing student is regarding the concept of spiritual care, the better spiritual care nursing is practiced. Certainly the greater the number of years of experience in nursing practice that the practitioner has, would influence the extent to which there is a better understanding of the concept of spirituality and spiritual care in nursing.

4.3 Discussion of Findings

4.3.1 Understanding the concept of spiritual care among nurse educators, nurse clinicians and nursing students

This section aims to develop an understanding of the concept of spiritual care within the context of holistic nursing care using 'The role of spirituality in nursing practice/spirituality and spiritual care scale,' as follows:

4.3.1.1 Meaning of spirituality and spiritual care-giving in nursing

Most of the respondents viewed spirituality as a basic aspect of being human and agreed that spiritual care is an important part of nursing care and is concerned with a faith in God. It was also viewed by most as a unifying force that enables individuals to be at peace with themselves and the world through the need to forgive and be forgiven. Some were of the opinion that it has to do with deriving purpose in both good and bad occurrences embedded with living in the world. The respondents generally attached multiple meanings to spirituality and spiritual care. This affirmed the statement of Van Leeuwen and Cusveller (2012) that it is difficult to tie the concept of spirituality and spiritual care to just one definition, as spirituality refers to a 'variety' of many connected meanings. Hence, to have a definition for use in this survey, Van Leeuwen and Cusveller never attempted to find a meaning that defines spirituality. Instead, they focused on a number of activities that people engage in, in which they derive pleasure. Human beings are capable of functioning in physical, mental and social capacities.

This method of defining human spirituality is 'functional' rather than substantive. Rather than having a particular definition, it emphasizes how people create meanings (Fitchett, 2012). Furthermore, Tanyi (2016) stated that many theorists explain spirituality in many ways that have a religious context.

The respondents in this study expressed the opinion that various languages and terms used to describe notions, insights and opinions are related to spiritual care and spirituality. Puchalski et al., (2014) affirmed that a consensus definition of spirituality was a great challenge because terms such as 'sacred', 'history' and 'transcendence' were recommended as basic components of spirituality. Some of those who responded were opposed to these terms because of their exact meanings in their exceptional cultural settings. In strict abstract terms, Puchalski et al., (2014) further pointed out the challenges concerning spirituality because it is not a product, but an experience that springs from commitment in life. It is not simply produced but materializes over time.

This study also revealed an association between the role of spirituality in nursing practice and spiritual care, professional qualifications and years of experience of the participants. Certainly, the better qualified a nurse educator, nurse clinician or nursing student was, the better their understanding of the notion of spiritual care in nursing. This may be due to the fact that qualifications determine the knowledge while years of experience may determine their professional exposure to spiritual nursing practice.

Shores (2010) conducted a survey on the concept of spirituality using American nurses (n=208). In this study of Shores, it was discovered that of the nurses who participated, 74% were spiritually aware, thus they were better placed to provide spiritual care; as opposed to those who were less spiritually aware.

4.3.1.2 The role of nurses in spirituality and spiritual care practices

Most of the participants believed that nurses render care spiritually when they respect patient's cultural beliefs, religious beliefs, dignity and privacy. This notion is supported by the Malta Code of Ethics for Board of Nurses and Midwives and it states that it is in the nurse's best interest to ''recognize and respect the uniqueness of every patient/client's biological, psychological, social and spiritual status and needs''. Although care is rendered to

patients by a healthcare team comprising of various professionals, this code of ethics covers every health worker providing holistic care to the patient. For instance, some acclaimed nursing professionals became so due to giving patients holistic care that is rooted in spirituality, which eventually led to full recovery. Furthermore, in Shores' (2010) study, the majority of participants said that nurses create an environment that allows patients time to discuss and explore their fears, anxieties and troubles, saying that the nurses spend time with patients, giving support and reassurance in times of need. According to Baldacchino (2015) the Code of Ethics of the International Council of Nurses (ICN) states the role of the nurse is ''to promote an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected''. Globally conducted studies revealed that spiritual care and spirituality are crucial elements of nursing practice (McSherry, 2011; Narayanasamy & Owens, 2015; Shin et al. 2014; McSherry et al., 2010; Sessanna et al. 2010; Mahmoodishan et al., 2010). These studies suggest that careful attention to patients' spiritual needs should be ensured by nurses. Monareng (2012) affirms the above suggestion by asserting that nurses must exude a caring presence that encompasses attentiveness, listening, touching and being a spiritual presence, thus integrating spirituality into various cultural settings.

4.3.1.3 Difficulties of understanding spirituality and spiritual care in nursing

Nurses are faced with various challenges on understanding how to best provide spiritual caring to their patients. These difficulties included feeling spiritually inadequate to define the meaning of spiritual care and spirituality because of contrasting views espoused in literature about the meaning of spirituality and spiritual care, with there being no consensus among the authors (Puchalski, 2014; Mahmoodishan et al. 2010). The majority of the participants (68%) in this study, expressed contrasting views on the meaning and concept of spirituality. Other challenges identified in this study by the researcher include confusion between religion and

spirituality, which leads to disagreement on how and what constitutes spirituality. For example, different religious beliefs, multi-religious practices of the participants, regimented care-giving, lack of training of the participants, refusal to accept new trends in nursing education and practice and the preference for males to provide spiritual care as well as sensitivity on issues of religion were part of the major challenges raised by the respondents of this study. Thus, their understanding of the concept of spirituality and spiritual care in nursing is hindered because of their varying views.

4.3.1.3.1 Education as a challenge:

Education, as far as the concept of spirituality and spiritual care in nursing is concerned, does influence understanding the concepts of rendering spiritual care. For example, in this study only about 2-5% had either received education on the concept of spirituality and spiritual care during training or independently sought this type of training outside of the academic settings. These findings further support, the studies conducted by Sellers and Haag (2017) and of Stranahan (2011) concerning the absence of education being an obstacle to spiritual care.

4.3.1.3.2 Religion and Culture:

Spirituality and spiritual care perspectives were influenced by religious affiliation and ethnicity of the participants. They see spirituality as an individual belief that is affected by some factors such as connections, life experiences, spiritual values, cultural heritage and ethnicity. In this study, there are substantial dissimilarities between religious association and spiritual views. Religious background or association can in fact affect the rendering of spiritual care. This was explained by Luckhaupt et al., (2016) who conducted a survey among resident physicians. His findings were that personal religious rituals affected their faith on the integration of spiritual care into healthcare practice. Although, these associations may help individuals attain a certain perspective, they may or may not be responsible for forming the bulk of that person's perspective either now or in the distant future. When one has difficulty

seeing the interconnectedness in its entirety, the reverse may be the case (Buck, 2012). In cases such as these, denominational associations with a faith community may develop or change one's spiritual perceptions. A person may be connected to God through religious associations with spiritual settings (Springer, et al., 2015).

4.3.1.3.3 Culture:

Conner and Eller (2018) has shown support for cultural influences on spirituality and spiritual care. How a person views the world together with his/her spiritual conceptions are deeply rooted to his/her cultural inheritance. Findings by Conner and Eller (2018) debated that adult African-Americans still revere and anticipate spiritual care from healthcare professionals when admitted in the hospital, but the opposite was identified in elderly Caucasian males (Ross, 2014).

4.3.1.3.4 Gender:

Based on a sample analysis of this study, the number of females in the nursing profession globally, Nigeria inclusive, constitute 72.4% of nurses. As a result of various factors affecting gender, the researcher concedes that men and women experience life differently. However, because of the low number of males participating in this survey, it cannot be inferred that males have lower spiritual qualities; even when the literature scores women higher on spiritual rating.

4.3.1.3.5 Age: To age means to advance in years.

A question that must be considered, based on the fact that one has aged, is whether advancement in age is closely related to understanding of the concepts of spirituality and spiritual care in nursing. The findings showed that as the age of the participants increased and their years of professional exposure increased, their understanding grew. Some developmental theories (Tornstam, 2011) as well as Conner and Eller (2018) agree that as

one ages, one becomes more spiritual and is thus in more need of spiritual care from healthcare professionals.

4.3.2 Competencies required for teaching and practicing spiritual nursing care

Six scopes of spiritual care competencies were obtained from the survey. They comprise the following:

1. Spiritual care assessment and implementation.
2. Professionalization and increasing the quality of spiritual care.
3. Rendering personal support and counselling sessions to patients.
4. Referral of clients/patients to professionals for advanced spiritual care.
5. Developing an appropriate approach/attitude towards patient spirituality.
6. Effective communication.

4.3.2.1 The 'assessment and implementation of spiritual care' dimension

This can be defined as the ability to determine the spiritual needs or challenges of the patient in order to deliberate an effective spiritual care plan. This requires that intra- and inter-professional communication of patient's spiritual needs and care is put into writing. Findings of this study points out that nursing students who tend to evaluate and assess a patient's spiritual needs and devise spiritual care strategies in healthcare settings, and participants who hold spiritual care in high esteem as a significant part of healthcare delivery, are the ones more likely to transfer patients with spiritual needs to experts in spiritual care. According to results of these findings, students may feel inadequate in the provision of spiritual care hence, seeing their own role as limited. It was stated by White (2018) that even when health professionals most especially nurses, recognise the need for spiritual assistance, most were unable to help. Lack of confidence and understanding is the major cause of this. Because of this reason, nurses relegate spiritual matters to the hospital priest.

The key to unlocking nurses' confidence and consciousness in spirituality and spiritual care is education.

4.3.2.2 The 'professionalization and spiritual care' quality improvement

Activities of the nurse is expected to be targeted at quality assurance and policy development in the area of spiritual care so that there can lead to increase in the quality of the various patterns of spiritual care. Some assistance rendered by nurses at the institutional level should be seen to go beyond primary healthcare. The knowledge and skills acquired by the nurse will determine the attitude that will be exhibited by the nurse in rendering spiritual care and this will lead to the promotion of nursing profession (Van-Leeuwen, 2012).

4.3.2.3 The 'personal support and patient counselling' dimension

Van- Leeuwen, et al. (2011) state that personal support and patient counselling is the core of spiritual care-giving, with materials put in place to provide timely interventions. Giving personal support shows the actual provision of spiritual care-giving and this will include the nurse identifying him or herself with the needs of the clients and setting out to meet those needs. Before a nurse can meet the spiritual needs of the clients, he or she has to do a spiritual assessment of herself and that of the clients as this will guide her preparation for meeting the spiritual needs of the clients. The knowledge in the subject matter will aid the assessment, the skills to exhibit in meeting spiritual needs and the positive attitude that will enhance the personal support and patient counselling dimension.

4.3.2.4 'Referral to professionals' dimension

This relates to cooperating with various healthcare professionals working together hand-in-hand as a team to achieve optimal spiritual care for the patient. Here the chaplaincy has a major role to play. Spiritual care in nursing demands total commitment, sacrifice and attention, considering the needs of other patients that must be met by the nurse, it may be

difficult for the nurse alone to meet the changing spiritual needs of the patients, hence, referring the patients to other professionals for the spiritual care needs will not be out of place. The nurse must assess the spiritual needs of the patients and decide who the professional is to refer the patients to (Van-Leeuwen & Cusveller, 2010). Spiritual service is a team work and every member of the spiritual team must have got areas of specialization which is known to the team members and by this, will enhance a smooth referral means for quality attention.

4.3.2.5 The attitude towards patient spirituality

This entails accepting all clients for who they are, avoiding imposing one's own faith or belief on the patient. The findings of this study show that nursing students who tend to evaluate and assess a patient's spiritual needs and devise spiritual care strategies in healthcare settings; and participants who hold spiritual care in high esteem as a significant part of healthcare delivery; are the ones more likely to transfer patients with spiritual needs to experts in spiritual care. When the inter-connectedness between the attitude towards assessment, evaluation and referral to more skilled professionals was appraised, the same outcome was noted. Results from evaluation carried out by a research group comprising of van Leeuwen and Cusveller (2010); Baldacchino (2015) revealed that an important element in nursing competency is the aspect of nurses' attitudes towards patients' spirituality as a component of spiritual care. The findings further revealed that nurses who are in tune with their own spirituality are able to give quality spiritual care to patients when the need arises (Highfield et al., 2013; Meyer, 2017; Wasner et al. 2011). However, students differently interpreted what 'attitude towards patient spirituality meant,' which caused diversity in response, as it varied significantly. During their studies in the field of healthcare, students develop general knowledge on basic concepts of the importance of an efficient

communication skill, quality control and assessment even though areas addressing attitudes were based on the personality of the nurse in question as far as this survey is concerned.

Conclusively, students' personal views on spiritual care-giving were significant as became clear from the questionnaires completed for this study. Students' exposure to the clinical setting also played a major role in their responses to questions concerning the 'demonstration and control of attitudes' as well as on views about patient spirituality, and where aspects of attitude were concerned. In accordance with Meyer (2017), exposure to the clinical setting helps reassess one's core values in spiritual care-giving. For this reason, Highfield et al (2013) and Wasner et al. (2011) included materials in their survey evaluation tool that points to the fact that the attitude of nurses influenced the level of spiritual care patients received. Research has been carried out to ascertain the effect of nursing education on individual nurse's spiritual wellbeing (Pesut, 2013; Meyer, 2017; Wasner et al., 2011; Sandor et al. 2011; Loviano & Wallace, 2017). Meyer (2017) stated conclusively that a student's spirituality is the highest determining factor of his/her ability to give spiritual care.

4.3.2.6 Communication with patients

This entails trusting and being confident in one's communication skills. It comprises being able to talk about spirituality, encouraging, counselling, attentive listening, confirming, expressing and channelling emotions to the appropriate quarters, taking time and not being solution focused. The study revealed that all six dimensions of spiritual competence identified with $P<0.05$. This implies that the attitude towards patients on matters of assessment and implementation of spiritual care, spirituality, communication, referral to other health professionals, personal support, counselling of patients, professionalization and improving the quality of spiritual care were significant to spiritual competence. This result is not absolutely in concord with Singh and Premarajan (2014) in their study on 'individual spiritual orientation at work: a conceptualization and measure'. In this study they reported

that the principal element analysis with Varimax rotation gave indications of the multiple dimensions of the SCCS, and that the associations between assessment, referral and professionalization were appraised as being significant (after showing proportions of explained variance >0·20). This indicated that those nurses who esteemed spiritual care as an important aspect of an effective health care delivery and policy creation, are very likely to devise helpful strategies, gauge patient's spiritual desires and refer them to professionals who are highly skilled in the field of spiritual care-giving.

The findings further revealed only 'attitude towards patient spirituality' and 'referral to professionals' were positively correlated with both years of experience and qualifications of the participants. Other competencies were either correlated with professional qualifications or years of experience, except 'communication', which was negatively correlated. These findings show that negative correlation with 'communication,' are at variance with major tools in nursing practice. 'Communication' is an important tool in nursing practice and a better qualified nurse educator, nurse clinician or nursing student with many years of experience on the job is assumed to be a better communicator than another without this advantage. Jena and Pradhan (2014) in their studies of workplace spirituality submitted that two factors that make up spirituality at work are individuals and their organization. Organization refers to policies and practices. Individuals give real meaning to policies and practices whilst still following them. Hence, individuals must be capable or spiritually experienced so as to develop and sustain spirituality in a work environment. The segment that follows tries to intellectualize the meaning of spiritual competence. In the spiritually competent model of nursing care Campinha-Bacole (2013) views spiritual competence as a process and not an endpoint. Spiritual competence was defined by her as comprising of three components. These are:

1. Spiritual skill.
2. Spiritual awareness.
3. Spiritual knowledge.

While talking about 'Spiritual intelligence,' Zohar and Marshall (2012) seem to be talking about the knowledge and awareness components of spiritual competence. According to them, spiritual intelligence is the key that unlocks the door to vision, use of meaning and value in the way that we think and the decisions that we make. This intelligence completes us and gives us our integrity. It is 'the core of the soul' intelligence, the intelligence of one's inner self. Fundamental questions are asked and answers are re-constructed with this intelligence. It is the intelligence that transforms us. We need to understand how authors define competence before conceptualizing what we mean by spiritual competence. Competence is defined as relative knowledge, skills and attitudes (KSA) that affects our responsibility, which corresponds with on-the-job performance. This can be enhanced through constant training and can be measured against acceptable standards (Parry, 2014).

With respect to the description given to competence and spirituality, recent studies view spiritual competence as a set of knowledge, skills and attitudes causally related to a person's ability to derive meaning and relevance in life. Spiritual attitude means to keep a positive perspective, transcending the superficial and experiencing inner peace. Spiritual knowledge occurs when one understands the needs of others, knowing that everything is affected by various factors and being close to self. Spiritual skill is the ability to practise spirituality, the ability to live in the present and being responsible.

4.3.3 Comparing the required competencies with the available care competencies, if any, that exist within the content of the nursing curriculum in Nigeria

4.3.3.1 Personal spirituality/religious orientations

The majority of the respondents had more than one professional qualification, with several years of experience in the profession, but they were never exposed to the acquisition of knowledge in spirituality and spiritual care in nursing. A total of 82% said that they were never taught in their various institutions of training the anatomy of the how, what, when, who and where of spirituality and spiritual care in nursing, as this concept was not part of their curriculum. This deficiency in the curriculum shows the need for its integration into the curriculum so that nurses can meet their patients' spiritual needs. Data obtained showed a link between nursing education and nursing practice, hence, content related to spiritual diversity should be included into nursing education and more knowledge about spiritual care in nursing should be taught and learnt. Clearly the more the curriculum is laced with spiritual care content, the better it will be for the nurses to acquire the skills, positive attitudes and knowledge for effective delivery of spiritual care. If nursing education has rich content on tenets of coping with spiritual issues in nursing, nurses will be able to offer spiritual care by showing cheerfulness, kindness, and genuine concern to patients (Chandramohan, 2013).

4.3.3.2 Religious and spiritual diversity

The literature revealed that religion and spiritual diversity intersect with issues of health and recovery and are in the set of competencies a professional nurse must acquire before effectively providing spirituality and spiritual care (Chandramohan, 2013 & Monareng, 2012). Special attention to complementary and alternative therapies including spiritual care implanted in various ethnic backgrounds of the respondents which are missing in the current curriculum because the curriculum only focussed on the modern health care of patients hence,

the need for review the curriculum and integration in the curriculum the spiritual care to meet patients' holistic needs.

Issues for consideration in spiritual education and practice: Van Leeuwen (2009) identified six areas of spiritual competence. These are:

1. Assessment.
2. Professionalization.
3. Personal support.
4. Referral.
5. Communication.
6. Attitudes towards patient spirituality.

These are to be acquired in the course of training in order to fully acquire the full range of the competency. The results of this study showed, however, that the majority (85%) of the participants said that they had never heard of these attributes of spiritual competency, to say nothing of implementing them in the course of rendering nursing care. This was as a direct result of the topic being absent from the curriculum during the course of their study. In the analysis carried out by Lind, Sendelbach and Steen (2011), it was asserted that efficient all-inclusive educational programmes form the basis of purposeful learning and that training in nursing has been instrumental in helping nurses to render spiritual care-giving. It is therefore of great importance to have an aligned teaching content with information on spirituality and spiritual care in nursing education. A review conducted by Wu and Lin (2011) found that fifty- three Chinese student nurses, which signifies (58%), received lectures on spiritual care. An additional fifty- eight, which constitutes 74% of these nurses, received on-going spiritual care education even after qualifying as nurses. Subsequently, 30% of these nurses agreed that

these workshops enabled them to better meet their patients' spiritual needs. They acquired this knowledge because the content was included in their curriculum of training.

4.3.3.3 Attributes of spiritual care in nursing practice

Eight components were identified in the study. These are as follows:

1. Having a concerned attitude.
2. Being sympathetic/empathetic.
3. Being inspiring.
4. Trust.
5. Confidence.
6. Authenticity.
7. Sincerity.
8. Being Supportive.

Majority (91.3%) of the respondents in this study confirmed that they never learnt about these attributes in their training but acknowledged that doing so would have contributed to their competency in rendering spiritual care to patients. Understanding the various aspects of the characteristics of spiritual care-giving in nurses' professional practice helps to ensure that they provide care in a holistic manner.

4.4 CONCLUSION

The quantitative aspect of the study revealed multiple opinions of respondents regarding the rendering of spiritual care. It was observed that the majority of the respondents attached multiple meanings to spirituality and spiritual care. From this study, it was observed that all of the characteristics of respondents except gender and marital status were found to have wide-ranging and positive impacts on their accepting of the concepts of spiritual care within

the context of complete care in nursing. The better qualified the respondents, with an increased number of years of experience in the profession, the better their level of understanding of the rubrics and components of spiritual care in nursing. In addition, the variables determining competence such as skills, knowledge and positive attitude are significant in rendering competent spiritual care in nursing to a range of patients, to meet their spiritual needs (Chandramohan, 2013). This proved pivotal in managing the patients' spiritual care at every point in the duration of their time with nurses and nursing management. The next chapter i.e. chapter five is on the qualitative results and discussion as a follow-up to the quantitative results and discussed in this chapter.

CHAPTER FIVE

QUALITATIVE RESULTS AND DISCUSSION

5.0 INTRODUCTION

This section presents the outcomes and dialogue of the qualitative phase of the study, in which several focus group discussions were conducted. Results of participants' experiences were presented under the main theme that emerged during the study. Direct quotations of the participants' statements are given to preserve their original responses relating to specific themes. The themes and sub-themes were discussed with reference to the relevant literature. The participants were purposively selected by the researcher from among those used for the quantitative study.

5.1 QUALITATIVE DATA ANALYSIS

Qualitative data analysis and interpretation is the process of assigning meaning to the collected information and determining the conclusions. It is conducted by organizing the data into common themes or categories. Qualitative data analysis is aimed at generating themes and making sense out of the data. In this regard content analysis was employed to analyze the data. Thematic analysis is used for exploratory or explanatory research, but most often in descriptive research. The process of analysis consists of moving from the reading and memo-ing loop into describing, classifying and interpreting (Creswell, 2014). The tape-recorded data were transcribed, then cleaned and prepared for the analysis. The huge volume of data had to be condensed and categorized to a manageable size. Meticulous readings were conducted to filter and clean the data. The FGDs with nurse educators, nurse clinicians and nursing students were analyzed separately. The FGDs were conducted in the English language hence, translation of the transcribed texts was not necessary. The transcribing and analysis were done concurrently with the data collection process.

In this study, thematic analysis of issues recurring in each interview was done and themes emerging from the various categories of data were conceptualized into meaningful themes on the basis of regularities and convergence in the data. Data were analyzed according to the five stages of data analysis described in the Framework approach by Ritchie and Spencer (1994, 2013) as outlined by Gerrish and Lacey (2016).

1. **Familiarization**: This step was achieved through immersion in the data to get an initial feel for the key ideas and recurrent themes. The researcher immersed himself in the details of the data; thus, developed insight about the whole sense of the data, learnt more about it and then drew an impression of the whole ideas of the data. In order to do this, the researcher first read and reread all the information to obtain a sense of a general overview of all the transcribed information by jotting down notes and reflective notes in the margin of the text and/or highlighting text with different colours. Then the researcher started to look closely at the words used by participants in the study. Development of the themes was done by immersion in the data to understand and seek further explanation, and generating the theme. A code was assigned to individual text and line numbering was allocated to text, which enabled the researcher to trace back from which text the data was extracted.

2. **Identifying a thematic framework**: This is the stage of identifying key issues, concepts and themes and the setting up of an index or framework. This stage was achieved by writing memos in the margin of the text in the form of short phrases, ideas or concepts arising from the texts and categories were developed which form the key issues, concepts and themes that were expressed by the participants and this was used to filter and classify the data

3. **Indexing:** In this stage, the researcher identified portions or sections of the data that correspond to a particular theme and it entails sifting the data, highlighting and sorting out quotes and making comparisons both within and between cases. For the sake of convenience, a numerical system NVivo was used for the indexing references and annotated in the margin beside the text.

4. **Charting:** In this stage, quotes were 'lifted' from their original context and re-arranged according to themes under the subheadings that were drawn during the thematic framework in the manner that is perceived to be the best way to report the research (Ritchie & Spencer, 1994). The themes were presented in chart and separate charts were used for each major subject or theme

5. **Mapping and interpretation:** This involves the analysis of the key characteristics as laid out in the charts. This analysis provides a schematic diagram of the event/phenomenon thus guiding the researcher in his interpretation of the data set. It is at this point that the researcher was cognizant of the objectives of qualitative analysis, which were: "defining concepts, mapping range and nature of phenomena, creating typologies, finding associations, providing explanations, and developing strategies" (Ritchie & Spencer, 1994). Therefore, the charts were used to define concepts, map the range and nature of the phenomena, create typologies, and find associations between themes in order to provide explanations for the findings. This process was guided by the original research questions as well as the themes and relationships emerging from the data.

5.2 Demographic data of the participants

A total of thirty-six participants which comprises of twelve nurse-educators, twelve nurse clinicians and twelve nursing students participated in semi-structured interviews. The

majority of participants interviewed were females. Most of them were between eighteen (18) and fifty-eight (58) years of age. Participants expressed their general understanding of spiritual care, and it was not long before they settled into the discussion. They listened to each other's contributions, which often stimulated new insights and helped them to develop their ideas more clearly. The themes represent the group responses. Verbatim quotes were used to support the generated themes. Table 5.1 below represents the results of the semi-structured interviews conducted

Table 5.1: Results of semi-structured interviews for nurse educators', nurse clinicians' and nursing students' data

Five main themes emerged from the study, which included understanding spiritual care, challenges to and facilitation of spiritual care in the nursing curriculum, competencies of nurse educators/nurse clinicians/nursing students, possible limitations and solutions of spiritual care in the nursing curriculum.

MAJOR THEMES	SUB-THEMES
1. Understanding spiritual care.	• Aspect of holistic nursing care • Understanding patient's religion • Ways of assisting with patient's care • Invitation of religious leader(s) into patient's care • Religious aspect of the nursing profession
2. Challenges to and facilitation of spiritual care in the nursing curriculum.	• Excluded from universal nursing curriculum • Useful for patient with chronic terminal illness • Enhance patient's recovery • Improve confidence level
3. Competencies of nurse educators/nurse clinicians/nursing students.	• Lack of academic competencies • Employing religious expert • Limitations of experts in the field

4. Possible limitations that may be encountered.	• Lack of academic competencies • Different religious beliefs/practices • Imposing personal beliefs on other people Lack of interest • Infringement of other(s) people's religious beliefs • Atheism • Misconceptions • Lack of competent lecturer(s)
Solutions to challenges as suggested by participants.	• Conducting a training programme for educators • Identifying each religion • Appointing religious/spiritual leader • Availing seminar(s)/workshop opportunities by the regulatory bodies • Inviting expert(s) in the religious field • Involvement of nursing regulatory bodies in inclusion of spiritual care • Bridging the different religious gaps • Relaying outcome to regulatory bodies • Introduction of spiritual care at the start of nursing education course • Exercising patience and perseverance

5.2.1 General Understanding of Spiritual Care

5.2.1.1 Spiritual care-giving is a part of holistic nursing care

All participants acknowledged spiritual care as part of holistic nursing care and agreed that holistic care is incomplete without spiritual care. Thus they emphasised that for patient care to be complete, there is a need for the spiritual aspect of the care in nursing, as stated below:

'Spiritual care is one of the aspects of patient care to address the issue of holistic care. Holistic care is an approach of care. When we talk of nursing care then spiritual care is inclusive,

therefore to achieve or to go by the concept of holistic care, we need to include spiritual care into the patient's care.' (Participant 5)

'Where is holistic care without spiritual care? Ah…ah… no no no…..' (Participant 6)

'...I think while we talk about caring for the patient, you bring in all the aspects of healthcare such as: physically, mentally, socially and even spiritually, because health cannot be complete if the spiritual aspect of the patient is being ignored……' (Participant 18)

Spiritual care-giving is a vital aspect of providing well-rounded care and according to Milligan (2011), within the scope of the nursing profession spiritual care-giving is at the heart of an all-inclusive care that fully merges the psycho-social and physical care. According to Koslander and Arvidsson (2018) nurses' primary goal is to assist clients in achieving 'a higher degree of harmony within the mind, body and soul which generates self-knowledge, self-reverence, self-healing and self-care processes.'

5.2.1.2 Understanding patients' religions

Most respondents lacked an adequate understanding of the concept of spiritual care as they could not distinguish spirituality from religion. Some of the participants believed that understanding the patient's religion is spiritual care as humans are spiritual beings who have spiritual needs:

'*Spiritual care in nursing is the need of the religious belief of background knowledge of…er…. maybe the patient, even the people who is taking care of the patient' (Participant 8)*

'Spiritual care is all about inviting God into nursing care or supreme being ….you will have to put into consideration, the patient faith, the belief system, what the…. what seem to be important to the patient.' (Participant 14)

'My suggestion is that if at all, this type of. ..ehn…study is accepted to be part of the curriculum…ehn….they should make sure the students are able to apply this study according to the religion of that person and not forcing it on the patient to believe in certain religion, because it can trigger problem.'(Participant 17)

'We consider the patient's religion…. that will assist you in going deep and for the acceptance for what you are trying to put forward…. Since we are spiritual individual….' (Participant 15)

It was observed that most of the participants in this study saw spiritual nursing as tantamount to religious beliefs and care. This idea is a reflection of a partial understanding of the concept of spiritual care, which may limit their care. Spiritual nursing care, on the other hand, is broader as it totally assimilates the innate, social, humane and compassionate company of the nurse, which is reliant on the nurse's consciousness of the supreme facet of life and reveals the patient's reality (Sawatzky & Pesut, 2015).

Ross (2014) also observed that spiritual care nursing is only occasionally rendered. Having no understanding of human spirituality and not being able to decode the expression of people's spiritual longings can hinder and frustrate the nurse's effort to render a holistic care graced with spirituality. Understanding the patient's religion will provide insight into the appropriate spiritual care to be administered for effective spiritual nursing care.

5.2.1.3 Ways of assisting with the patient's care

Some of the respondents viewed spiritual care as ways of assisting with a patient's care. They believed that the introduction of spiritual care into nursing will assist nurses in giving patients quality care, especially terminally ill patients with cancer or advanced HIV/AIDS. This they discussed as follows:

'…..it is very important in the sense that….. er…..especially with patient with terminal illness, terminal illness in which the hospital have to keep on managing, not really treating, you keep on managing maybe to…keep the patient in very comfortable position until the final bell rang, I

mean dies, so in that kind of a case, spiritual care is very important, because patient is already preparing for home in coat….' (Participant 11)

Most of the participants viewed spiritual nursing care as being nursing care, for both acutely and chronically ill patients, is the foundation for spiritual nursing care. Hermann (2011) states further that spiritual care-giving in nursing is connected to encouraging hope in ailing and recovering patients and assisting them to find meaning and significance in their pain. Koslander and Arvidsson (2018) view spiritual nursing as recognizing clients' self-worth and showing them acceptance and love so that they can experience peace and spiritual wellness. Hence, spiritual care is essential in patient's care.

5.2.1.4 Invitation of religious leader(s) into patients' care

Recognising the importance of inviting a religious leader to participate in the care of the patient by praying for the patient was stated by some respondents, as demonstrated in the statement below:

'When talking about spiritual care... maybe we can go and bring the spiritual leader maybe Imam or pastor, to come and pray for the person, thereby meeting their needs…' (Participant 9)

It is the belief of people in this part of the world (Nigeria) that spirituality has to do with religion and that only the spiritual leaders (clergymen) can provide support for this. Mathew et al (2018) also asserted that religious commitment or involvement appears significantly in the prevention of illness, recovery from illness and coping with an illness. They identified clusters of research reports supporting a link between religious commitment and decreased prevalence of depression, substance abuse and physical illness such as hypertension. Religious commitment may also increase longevity. These authors conclude that physicians should inquire about and, if appropriate, encourage a client's religious convictions.

5.2.2. Challenges to, and facilitation of, including spiritual care in the nursing curriculum

5.2.2.1 Spiritual care was believed to be excluded from the universal nursing curriculum

Most of the respondents were of the opinion that spiritual care as a concept is not included in the nursing curriculum in Nigeria, which makes teaching the concept in institutions difficult. Sometimes it may be mentioned briefly when teaching holistic care. The following were among the opinions shared by respondents:

> *'.... our exposure in this part of the country is yet to embrace spiritual care. When we talk of spiritual care, a lot of nurses or health workers, nurses in particular, may think they are doing spiritual care, but for you to go into the spiritual care, it entails a lot of questioning. We need to identify the issue for the need of spiritual care. Take for example, people come to the hospital to receive medical care and they know that in the hospital, they will meet with the doctors and nurses who will take care of their physical problem, but people hardly identify spiritual care. And before you can give spiritual care, you need to know what are the problems to identify are.' (Participant 17)*

> *'No for now because we don't have spiritual care it in the curriculum, but with the inception of pain management and palliative care, I think we are coming up with spiritual care.' (Participant 19)*

> *'We the students, we were given the curriculum for all the courses we are to take in school, but there is no…er…. spiritual care in the curriculum, I think that is why the school is not teaching spiritual care…' (Participant 11)*

> *'Because it has not been incorporated into the curriculum of nursing education in the university, we were not taught…' (Participant 9)*

Spiritual care as a concept has not been formally included in the curriculum and it is not taught during training, but while caring for the patient his/her religious beliefs must be taken into consideration to make the nursing care holistic, as society demands. It was therefore no surprise that most of the participants stressed the need for the introduction of the concept into the curriculum so it can manifest in nursing practice.

> *'It is a welcome idea, because that will further collaborate the further understanding and the management of holism in nursing' (Participant 12)*

> *'Yeah, with the new trend where particularly majority of Nigerians are religious…. religiously inclined, anything that has to do in….an average Nigeria, without even mentioning the word in religion or the concept of their believe, it appears we have never done much to them and the majority of our patient in our ward now …. want to have it as part of their care and including it in a curriculum and… er…. part of teaching, and learning curriculum, I think is a welcome idea, which I subscribe to.' (Participant 7)*

Conner and Eller (2018) state that: 'clients have also recognised the yearning of humans for an all-inclusive care; where relationships and spirituality enhance recovery and well-being.' Taylor (2012) is of the opinion that clients must be given nursing care that centres on these needs in-relation to all human aspects. When an individual is sick, the whole being is affected, including the spiritual dimension. There are claims in the literature that members of the nursing profession treat patients as both physical and spiritual beings (Van Leeuwen et al., 2015). Giske (2012) affirmed the belief that a holistic perception enables nurses to see clients as spiritual beings in need of a well-rounded care that will allow spiritual development amidst sorrow and pain.

5.2.2.2 Useful for patients with chronic terminal illness

Most of the participants stated that spiritual care is beneficial for patients, especially terminally ill patients, because their belief at that point is that only God's intervention can heal them. A nurse clinician said:

> *'....but by the time they involve in chronic illness, that is when the heighten for spirituality becomes a necessity....' (Participant 3)*

> *'When the outcome of disease is bad or unknown, then the patients clamour for spiritual care is their own way once they are getting it from the hospital.' (Participant 23)*

Some respondents believed that the introduction of spiritual care into nursing care will bring patients closer to their God, especially those with terminal illnesses. This was expressed in the quotations below:

> *'I think it will bring patients closer to their maker, especially the terminally ill ones.' (Participant 9)*

> *'because..... er.....for me I believe there is not.... there is nothing that happen except God is at work, so, if we bring God into our help, I believe is going to turn the situation around and increase faith in God.''(Participant 11)*

Spiritual nursing care is crucial in chronic/terminal illness as it has positive consequences or outcomes for the patients. Freshwater and Maslin-Prothero (2016) defined consequence or outcome as a practical or visible effect, result or product. Meraviglia (2014) further stated that consequences within the context of the provision of spiritual care-giving in nursing practice, helps to address areas of spiritual care that includes variables, relationships and ideologies that have long been ignored, but which may proffer new solutions to spiritual care giving within clinical settings.

5.2.2.3 Enhancing patients' recovery

Most respondents agreed that spiritual care-giving could help patients deal well with their condition and enhance recovery, as demonstrated in the statements of the participants below:

'Their religious leader to come and pray for them like pastors, Imam and co, they…they believe that their prayers will help them to recover faster…' (Participant 27)

'Based on the experience I have with patients, and I discovered that even the patients don't come to hospital to collect drugs alone, and at times you will see that….they have that interest .....that they wanted to be cared for spiritual and ...er… some of them do take permission, they want their spiritual leader to pay them visit and give them….spiritual support, …' (Participant 14)

'….if spiritual care is included in one's care for a patient, it can help to…er…help the patient to cope better when they are sick, because… er….using the patient religious belief can also help the patient to heal faster…' (Participant 4)

5.2.2.4 Improving confidence level

The respondents further agreed that spiritual care provides a sense of hope for the patients, which will serve as encouragement to the patients, which will in turn promote the recovery process. This is captured in the statements below:

'It will help us in nursing a lot, to attain our…I mean aim and objectives, that is getting the patient…. well easily and quickly...er.... but the psychological aspect of the treatment is the most important thing, and when you can get into the patient and you know what is in his or her mind, that one will help a lot in nursing' (Participant, 4)

'… I want it to be integrated because it will help the patients the more, especially psychologically, and even spiritually, it will also help them as well…compound'.(Participant, 9)

'It gives the patient sense of hope when you introduce spiritual care and this promotes the health and quality of life…' (Participant 8)

Spiritual care gives the patient a sense of hope and promotes quality of life. Conner and Eller (2018) were of the opinion that beliefs, behaviours and insights of spiritual care patients are vital as the patients open-up to spiritual care-givers. However, the personal beliefs and attitude of the patients vary by gender, disease progression, age and cultural beliefs. Every healthcare provider should be able to use his or her discretion to handle every case as it comes.

5.2.3 Competencies of Nurse Educators/Nurse Clinicians

5.2.3.1 Lack of academic competencies

Most participants stated that nurse educators and nurse clinicians are not competent to teach or practice the concept of spiritual care in nursing, since they have not undergone the relevant training as students. They therefore lack the academic competence to teach the concept of spiritual care to students:

> *'I will say they are not competent, even though they have an idea of what to teach, if their idea is… towards the construction, then I believe very well that the course, if integrated, it will be well taught by the teachers that have gone through the training ….' (Participant 34)*

> *'I will say they are not competent…Yes, academically they are knowledge and skills…' (Participant 28)*

The responses of the participants indicated that they concur with Brownell (2015) who stated that competence embodies a person's knowledge, his/her actions, and the outcome of the actions. According to Johnson, Barnet, Elman, Forrest & Kaslow (2012), competence was defined within the context of professional psychology as developmentally suitable stages of knowledge, skills and attitudes and their incorporation into several foundational spheres of functioning while Rodolfa et al. (2014) affirmed that when healthcare professionals are

competent, they are better qualified to deliberate and implement appropriate healthcare strategies with a timely approach. These theorists assert that competence entails 'what a person brings to a job or role (knowledge), what the person does on the job or role (performance), and what is achieved by the person on a job or role (outcomes).'

Furthermore, some other participants suggested that training for trainers (nurse educators and nurse clinicians) may assist them in carrying out their roles effectively, if this area of expertise is eventually integrated into the nursing curriculum.

> *'There must be a special course for them; yes ooooh, there must be a special course for them to get them to know within the boundary of the curriculum, the new curriculum being developed, which included spiritual concept.' (Participant15)*

> *'Yes sir, the concept is a good one and if nursing is to be taken, if nursing care is to be taken holistically, and I think the nurse that is practising it already have to be aware of this concept, in other words, seminars can be organised, where this concept will be explained to them.' (Participant 32)*

5.2.3.2 Employing religious experts

Some respondents suggested that there is a need to employ religious experts to teach the concept and that this would facilitate better understanding by the students.

> *'They should look for people who have maybe B.Sc. Theology, B.Sc. Religious Studies, BA, people that are professionals, that knows a little bit of the course, so that people will understand it better…'*
>
> *'I believe it can be integrated by employing people with a higher understanding of the topic, particularly theologists….' (Participant 33)*

Taylor (2018) stated that hundreds of studies that explored the connection between religious conviction and physical and mental health have demonstrated a positive relationship. Koenig (2012) and Jarvis and Northott (2018) on the other hand concluded after reviewing research on the influence of religious belief on morbidity and mortality, that it is impossible to make

grand statements affirming a definite relationship between these factors. However, they did recognise that it is becoming evident that religion has a powerful effect on the way many people live, on their quality of life and on the length of time they live to experience that quality. Levin (2012) stated that an association exists between religion and health. Levin suggested that the answer to the question of whether the association is valid (i.e. not due to chance) is 'probably'; and the answer to the question of whether religion can cause healthful outcomes is 'maybe'.

5.2.3.3 Limitations of experts in the field to train nurse educators

Introducing the spiritual care component into nursing care will require adequate training for the nurse educators, who will in turn train students. Those responsible for meeting this need should organize seminars or workshops for nurse clinicians, to translate this concept into practice. However, the educators were of the opinion that there is no expert in the field at present to initiate the training.

> *'The nurse educators need to be trained, but there will be problem of people who are competent enough to train them….' (Participant 1)*

> *'There must be a body that will develop the curriculum for the training, either at basic level, diploma level or even in advanced level. There must be a curriculum development that will help to guide the educators who will give them the expected training on this spirituality.' (Participant 14)*

> *'..so, training is very important. It will be a big challenge if people are not trained, because without training, you cannot get what in particular religion oppose to or support and don't know how fulfil[led] they are in their spiritual level. So training, if there is no training, it will be a challenge.' (Participant 21)*

All these responses are supported extensively in the literature. The participants at various levels have been through several professional training courses and workshops, but have no

specific exposure to spiritual care in nursing. There is no specific mention of spiritual care in nursing care even though nurses are trained on the basic aspects of patient care. This is why it is assumed that spiritual care in nursing is neither taught by the nurse educators nor practised by the nurse clinicians. It is evident that spiritual care in nursing is not specifically included as a discrete item in the current nursing curriculum in Nigeria. This concurs with the assertion by Collins (2011) and Hurley (2012) that nurses are still struggling to teach and integrate spiritual nursing care into nursing education and practice. This despite the fact that some of the literature indicates that this is not the case, and more particularly that spiritual care has been included in the education of other health professionals, but not in the nursing curriculum in Nigeria as no particular attention is paid to the teaching and practice of spiritual care in nursing.

5.2.4 Possible limitations that may be encountered

5.2.4.1 Different religious practices/beliefs

Some of the respondents stated that religious practice in all its diversity will be a challenge to the proper integration of spiritual care into nursing care. The following statements illustrate this:

> *'Some of the challenges that they will come up will be in [the] form of the practices involve [d] in people[s] religion ….' (Participant 19)*

> *'….er…..there is….between the two religions, Islam and Christianity, they have a sort of cosy relationship, they are the two issues because I grew up with a Moslem friend that I got to discover that in their religion, is even forbidden to touch a Quran when you are not a Muslim, I don't know if it is the same with some churches, so, it is, they have a conflict [of] understanding between the two religions that as a Christian, you can't talk freely about the Islam, and they too they can't talk easily about Christianity. So, it is going to be a challenge in term[s] of understanding.'(Participant 2)*

People express their beliefs in the way they live. The participants expressed their spiritual preferences in terms of Christianity or Islam and the way they practise their choice of religion, and they seem to dread the notion that clients may feel uncomfortable that the nurse's religious belief is being imposed on them. No doubt, there is this risk even among the participants, who are understandably reluctant to talk about the other person's religion. Christian believers seem to be more affected by this stigma because of the practice of sharing the gospel with others, which is a Biblical injunction according to Kumar (2016). Sharing the gospel with patients or even with other health professionals is interpreted as imposing one's beliefs on others and being insensitive to other people's beliefs.

5.2.4.2 Enforcement of other's people belief (s)

One of the challenges of integrating spiritual care into nursing practice is religious coercion. If the concept of spiritual care is eventually integrated into nursing services, some caregivers may take advantage of the situation to impose their beliefs on their patients. The following quotations illustrate this assertion:

> *'hum hum…….especially in Nigeria here even where people always want to force their own belief[s] on patients. For instance, now, if am a Christian and someone else, my patient is a Muslim, there is that tendency…that hidden tendency in people, trying to force their own belief[s] on the patient and that is a barrier already.' (Participant 8)*

5.2.4.3 Lack of interest

A low level of interest in the concept is another challenge identified by the researcher, based on respondents' input. They stated that students, clinicians and nurse educators may not be interested in the concept, especially if they feel that it is irrelevant to their religious beliefs.

> *'……the possible challenges will be students or nurse educators or nurse clinicians may start losing interest in the particular topic….' (Participant 13)*

> *'….or that the students' interest, and even the lecturers' interest, it may be very low….'*

'I also see it as a challenge because they might not be so willing to even learn the tenet of some other religions….' (Participant 6)

5.2.4.4 Infringement on other people's beliefs

Respondents agreed that infringements on other people's religious beliefs may present a challenge to the administration of spiritual care, especially where nurses and patients come from different religious beliefs:

'….it can infringe on other people's religions….'

'….some people might not like it, in the sense that we all have different religious beliefs, and values, so, there might be contradicting ideas about spiritual care, am a Christian, some people are Muslims, so, there might be contradicting ideas about spiritual care and that is part of the constraints ….' (Participant 34)

5.2.4.5 Atheism

Another challenge identified by some respondents was how to incorporate atheists into the concept of spiritual care:

'….like people that are humanist now, that they don't believe in anything, so you can ask them to...they believe in nothing, will you ask them to believe in something for them to get healed?' (Participant 31)

'….some people are peace-makers that they don't even believe in God, so a lecturer teaching them that will be as if he is incorporating something they don't want in them….' (Participant 28)

5.2.4.6 Misconception

Misconception is another area of challenge identified by respondents, in that spiritual care may be misinterpreted as religious care, whereas there is a distinct difference between the two i.e. spirituality and religion.

'….one of the challenges that we could face is the challenge of misconception… many people when they hear spiritual care, what come[s] to their mind is religion, God and … spiritual care is not only about all these things, it goes beyond this, and so misconception…' (Participant 5)

5.2.4.7 Lack of competent lecturer (s)

Most of the respondents talked of the current lecturers being incompetent to teach spiritual care in nursing since they too went through the same curriculum (which is still used today) that does not contain spiritual care in nursing, so it will be difficult for them to teach it:

> *' Eh sir, lack of competent lecturers will hinder the introduction of spiritual care in nursing because none of us went through it in the course of our various trainings in nursing except they are further trained in the concept so I suggest retraining of the lecturers in this area to provide holistic care to patients….' (Participant 35)*

5.2.5 Possible means to address barriers as suggested by participants

5.2.5.1 Conducting a training programme

Most respondents stated that training in the concept of spiritual care is essential to achieve the goal of integration of the concept into nursing care and to avoid conflict in the process of rendering the care to the patient, as demonstrated in the statements below:

> *So, training is very important. It will be a big challenge if people are not trained, because without training, you cannot get what in particular religion oppose to or support and don't know how fulfil[led] they are in their spiritual level. So training, if there is no training, it will be challenge, and the religion, for the religion aspect, we need to the prone and cone aspect for each religion. Apart from religion, we have so many denominations practising a religion, we need to know what they accept, what they believe in and how they practise their norms and that will help us to overcome some of the religion. Knowing this well…fully well will help us to give a detailed curriculum for a student what (sic) we need to train. (Participant 6)*

'….as long as the lecturers are being given some orientation and then re-exposed to some kind of training, there will be no barrier…' (Participant 17)

5.2.5.2 Identifying each religion

The majority of the respondents stated the need for identification of various religious doctrines and belief systems as a key area for successful integration of spiritual care into the nursing curriculum.

We have two major religions, the Islamic religion and the Christianity. And aside from that, there are other traditional believers. So, when the curriculum is to be developed, we need to consider the pillars of their religion and the importance of each religion, even the traditional, because we cannot say all the patients coming into the hospital will fall into either Islamic religion or Christianity because they are the majority religion, yes, we come up with their believe (sic) to know how we can help the patients when they [are] receiving spiritual care and aside from that, we still need to delveinto other religions like traditional religion, Sango worshippers, others idols worshippers. Some worship the god of thunder, some worship the god of river, the goddess of river and all sort of. So, before we can develop curriculum, concerning the spirituality, we need know how many people believe in what faith, and how are they practising it and what are the expected…hum…what are the expected support to get their spirituality. (Participant 29)

5.2.5.3 Appointing each spiritual leader

As stated by some respondents, religious leaders should be involved in the process of integration of the concept into the nursing curriculum so as to understand the diversity of each religious belief and to have maximum cooperation of the patients. The following quotations illustrate this:

'I think we have to look at some religions, I will…I will call them 'elders', as a way of….The way I see Christianity, so we need to identify people in that area …in that…. in that religion, be it Christianity or Islam. They will be the one[s] to handle this area because they are part of the system because they know the pro's and cons of their religion….' (Participant 34)

'Each of those religions have their own leaders, so you can now go to the leaders and I know that [the] majority of our people, they believe in what their leaders tell them….' (Participant 31)

5.2.5.4 Availing seminar opportunities by the regulatory bodies

Some respondents agreed that organizing seminars or workshops to train nurses in the concept will assist in proper implementation, until this area of knowledge is eventually integrated into the curriculum. The following quotations illustrate this:

> *'I believe with that if more seminars, nursing symposium from among those who are stakeholders, it will be a welcome idea….' (Participant 36)*

> *'They should organise maybe [a] conference or a workshop or close to in order to enhance the knowledge of the nurses concerning spiritual nursing care and to emphasise to them as we know that religion should not be a...should not be a determinant of a relationship, of nurse- patient relationship, so, er…religion should not be a cha…maybe a challenge or solu…should not be one of the challenges right now causing problem[s] in our spiritual nursing teaching.' (Participant, 2)*

> *'The institutions can organise maybe seminar, to…. disseminate information about spiritual care, so that patients can have…hum… some ideas about spiritual care, so that they can also render spiritual care during their course of rendering care.' (Participant 11)*

5.2.5.5 Inviting expert(s) in the religious field

Some respondents stressed the need for expert religious involvement in the incorporation of spiritual care-giving into the nursing syllabus, as demonstrated in the statement below:

> *'We can overcome it if we call on people; I mean experts in religious…hum…in religious studies….' (Participant 15)*

5.2.5.6 Involvement of nursing regulatory bodies in the inclusion of spiritual care

Most of the respondents agreed on the need for the involvement of regulatory bodies such as the National Universities Commission and the Nursing and Midwifery Council of Nigeria, as they are responsible for the regulation of training and the practice of nursing in Nigeria. This opinion was expressed in the quotes below:

'There must be a body that will develop the curriculum for the training, either at basic level, diploma level or even in advanced level. There must be a curriculum development that will help to guide the educators who will give them the expected training on this spirituality.' (Participant 19)

'....university, nursing committee have a role, but most of the role that nursing university commission had in the training of nurses are gotten from the nurses council of Nigeria, nursing council of Nigeria can sort of....organise a...review the curriculum for teaching nurses, let me say curricula for all category of nurses, general nurse, midwives, psychiatric nurse, the green nurse, what have you, all those curricula have to be reviewed and inculcate spiritual care into it, but they will not just give it to us teachers, I mean lecturers, this is curriculum for you, start using it, no, they must...they must first of all gather us in place, give us in service training, it could be two week, one week, one month or whatever and we get a cert...the certificate for it, before you can actually teach, that is my view.' (Participant 22)

''Well, to be frank, this cannot be actualised if nursing council doesn't have ...if an approval is not gotten from a council, I think ...hum...with the findings of the research, possibly at the end of it, when the findings are being conducted, perhaps a written document can be presented to them, to see it to them, the need for incorporating it, the need for spiritual care into nursing, by that is it is being considered and been approved, I think it will actually help in this....' (Participant 29)

5.2.5.7 Bridging different religious gaps

Some of the respondents stated that religious gaps can be bridged by involving religious experts before integration of the concept into the curriculum:

'.....I think we can...we can overcome it if we call on people, I mean expert[s] in religious...er...in religious studies before one can go to university, there are religious study in the university, for instance, and when one go[es] for religions study to study both the two major religion[s] that we have in the world, they will teach you about the Islam, they will teach you about Christianity and they teach you about traditional African religion and I believe the three of them have a kind of unity, a kind of ... er...meeting point somewhere, so that is why does who

are expert in religious belief are not always biased when they want to advise people concerning certain religions, some of them, majority of them are religious, they have their personal belief, religious beliefand they don't log it on others because they've got knowledge in that, if they call those people to teach us, I mean those of us lecturers in nursing, about this one, about religion, if you know about religion not just about bi ..bible, I may be a Christian, I may know bible from beginning to the end, I may be a Muslim knowing Quran from the beginning to the end, that has not made me… er…an expert in teaching en….spirituality in nursing, but if this (sic) people come in, it will be better for us.' (Participant 17)

'When we start, the Muslim will take it, the other religion will take it to be another affair, but if they can teach them and then they understand it very well, it will help the patient and even the nurses that are taking care of the patients.' (Participant 4)

5.2.5.8 Relay outcome to regulatory bodies

Some respondents suggested that the outcome of this study should be made available to relevant bodies for possible consideration:

'I want to request or am expecting the result, at the end of this study.We want the end of this study made public to various health institutions all over the world, so that this good initiative will be …can encourage and be imbibed by various bodies that are responsible for nursing education and practice all over the world, particularly [the] African continent….' (Participant 28)

'I believe if after the completion of the project, then the message and the information is well disseminated and then…published; I believe very well, that that beneficiary will benefit especially the…. the…the…stakeholders in nursing education and nursing practice…' (Participant 21)

'I will pursue them to ensure that after the study have (sic) been finished and have(sic) been published, every nursing student, all schools, universities should have a copy of this, so that they will appreciate…it will be appreciated in every area of the field or everywhere in the world where they will use it….' (Participant 35)

5.2.5.9 Introduction of spiritual care at the start of nursing education

Most respondents agreed that the introduction of spiritual care from the word go will assist in ensuring the students' interest in the concept and will be a solid foundation for the students.

> *'I think that the idea is good; and it should be brought up at this level of education, not at this tail end when we are almost going out of the school, maybe once the student enters….''(Participant 19)*

> *'It will be good if it is being integrated at the earlier stage of students that are in the first level or 2nd year of education….' (Participant 23)*

> *'….by teaching this topic at the early stage of the nursing education…yes… (pause)…..even among the lots of people that will be…. we can still see like one or two that will be interested, from there, there will be an increase in the people that will be interested in the topic…' (Participant 7)*

5.2.5.10 Exercising patience and perseverance

A respondent stated the need for perseverance. If spiritual care is to be integrated into the nursing curriculum, it will be new, and getting used to new concepts like this will require great patience and perseverance:

> *'ah ah…..any change will need perseverance because it will take time, so it will be learnt over time, then we have to be patient, then to put in all efforts…I mean for it to succeed… since we have not been practising it at all before now….' (Participant 11)*

5.3 CONCLUSION

This section presents the investigation and discussion of the results of the study, with a focus on the qualitative study. A non-mathematical method of investigation and clarification was applied. The major subjects, classifications and sub-themes that emerged from the data were presented and discussed. The findings reveal that the majority of the participants were not taught spiritual care in nursing in any course of their nursing training because it is not covered in any curriculum or nursing programme in Nigeria. Since they were not taught in this area, they cannot teach or practise it effectively, due to their lack of competence in

spiritual care. The next chapter will be presenting the findings from the experts' review using Delphi technique because experts' opinions are critical if effective changes will be made in curriculum development.

CHAPTER SIX

EXPERTS' REVIEW USING DELPHI TECHNIQUE

6.0 INTRODUCTION

The study was mixed methods research with both quantitative and qualitative strands. While the quantitative survey results provide information that meets the first three goals (i.e. Objectives 1 to 3) of this study, the qualitative strand presents the report of the dialogue among the experts. According to the report of the quantitative aspect of the study, majority of the respondents attached varying meanings for spirituality and spiritual care. The qualifications and work experience of the respondents impact their level of understanding of the rubrics and components of spiritual care in nursing positively. Specifically, the interviews with FGD participants revealed that they had never been exposed to spiritual care in nursing during the course of their nursing trainings, because it was not covered in any curriculum or nursing programme in Nigeria. The reports of the two strands of the mixed methods research were disseminated to a group of nursing and non-nursing experts using Delphi technique. The experts' opinions are critical to the study, if integration of spiritual care into nursing curriculum is going to be achieved. All the participants of Delphi technique reached a consensus on the issue of integrating spiritual care into the nursing.

The Delphi technique is a widely used and accepted method for gathering data from respondents within their domain of expertise. The population identified for this section included senior nurse educators, nurse administrators, nurse clinicians, university administrators, Professional association leaders, Nursing and Midwifery State Committee members, nursing university lecturers, curriculum experts/ developers/educationists. These experts were identified considering their wealth of experience so that this can be impact on the quality of their suggestions. Among them, fifty of the experts were contacted, but only forty responded by phone and/or email communication. The forty experts who responded

positively by indicating their willingness to participate in the study were further communicated with through email. The questionnaire was sent to them through the email addresses provided by the expert committee members, along with information about the study, the consent form and protocols for the study. The questions were based on the results and conclusions from the focus group discussion with the nurse educators, nurse clinicians and the students. The views of individuals were collated and analysed on the research subject matter in the Delphi Round One.

6.1 DELPHI STUDY ROUND ONE

The aim of Round One was to determine the level of consensus about the general understanding of spiritual care, components of spiritual care in nursing practice, competence required to teach and practice spiritual care in nursing and possible limitations to teaching and practicing spiritual care in nursing, from the experts on the panel. Experts were also asked to propose additional information that they considered important if this information was not included in the initial document.

6.1.1 SOCIO-DEMOGRAPHIC DATA OF THE PARTICIPANTS

Table 6.1: Socio-demographic distribution of Delphi Study participants (n=40)

Variable	***F***	***%***
Age Range (years)		
45-49	10	25
50-54	11	27.5
55-59	18	45
60-64	1	2.5
Gender		
Female	22	55
Male	18	45
Religion		
Christianity	23	57.5
Islam	17	42.5
Rank		
Senior Assistant Registrar	1	2.5
Assistant Director of Nursing	11	27.5
Deputy Director of Nursing	12	30

Variable	*F*	*%*
Deputy Director	2	5
Director of Nursing Services	2	5
Reader	6	15
Professor	6	15
Roles related to the Research		
Nurse Educator	17	42.5
Nurse Clinician	14	35
Curriculum Expert/ Educationist/Religious Leaders	2	5
Nurse Educator/Curriculum Expert	4	10
State Nursing and Midwifery Committee	3	7.5
Years of Experience		
Less than 30	16	40
Less than 40	23	57.5
Less than 50	1	2.5

Table 6.1 illustrates the socio-demographic representation of the forty experts. The data were analysed using simple percentage, where most of the respondents were female and aged between 55 and 59 years of age. Twenty-three of the participants, who constituted more than half of the experts (57.5%), were Christians and had more than thirty years working experience. The researcher considered the high status of the participants because of their wealth of professional experiences and many of them must have gone through many curricula of training and as approved by the supervisor.

TABLE 6.2: DATA ANALYSIS OF DELPHI ROUND ONE RESULT (n=40)

General understanding of spiritual care	**Agree**	**Undecided**	**Disagree**	**REMARK**
It is an important aspect of holistic nursing care.	40	0	0	100% **Consensus achieved**
It is often neglected in nursing practice.	38	1	1	95% **Consensus achieved** Some give spiritual care out of goodwill, but not as routine.
Spirituality is a basic aspect of being human.	40	0	0	100% **Consensus achieved**
Knowledge of patients' spiritual beliefs is important for effective nursing practice.	40	0	0	100% **Consensus achieved**
Spiritual care inclusion in nursing curriculum in Nigeria				
It is excluded from the nursing	38	1	1	• 95% **Consensus achieved**

General understanding of spiritual care	**Agree**	**Undecided**	**Disagree**	**REMARK**
curriculum.				• Included although not usually implemented
It is not projected in the way other aspects of nursing care are projected.	40	0	0	100% **Consensus achieved**
Nurse education should include content on how to deal with spiritual issues in nursing.	40	0	0	100% **Consensus achieved**
Components of spiritual care in nursing practice				
Concerned attitude.	32	8	0	• 80.0%**Consensus achieved** • Attitude has nothing to do with spiritual issues
Sympathetic/empathetic.	40	0	0	100% **Consensus achieved**
Inspiring.	36	3	1	• 90% **Consensus achieved** • People's inspirations differ; this should not be part of the component
Trust and confidence.	40	0	0	100% **Consensus achieved**
Authenticity	38	1	1	95% **Consensus achieved**
Sincere and personal.	38	1	1	• 95% **Consensus achieved** • Too vague.
Adequate communication.	40	0	0	100% **Consensus achieved**
Personal support.	32	6	2	80% **Consensus achieved.** Not necessary
Importance of spiritual care in nursing practice	**Agree**	**Undecided**	**Disagree**	**REMARK**
Useful in the case of terminal/chronic illnesses.	40	0	0	100% **Consensus achieved**
It helps to understand different beliefs.	40	0	0	100% **Consensus achieved**
Nursing practice with a spiritual component has a better chance of empowering patients than practice without such a component.	40	0	0	100% **Consensus achieved**
Competence required to teach and practice spiritual care in nursing				
Ability to recognize complex spiritual, religious and ethical issues.	40	0	0	100% **Consensus achieved**
Confidentiality in the recording of sensitive and personal patient information.	40	0	0	100% **Consensus achieved**
Clear understanding of personal beliefs and ability to journey with others focused on those persons' needs and agendas.	40	0	0	100% **Consensus achieved**
Distinguishes spiritual and religious needs.	40	0	0	100% **Consensus achieved**
Basic skills of awareness, relationships and communication.	40	0	0	100% **Consensus achieved**

General understanding of spiritual care	Agree	Undecided	Disagree	REMARK
Ability to refer concerns of patients/clients to the multidisciplinary team.	28	0	0	• 70.0% **Consensus achieved** • Statement is not clear • Not particular to spiritual issues • Not necessary
Assessment of spiritual and religious needs.	40	0	0	100% **Consensus achieved**
Developing a plan for care.	39	1	0	97.5% **Consensus achieved** • This may be cumbersome • May not be relevant at all times
Possible limitations to the teaching and practice of spiritual care in nursing				
Lack of understanding of the meaning of spiritual care in nursing.	40	0	0	100% **Consensus achieved** while in training
Lack of training of both educators and clinicians.	40	0	0	100% **Consensus achieved**
Multi-religious practices of the populace.	39	0	1	• 97.5% **Consensus achieved** • This might make it difficult to understand and implement
Regimented care-giving.	30	8 (20.0%)	2 (5.0%)	• 75% **Consensus achieved** • Spirituality is diverse and means different things to different people
Refusal to accept new trends in nursing education and practice.	37	1 (2.5%)	2 (5.0%)	• 92.5% Consensus achieved • Common in initial stage of anything new. • People usually resist change
Possible ways to overcome barriers				
Training and re-training of nurse educators and clinicians on spiritual care.	40	0	0	100% **Consensus achieved**
Review of nursing curriculum.	39	0	1	97.5% **Consensus achieved**
Inclusion of spiritual care into the nursing curriculum and allocation of time (hours).	39	1	0	• 97.5% **Consensus achieved** • Can be included as a unit in psychology or behavioural science
Properly spelling out the components of spiritual care in the curriculum.	39	1	0	• 97.5% **Consensus achieved** • This will cause confusion because there are over 100 religions and types of spiritual care worldwide • This will cause problems around supernatural topics with the patient and the carers
Allocating practical demonstration time for spiritual care in nursing.	39	1	0	97.5% **Consensus achieved**

The experts also provided comments in some areas, for the researcher to consider robustly in the study. These areas the researcher considered for Round Two of the Delphi study. The comments of the experts are shown below.

6.2 DELPHI STUDY ROUND TWO

Round Two took the form of structured questionnaires incorporating feedback to each panel member. The first round was analysed and re-circulated, a process that encouraged members of the research team to be more involved and encouraged to participate (Walker & Selfe, 2017). According to Buck et al. (2014) an efficient and rapid collection of expert ideas together with well-ordered feedback was achieved by using the Delphi model. Panel members were actively involved in developing this tool because Delphi was able to include and inspire them at the onset. Because of this the results were accepted (McKenna, 2017). The active involvement of staff in the identification of their own development needs is crucial. In accordance with the views of Shepherd (2015); for the success of any development programme, members of staff must be actively involved in identifying needs paramount to their own development. This is an added-advantage as well as a form of encouragement.

Round Two followed the same process as Round One. All forty experts who were used for Round One were invited to participate in Round Two but only thirty-two of these responded – an 80% response rate. The thirty-two experts who responded positively as this showed their willingness to participate in the study were sent the questionnaire through their email addresses and attached to the questionnaire was the consent form. The questions were based on the results and conclusions from Round One where consensus was not formed. The respondents' views were collated and analysed by simple percentage as in Delphi Round One. The respondents Round One indicated 85% consensus, hence the issues generated from Round One were used to compose the questionnaire for Round Two. The experts were asked to choose among the options of 'Agree', 'Undecided' and 'Disagree' and also make suggestions they deemed relevant or useful, on any item of the questionnaire or the focus

of the research. Consensus was reached at the end of Round Two of the Delphi study, where the consensus reached set out to obtain 100% in both rounds.

6.2.1 Analysis of data for Round Two

The quantitative data were collated and analysed using simple percentage which was also presented using the mean and mode for each sub-section.

6.2.2 Results of the Delphi Study Round Two

The results of the Delphi Round Two are as follows:

TABLE 6.3: EXPERTS' REPONSE FROM DELPHI ROUND TWO (n=32)

Variables	**Agree**	**Undecided**	**Disagree**	**REMARK**
General understanding of spiritual care.	32 (100%)	0 (0.0%)	0 (0.0%)	Consensus achieved
Spiritual care inclusion in nursing curriculum in Nigeria.	32 (100%)	0 (0.0%)	0 (0.0%)	Consensus achieved
Competencies required for teaching and practicing spiritual care in nursing care.	32 (100%)	0 (0.0%)	0 (0.0%)	Consensus achieved
Possible limitations to teaching and practicing spiritual care in nursing.	32 (100.0%)	0 (0.0%)	0 (0.0%)	Consensus achieved
Possible ways to overcome barriers.	32 (100%)	0 (0.0%)	0 (0.0%)	Consensus achieved

N.B: The consensus in Round Two was 100% in all opinions and responses.

6.3 DISCUSSION FROM THE DELPHI STUDY

The Delphi study further revealed major areas that should be looked into for adequate integration of spiritual care in the nursing curriculum, such as the general understanding of spiritual care to form

the introduction in the curriculum. The inclusion of spiritual care in the curriculum is very germane if nursing care must be holistic. Indeed, there are competencies that must be exhibited by nurse educators, nurse clinicians and nursing students for effective and efficient delivery of spiritual nursing care at all levels and in all settings. There were possible hindrances identified and it was felt that these would limit the delivery of spiritual care in nursing. Further to this, the respondents felt that all nurse carers must be aware of these hindrances in order to ensure adequate delivery of spiritual care in nursing. Koenig (2013) stated that there are many reasons why nurses are not assessing or addressing spiritual issues more regularly. Unfortunately, the barriers responsible for these reasons are not well known, although they are probably similar to those reported by the physicians. They include lack of time, lack of education about spiritual assessment or care, confusion about what spirituality is (i.e. how it should be defined), fear of intruding on or offending patients, feeling the area is too personal to inquire about in situations where privacy is lacking, discomfort about assessing spirituality and the nurse's personal attitude.

Taylor (2013) asserted that the incorporation of spiritual care is rooted in nursing theory and history and then reinforced by research and professional mandates. The implications for nursing practice that follow are drawn from these foundations. The history of spiritual care in nursing should encourage nurses to examine and value the spiritual beliefs that motivate their work – or service – as nurses. History also suggests that organized religion may have a beneficial influence on creating an environment that fosters quality care and outreach to under-served populations. Religious healthcare centres and universities often provide supportive environments in which nurses may develop and teach best practices, particularly in the area of spiritual care. A number of nurse theorists support the view that the spiritual dimension is an important element of a nursing care that is all-encompassing. Some propose that the nurse's spirituality contributes to the client's healing environment. Theories from social sciences posit that certain life events may challenge a client's spiritual beliefs and their sense of meaning. Effective nursing care requires that nurses prepare themselves to address the

client's spiritual needs. Clients may especially benefit from spiritual care when critical life events challenge assumptions about the world. As holistic nursing theory posits, spiritual needs do not occur in isolation. Health-related challenges often incorporate spiritual elements, and effective nursing care will address them. Loneliness that keeps a client awake at night, for example, may reflect a sense of neglect, or the betrayal of loved ones, or the absence of God. A client in pain may also be struggling with questions such as ''Why me?''

6.4 CONCLUSION

This chapter focused on Phase Two and Step Four of the IM, which was to produce programme components and materials. Findings described and analysed in this chapter showed that 100% consensus was achieved among panellists on the need to include spiritual care in the nursing curriculum, as well as the competencies required to teach and practice spiritual care in nursing. There was also consensus on possible limitations to the teaching and practice of spiritual care in nursing in Nigeria, and ways to address these. These findings inform the next chapter, which outlines the drafting of the model for the incorporation of spiritual care-giving into the Nigerian nursing syllabus.

CHAPTER SEVEN

DEVELOPMENT OF THE MODEL

7.0 INTRODUCTION

This is the continuation of Phase Two of the study. This section utilizes the fifth step of the IM strategies, which is the adoption and implementation of the plan of action. Bartholomew et al. (2011) identified a few steps in this phase such as identifying adopters and implementers of the programme, re-evaluating the planning group to ensure representation of potential programme adopters, stipulating factors of programme implementation, execution and maintenance, developing a medium of amendment goals for programme adoption, designing interventions for programme use, and execution and maintenance. Twenty participants as experts in curriculum development; nurse administrators/clinicians as providers of the spiritual care; and nurse educators teaching the concept of spiritual care were contacted, curriculum experts/ religious leaders were also involved and they have been active participants in the study before now. All twenty experts responded positively and participated in the study. Below is the profile of the participants who were involved in the development of the model for integration of spiritual care into nursing curriculum.

TABLE 7.1: PROFILE OF THE PARTICIPANTS INVOLVED IN DEVELOPMENT OF THE MODEL (n=20)

S/N	Gender	Years of experience	Current Status	Role performed in this Project
1	Male	58	Director of Nursing	Nurse clinician/administrator
2	Male	55	Deputy Director of Nursing	Nurse educator
3	Female	50	Deputy Director Nursing Education	Nurse educator

S/N	Gender	Years of experience	Current Status	Role performed in this Project
4	Female	47	NANNM Representative	Nurse clinician
5	Female	53	N&MCN Representative	Nurse educator
6	Female	54	Director of Nursing (Education)	Nurse educator
7	Male	56	Deputy Director Nursing Education	Nurse educator
8	Female	62	Deputy Director of Nursing	Nurse clinician/administrator
9	Male	54	Christian Representative	Religious leader
10	Male	56	Islamic Representative	Religious leader
11	Male	63	Professor	Expert in curriculum development (Nurse educator)
12	Female	62	Professor	Expert in curriculum development (Nurse educator)
13	Female	57	Deputy Registrar	Representative of Director of Academic Programmes
14	Female	50	Deputy Director of Nursing (Clinical)	Nurse Clinician
15	Female	50	Deputy Director	Nurse Educator

S/N	Gender	Years of experience	Current Status	Role performed in this Project
			of Nursing (Education)	
16	Male	35	Professional editor/designer	Professional Designer
17	Male	60	Professor	Expert in Curriculum Development
18	Female	58	Professor	Expert in Curriculum Development
19	Female	60	Reader	Expert in Curriculum Development
20	Male	57	Reader	Expert in Curriculum Development

7.1 PROCESS

7.1.1 Preparatory phase: The researcher sent invitation letters to the selected committee members, inviting them to attend a meeting at the chosen venue and time. The purpose of the meeting was to adopt the consensus documents of the expert committee from the Delphi study and also implementing the same document by developing a model for the integration of spiritual care into the nursing curriculum in Nigeria being the major focus of the project, venue, time and agenda were clearly stated in the invitation letter to all the selected members. All invited individuals agreed to attend the meeting through text messaging and/or email response. They were informed that they would be signing consent forms in the first meeting of the committee. The committee had three scattered meetings. Although they are all busy people, the expectation was that everyone perused the documents in order to fast track the process of formulating the final document setting out the integration of spiritual care into the nursing curriculum. Text messaging, phone calls and emails were

used by the expert committee members and the researcher, which eased their interaction and made the task easier to execute.

7.1.2 First meeting: The researcher welcomed all the members and further explained the purpose of the gathering to them i.e. to consult as experts in the process of the adoption and implementation of spiritual care in nursing document, arrived at as a result of the research carried out by the researcher in order to develop a model that will successfully incorporate spiritual care into the Nigerian nursing curriculum. He further explained the journey so far on the research project, how it all started and since some members of the committee were already engaged at some point in the research project i.e. collection of data for both quantitative and qualitative data, it was easier for the researcher to clarify and for the members to understand. This was true for all except those who were new to the exercise.

7.2 Ethical Considerations

In this study, participants' rights were protected by getting their informed permission. Participants were given all the pertinent data about the study, which consists of its significance, goals and requirements. Participants were assured that private information about participants cannot be disclosed to unapproved individuals or to anyone without their knowledge, thus, ensuring respect for privacy (Burns & Grove, 2014; Polit & Beck, 2010). The right of participants to withdraw from the study at any time, even when the consent form has been completed, was protected and this attracted no bias or consequence. Respect for human dignity was preserved by giving participants the right to freely express themselves without any interruption, except when it was necessary. Questions were asked in a manner that participants were comfortable to answer.

The researcher ensured that the research assistants also completed confidentiality forms, including the professional editor/designer, which guided their conduct during the study. The researcher made sure that the subjects were not in any way harmed or affected by their participation in the study whether physically, emotionally, spiritually or economically. To ensure these, the researcher safeguarded the well-being of the respondents who had a right to protection from discomfort and

harm as the meetings took place in a safe environment conducive for living, asking questions in the group that may cause any of the participants to be embarrassed in front of the others were avoided. They were also given the freedom to operate as participants without coercion.

Consent forms were distributed to all the participants after thorough explanations by the researcher. All the participants voluntarily completed the consent forms, including the professional editor/designer. This first meeting discussed the 'what', 'when', 'how', 'who', and 'where' of spiritual care integration, which included the following:

1. Content of spiritual care in nursing.
2. The meaning of spiritual care: who should be teaching it, who is to be taught, where the teaching should take place, which methods will be used to teach, the duration/timing and the competencies for teaching.
3. The competencies for practicing spiritual care in nursing.
4. The barriers to effective teaching.
5. The administration of spiritual care in nursing.
6. The qualifications needed to teach the content and practice spiritual care in nursing.
7. The challenges in the integration and implementation of spiritual care in the nursing curriculum, or nursing education and practice.

The researcher encouraged each expert to bring on board their areas of expertise to make the spiritual care package robust, so as to arrive at a document that will be able to meet all challenges and be acceptable to the Nursing and Midwifery Council of Nigeria, the Senate of any university, the National Universities Commission, the National Association of Nigerian Nurses and Midwives, nurse educators, nurse clinicians, nursing students and the society at large.

Issues that were further discussed included the need to make a decision on how the spiritual care in nursing curricula will be structured so that it can be accommodated within the existing nursing curriculum. Speculation was that this will depend on how much time is allocated for this and the

position this occupies in the curriculum/timetable. Then there was also the question of whether spiritual care in nursing a specialized course of study will be, either as a compulsory certificate course made for all prequalifying nurses, or four to six hours of lectures and two hours of practical sessions per week within the basic nursing training, or two hours of lectures and a one-hour practical session per week.

Another issue discussed, which the expert committee apprised, was whether spiritual care in nursing should be a required compulsory course, or an elective. This was quickly settled, and it was agreed that it should be a compulsory course, considering how germane the course is to effective and efficient nursing care. Particular reference was made to Virginia Henderson's definition of nursing. She defined nursing as ''the unique function of the nurse … to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery that he would perform unaided if he had the necessary strength, will or knowledge' (Henderson, 1966). If the course is an elective one, many students who would need to render spiritual care in future may avoid the training, and if it is just required, then the students' commitment to it would not be total. The committee agreed that all students should have dedicated required course hours on spirituality in nursing care, and that there should be both lecture and practical sessions.

The expert committee also deliberated on when in the curriculum spiritual care in nursing should be taught. The nursing programme at the university in Nigeria is divided into two major sections i.e. preclinical years (2 years) and clinical years (3 years). Thus, the following concerns were grappled with:

1. Whether the course should be taught during the pre-clinical years or the clinical years.
2. Whether the course should be taught as a semester course or a sessional course. The committee examined each of the two major sections then noted that the first section (pre-clinical years) is spent on basic sciences and not clinical courses; it is a preparatory period for nursing students. On the other hand, during the clinical years of training, the students are

taught the relevant clinical courses and spirituality in nursing is a clinical/practical course. As such it should be taught during the clinical years when it would carry more meaning for the students because they would have contact with their clients/patients on clinical practice during this stage of their training. The researcher also posed a question to the committee of whether spiritual care in nursing should be taught as a separate course to avoid this being under-emphasized in the curriculum in terms of time/duration and credit load. If it is included in another clinical course, it may not be given the prominence it deserves, considering its significance in holistic nursing care.

The mode of teaching spiritual care in nursing was also discussed by the expert committee. From these discussions it was agreed that methods and approach can vary greatly in the quest for a better teaching-learning process and interaction among learners and lecturers. Musinski (2014), opined that the nurse educator functions in the vital role of facilitator by providing guidance and support for learning and that no ideal method was stipulated for coaching students in various backgrounds. No method can alter attitude in the three spheres of learning. Irrespective of the approach most preferred, if used in conjunction with other instructional techniques and instruments to elevate learning, it will become most effective. We cannot under-estimate the importance of choosing the right technique to meet the needs of learners. Decisions about which methods to use must be based on a consideration of such major factors as: audience characteristics (diversity, size, learning style preference), educators' expertise, objectives of learning, potential for achieving learning outcomes (acquisition, retention and recall), cost effectiveness, instructional setting and evolving technology.

Instructional methods may include lectures, group discussion, one-to-one instruction, demonstration/practical, role play, role modelling, self-instruction, article reading/studying, seminars and case presentation. Another area of focus of the expert committee was the content of the spiritual care component in the curriculum as this is critical in determining what the students will take away from the learning experience, all these led to preparation of a proposal by the researcher to be

presented to the expert committee for their consideration as a guide in preparing the model for the integration of spiritual care into nursing curriculum.

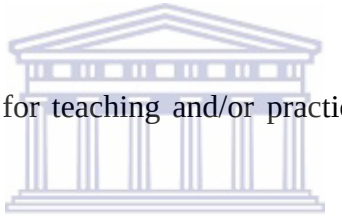
7.3 PROPOSAL PRESENTED TO THE EXPERT COMMITTEE

The proposal presented to the expert committee for their deliberation, amendment and adoption for implementation was as follows:

Unit One: Introduction to spiritual care in nursing/general understanding of spiritual care in nursing (meaning of spirituality, religion, and other related concepts, historical development of spirituality in nursing practice, spiritual self-awareness and client/patient care).

Unit Two: The inclusion of spiritual care in nursing education and practice/Relevance of spiritual care in nursing education and practice/Advantages of addressing spirituality in nursing education and practice.

Unit Three: Competencies required for teaching and/or practicing spiritual care-giving in nursing practice.



Unit Four: Models of spiritual care in nursing.

Unit Five: Application of spiritual care to nursing practice (communicating support for spiritual health, spiritual assessment, communicating support for spiritual health, providing spiritual support for clients/patients who are in pursuit of purpose, the task of the professional nurse in spiritual care-giving, team-building in spiritual care in nursing).

Unit Six: Addressing spirituality in a multicultural, multi-religious setting (pluralistic healthcare setting dealing with birth and contraception, diet, illness, death and dying).

Unit Seven: Possible limitations/barriers and boundaries to teaching and practicing spiritual care in nursing.

Unit Eight: Possible ways to address barriers to teaching and practicing spiritual care in nursing.

Unit Nine: Case studies on spirituality in nursing (identify a patient who is seriously ill, deeply religious and is using his or her beliefs or support from his or her faith community to cope with his or

her illness. Also present a patient who is not religious so that the students can compare and contrast different case histories).

Unit Ten: Case writing on clients/patients in relation to spirituality in nursing.

After completing these sessions, nursing students must have acquired adequate knowledge to build confidence in their ability to appropriately and sensitively address spiritual issues in the management of their clients/patients. They should understand why communication with their clients/patients about spirituality is crucial and should be skilled in how to approach matters relating to their patients' spiritual needs. They need to understand the role of other members of the health team including the religious leaders in the hospital environment.

7.4 RESOLUTIONS OF THE COMMITTEE

The expert committee, after exhaustive deliberations on issues proposed to them by the researcher, agreed on the following:

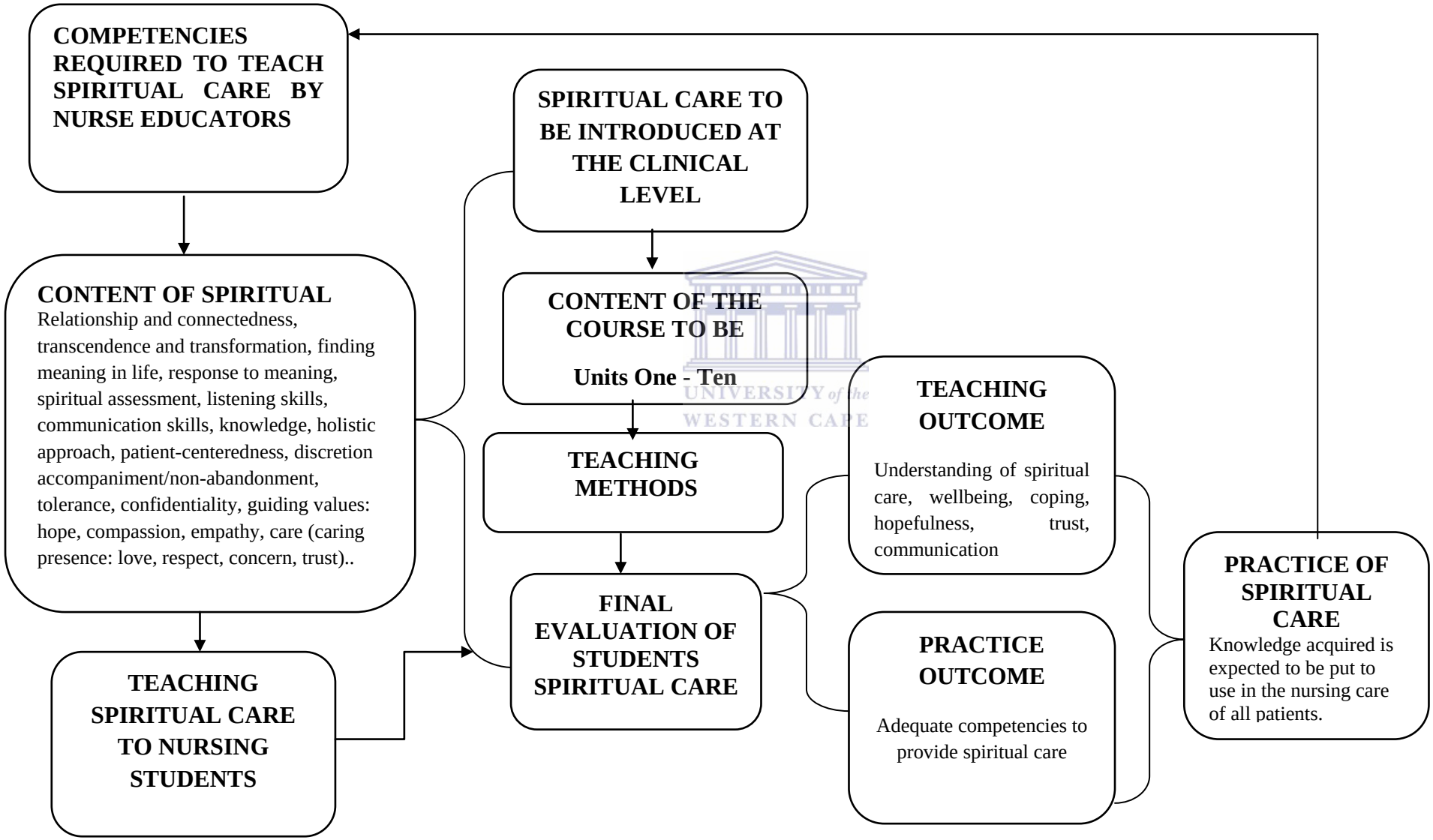
1. Spiritual care in nursing shall be a compulsory course offered to all the nursing students.
2. The duration of the course shall be two hours of lectures per week and two hours of clinical work per week of 15 weeks of semester.
3. The course will be a clinical one set to run for a session, either a third or fourth year course.
4. It will be a prequalifying course of study.
5. It will be a separate course and coded as a Nursing Science Course (NSC 301 & 302 or 401 & 402).
6. The mode of teaching will be varied to enhance the teaching-learning process.
7. The content of the course will be Units one to ten as set out above.
8. A case study will be written at the end of the course to form part of the final evaluation of the students. **(SEE FIGURE 7.1 FOR THE MODEL ON PAGE 208)**.

7.5 Step Six of the IM: Evaluation Plan

This step consists of the creation of an assessment plan. This entails using mechanisms for assessing the outcome of the spiritual care model for integration into the curriculum. The outcome may be measured in two ways i.e. developers of this program evaluate whether or not the platform is executed as scheduled and secondly, an outcome evaluation to ascertain whether the learning objectives recommended are realized, and whether the envisioned factors i.e. a model for the integration of spiritual care, have been adopted and implemented.

N.B.: Step 6: The Evaluation Plan will not be part of this study, but recommended for a post-doctoral programme in the near future.

Figure 7.1: MODEL FOR INTEGRATION OF SPIRITUAL CARE INTO NURSING CURRICULUM



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7.6 CONCLUSION

This chapter focused on Phase Two Step Five of the study; using Step Five of the IM i.e. adoption and implementation of the model for integrating spiritual care into the nursing curriculum in Nigeria. An expert committee was purposively selected to serve as a consultative team, called a linkage board, to work on the key task of formulating a model for the integration of spiritual care into the curriculum.

CHAPTER EIGHT

SUMMARY, CONCLUSION AND RECOMMENDATIONS

8.0 SUMMARY

This chapter looked at the summary, conclusions and recommendations based on the findings from the research objectives of the study. The main objective of this study is to create a model that will efficiently incorporate spiritual care-giving into the curriculum for nursing education in Nigeria. This study employed Intervention Mapping (IM) protocol using a mixed method approach. Intervention Mapping employed behavioural theory and evidence-based research to create precise learning objectives for the target populace, and to detect the private and peripheral factors of these objectives/goals. A number of methods were used to collect the right information, which enabled the researcher to produce a feasible and acceptable model for the incorporation of spiritual care-giving into the Nigerian nursing curriculum, an initiative that has the potential to change behaviour at school, hospital or clinic level and at student and educator level. The methods used included literature reviews, discussions with stakeholders (nurse educators, nursing students, leaders of the two major religions in Nigeria i.e. Christianity and Islam, the Nursing and Midwifery Council of Nigeria (N&MCN), Directors of Nursing Services (DNS) in various states, the focal person for the National Association of Nigerian Nurses and Midwives (NANNM) and experts in curriculum development. The study was carried out in two phases:

8.1.1 Phase One:

This phase focused on situation analysis of the teaching-learning status regarding spiritual care as it affects the nursing curriculum. The first three steps of the IM (needs assessment, matrices i.e. programme objectives & theory-based methods and practical strategies) process were used to answer Objectives 1-3 of the study. This phase used both quantitative and qualitative methods including a systematic review of the literature in order to meet the

objectives. Methods used were questionnaires, interviews, observation and focus group discussions. In this way the curriculum document of nursing was evaluated for its contents/elements of spiritual care, process, methods, teaching-learning process as well as hospital and classroom facilities. The findings and recommendations of the assessment phase informed the research activities in Phase Two of this study.

Step 1 – Needs assessment.

Step 2 – Matrices (programme objectives).

Step 3 – Theory-Based methods and practical strategies.

8.1.2 Phase Two: (Model development):

This phase focused on Steps 4 and 5 of the IM which involved programme development implementation, and adoption of the spiritual component into the nursing curriculum. This phase used mainly the Delphi technique/Focus Group Discussion. In addition, interactive sessions with stakeholders such as the NANNM focal person, leaders of the two major religions in Nigeria i.e. Christianity and Islam, experts in curriculum development, DAP and N. & M.C.N being the policy makers in Nigeria on nursing education and practice.

Step 4 – Producing programme components and materials.

Step –5 – Adoption and implementation plan.

The participants along with the researcher worked on Steps 4 and 5 listed above in order to fulfil Objective 4 of the study i.e. to develop a model that integrates spiritual care into the Nigerian curriculum.

8.2 Research Setting

The study was carried out in the Federal Republic of Nigeria, which is a federal constitutional republic. The Nigeria Demographics Profile (2013) stated that the population of Nigeria is estimated to be 170,123,740, distributed as 50.0% rural and 50.0% urban, with a population density of 167.5 million people **(**CIA World Factbook, 2014).

8.3 Population for the study

The population for this study included the nurse instructors, clinicians and students in all the geopolitical zones in Nigeria.

8.4 Procedure for data collection

Quantitative data were collected using the survey method with the aid of two standardized questionnaires, while qualitative data were gathered using focus group discussions, classroom observation, curriculum overview, field study which later translated into Delphi study technique, and finally with an expert committee serving as an advisory and linkage committee that worked and adopted the model for the incorporation of spiritual care into the Nigerian nursing curriculum.

8.5 Method of data analysis

Data analysis is the systematic organization and synthesis of research data (Polit & Hungler, 1995). Data analysis entails categorizing, ordering, manipulating and summarizing the data, and describing them in meaningful terms (Brink et al. 2016). The study used descriptive and inferential statistics for the quantitative data analysis. Focus group and interviews transcript were analysed using content analysis.

8.6 CONCLUSIONS FROM THE STUDY

8.6.1 DEMOGRAPHIC FINDINGS

8.6.1.1 Gender

The majority of the participants were females i.e. 72.4% of the respondents. In Nigeria, the nursing profession is dominated by females as observed by (McSherry & Jamieson, 2010; Chism & Magnan, 2013; Wehmer et al. 2010).

8.6.1.2 Age

Most of the participants (90%) were between 23 and 57 years of age. This indicates that the participants were mature in their thinking and had many years of working experience as nurses. It would be logical to conclude that they must have worked in several areas of practice during their time in the nursing profession. Their years of experience contributed widely to the study, as they could say with authority and confidence whether they practiced spiritual care in nursing either as nurse clinicians or nurse educators. A minority of participants were students who had little or no experience in the profession, except for a few who had done their general nursing certificate course with little or no practice before proceeding to their degree programme in nursing science.

8.6.1.3 Religion

Most of the participants were Christians (66.8%); adherents to Islam accounted for 32.0% of the sample population, and participants practicing other religions comprised just 1.2% of the sample population. The distribution showed that diverse opinions were obtained in the study, which helped the researcher to make better judgments for evaluating the findings. Religious diversity ensured that the study obviated lopsidedness.

8.6.1.4 Tribe

The distribution of the participants' tribes showed the following: Yoruba (53.0%), Igbo (18.6%), Hausa (13.8%), Fulani (4.6%) and others (10.0%). The study was thus representative of the four major ethnic groups in Nigeria, ensuring a broad range of views and perspectives.

8.6.1.5 Professional years of experience

The data showed that 72.0% of the participants had a range of professional years of experience as compared with 28.0% of the students, who had little or no experience at all. An exception is those students who had completed their general nursing course before

proceeding to their undergraduate programmes in nursing science. The number of years participants have worked reflects their years of knowledge, exposure and practice in nursing education. This practice and experience was of great value in their responses and participation in both the quantitative and qualitative data collection, even in the Delphi technique and expert committee.

8.6.1.6 Professional Qualifications

A total of 88.8% of the participants had varying levels of professional nursing qualifications, unlike the 11.2% who were students without any professional qualification. This showed that the majority were qualified and licensed to practice nursing either as educators or clinicians. This further indicated that they had gone through various types of training in nursing to develop themselves for the challenges in their nursing careers. Their various qualifications also enriched the study with particular reference to their exposure to spiritual care in nursing, in both teaching exposure and clinical practice.

8.7 DATA FINDINGS

The research was conducted using adapted Intervention Mapping (IM) techniques in two phases, as previously stated in the chapter.

8.7.1 Quantitative data findings

The research was conducted using two sets of structured and standardized questionnaires. The first was 'The Role of Spirituality in Nursing Practice', with thirty five items in the following sub-divisions: the role of spirituality; and spirituality and spiritual care. The second was the 'Spiritual Care Competence Scale,' which had twenty seven items grouped into the following sub-divisions: attitude towards patient spirituality, communication, assessment and implementation of spiritual care, referral, personal support and patient counselling, and professionalization and improving the quality of spiritual care.

There was cross tabulation between professional qualifications of the respondents and their attitude towards patients' spirituality in respect of them trying to impose their own spiritual/religious beliefs on a patient. The Chi-square value (x^2) of 52.702 at df of 32 is significant at p-value of 0.012 ($p \leq 0.05$). This implies that a significant association exists between respondents' professional qualifications and their capacity to avoid imposing their own spiritual/religious beliefs on a patient.

8.7.2 QUALITATIVE DATA FINDINGS

The followings sub-headings were products of the FGD and were used to conduct the Delphi technique:

1. Understanding spiritual care.
2. Challenges to, and facilitators of, including spiritual care in the nursing curriculum.
3. Competencies of nurse educators/nurse clinicians/nursing students.
4. Possible limitations that may be encountered.
5. Possible solutions to challenges as suggested by participants.

8.7.3 Curriculum observation

Critical/analytical analysis was carried out on the content of the nursing curriculum used to teach nursing courses in the departments of nursing in Nigeria. The curriculum document contained one hundred and seventy-nine pages and had been revised in 2013. Findings from the analysed curriculum for spiritual care in nursing showed that in all the courses in the curriculum, both core and non-core courses, spiritual care was never a focus of care. It was not even mentioned except on Page TWO of the curriculum, under the section that discusses philosophy, as follows:

'Man is a biological, SPIRITUAL, social and psychological individual unit….' [My emphasis]

8.7.4. EXPERT COMMITTEE

A 100% consensus was achieved in the Delphi technique after the second round. The researcher constituted an expert committee that served as a consultative team of experts who discussed the contents of spiritual care, completeness, suitability and relevance of spiritual care in nursing education and practice. The outcome of discussions formed the basis of the model and attempted to provide answers to questions relating to various aspects such as the 'when', 'how', 'what', 'who', 'where', and 'why' of spiritual care integration.

The expert committee with the researcher ended their interaction by producing a model that would integrate the concept of spiritual care into the Nigerian nursing curriculum. This was the crux of the study.

The model included ten components:

1. What to teach, i.e. content of spiritual care in nursing.
2. When to teach, i.e. duration and timing of the programme.
3. Where to teach, i.e. places such as classrooms, demonstration skills labs, wards.
4. Why teach spiritual care in nursing?
5. Who teaches, i.e. nurse educators/ nurse clinicians?
6. Who to teach, i.e. nursing students.
7. Who carries out spiritual care, i.e. nurse clinicians, nursing students, nurse educators?
8. What medium is used in the teaching of spiritual care in nursing?
9. Possible barriers to the teaching and practice of spiritual care.
10. Caring outcomes = Holistic care.

8.8. CONCLUSIONS

The findings from the study revealed the caring outcome of spiritual care given as being holistic in nature. The knowledge showed that without spiritual care the whole person is not taken care of. Man is seen as a tripartite individual i.e. body, mind and spirit. The literature

review revealed that man is a bio-psycho-social-spiritual being and that is what makes nursing and man holistic in nature. Hence, nursing an individual as a patient, without taking care of his spiritual needs, means that the individual is not managed holistically. A model for the integration of spiritual care-giving into the nursing curriculum in Nigeria was developed for easy incorporation.

8.9. SCOPE AND LIMITATIONS OF THE STUDY

The area of limitation of the study identified by the researcher was the scope; the study did not cover all thirty six states and Federal capital territory in Nigeria, and not all the accredited departments of nursing were used for the study. Not all the departments of nursing science have been accredited, not all teaching/specialist/training hospitals were selected for the study, and one geopolitical zone was not used for the study because of the security challenge (Boko Haram related issues) predominant in the region i.e. the North-Eastern Region. A possible criticism of the study is that it cannot be generalized. However, considering the universality of the nursing curriculum in Nigeria, and the fact that the body of the Nursing and Midwifery Council of Nigeria (N&MCN) is the only regulatory body managing nursing education and practice in Nigeria, in addition to being the custodian of nursing issues in Nigeria; the model developed by the researcher can be used to integrate spiritual care into the nursing curriculum. This is especially true as the findings of the study are germane to nursing education and practice in Nigeria, and the study has the objective of providing holistic nursing care (bio-psycho-social-spiritual nursing care).

8.10. RECOMMENDATIONS

Based on the findings of this study, the following recommendations were made:

1. The study adapted IM technique and utilized steps one to five without the sixth step. The sixth step should be used to assess the assimilation of spiritual care into the nursing curriculum in Nigeria after a minimum of five years of implementation by the schools.

2. The integrated curriculum should be pilot-tested in all the geopolitical zones in Nigeria. The North-Eastern zone, not used for this study, should also be used for pilot testing to assess the result of the product in this region.

3. Nurse clinicians should make concerted efforts to nurture caring values so that patients will enjoy their spiritual services and the nurse-patient relationship will be enhanced.

4. The drive for nurses to demonstrate their self-awareness, spiritual dialogue, spiritual competence and spiritual sensitivity will provide a guiding framework for rendering spiritual care to their patients efficiently and effectively.

5. Training and retraining of the nurse educators and nurse clinicians should be done by the employers so that nurse educators are exposed to the teaching of spiritual care, and nurse clinicians can deliver spiritual care with adequate knowledge and without bias.

6. Nurse educators should be sent for specialised training on spiritual care in nursing so as to be better equipped to effectively teach and practice spiritual care in nursing to nursing students.

7. Spiritual care in nursing must be a minimum of a two-credit nursing course and be made compulsory for all clinical nursing students. It should be a sessional course and should also attract clinical practice with clinical examinations, which should be compulsory for all the students.

8. Spiritual care in nursing may further be made a diploma or certificate or specialized course of study to be accredited by the Nursing and Midwifery Council of Nigeria. The duration of the course should be 12- 18 months at selected schools and should be a post-basic course of study.

9. Nurses should see spiritual care in nursing as part of a multidisciplinary approach, so the ability to work out an approach with other members of the health team should be

enhanced, while the nurse should bear in mind that he/she should serve as an advocate for his/her patients at all times and under all circumstances.

10. Nurses should avoid all actual and potential barriers to teaching and rendering spiritual care in nursing effectively and efficiently.

11. For the students and patients to develop confidence in the ability of the nurse educators and nurse clinicians to teach and practice spiritual care, the nurse educators/nurse clinicians need to demonstrate high levels of competence in teaching and rendering spiritual care in nursing. This raises the need for personal development of the nurse educators and nurse clinicians in the area of spiritual care in nursing; and improving skills using methods such as personal/open discussion of spiritual care, and personal study, research, reading, seminars, workshops, lectures and conferences.

12. Ward micro lectures/seminars/open discussion must be encouraged so that in each ward and even in the classrooms, issues related to spiritual care in nursing can be openly discussed among the nurses in the wards, for a better approach to the management of their patients.

13. Since the researcher could not find a domestic study previously conducted in Nigeria, the conclusion is that there is a need to publish the relevant information and the research findings in literature for public consumption; and that the study should also be made available to nurse educators, nurse clinicians and nursing students, including interested parties in Nigeria.

14. The board of the Nigerian Nursing and Midwifery Council, employers of nurses and relevant management bodies can make policies on spiritual care in nursing so that the patients can receive holistic nursing care.

15. The Nursing and Midwifery Council of Nigeria should give urgent attention to organizing an implementation workshop for nurse educators, nurse clinicians and experts in nursing curriculum development, to integrate spiritual care into the nursing curriculum.

16. The state committee of nursing and midwifery should also organize training workshops for the end-users of this new curriculum, so that they may be acquainted with integrating spiritual care into the nursing profession. Implementation can even be done at state level so that it can reach the grassroots almost immediately. This should also be evaluated after a minimum of five years following implementation.

8.11 CONTRIBUTIONS OF THE STUDY TO THE BODY OF KNOWLEDGE

A critical evaluation of the study shows that the researcher has surely contributed the following to the body of knowledge through this research:

General understanding of spirituality in nursing: In the study, the researcher found out that the trained nurse educators and nurse clinicians lacked the understanding of what spirituality in nursing is. Most of the participants could not differentiate between spirituality and religion and for this reason there was sensitivity around discussing religion and spirituality. With this study, a clearer meaning of the concepts has been brought out.

Capacity to teach and practice spiritual care in nursing: The study has explored the fact that without training and retraining, personnel cannot be developed to produce their best in the course of discharging their duties. Thus, to deliver effective and efficient spiritual care in nursing, the nurse educators and nurse clinicians as well as the nursing students, must undergo thorough training to become more competent to deliver holistic nursing care.

Model for the assimilation of spiritual care into the Nigerian nursing syllabus: The study has also been able to formulate a model for the easy integration of spiritual care into the nursing curriculum in Nigeria. The study proposes content for spiritual care in nursing to be taught by the trainers and also outlines the procedure for integration.

The researcher could not find any localized study of Nigerian society online. Indeed, it seems to be a new area of study in nursing education and practice in Nigeria, so the outcome of this study will be germane to knowledge development and constitute a contribution to nursing education and practice. To this end, when this study is published it will constitute a major contribution to Nigerian society.

8.12 IMPLICATIONS OF THE STUDY TO NURSING DEVELOPMENT

Rendering spiritual care-giving is crucial and critical to rendering holistic care to patients and families. Efforts have been made to give bio-psycho-social care to clients/patients with little emphasis on the spiritual component of holistic nursing care. Spiritual care in nursing represents a unique component of holistic nursing care and if nursing care is to be effective and efficient, special attention must be paid to this aspect of care. Implications of the study for nursing development will be based on the following:

8.12.1 Implications to nursing education

1. A caring presence is crucial to attaining holistic nursing care, and for patients to feel and enjoy the nurses' caring presence at all times. They must be formally taught in order to be skillful in the rendering of a caring presence; a presence that is a vehicle in the delivery of spiritual care in nursing practice.
2. Every nursing student should be trained to identify and meet the spiritual care needs of the patients and families as they can only deliver effective spiritual nursing care if they are properly trained to achieve these competencies.
3. The trend in nursing care today is to utilize the nursing process for the care of every patient and this includes the use of nursing intervention classification (NIC) and nursing outcomes classification (NOC). These are comprehensive, research-based, standardized classifications of nursing diagnoses, nursing interventions and nursing-sensitive patient

outcomes, which can also help to conduct spiritual assessments, diagnosing, documentation, planning, implementation and evaluation of such care.

8.12.2 Implications to nursing practice

1. Nurses need to discover the inter-relatedness between spirituality and nursing practice from a myriad of viewpoints, including nurses' assessment of patients' spiritual needs.
2. Nursing is really about being intuitive and spiritual. When the profession is seen as a call, then the individuals progress to a higher level, which is the vocation level. This adds a spiritual dimension to the profession, therefore nurses should always see their calling to the profession as a vocation so that they are able to model care rendered to the patients from this vantage point.
3. An essential component of cultivating self-awareness is to be someone who, by simply being present, becomes an instrument for healing. McKivergin (2012) discovered salient features that impact the nurse's capability to be a therapeutic tool of recovery. These are:

   - Being open to discovering self.
   - Avoiding a careless attitude and monotony by having a clear sense of the importance of life.
   - Self-consciousness about pertinent aspects of individual development in order to acquire and share views about inner processes of both the patients and the nurse.
   -Appreciation of the constant process of self-healing.
   - Nurturing of self to be a model of self-care for clients and patients.
   - Seeing sessions spent with patients and clients as a privilege to be able to share with and assist them.
4. Findings from the study showed that most of the nurses were unable to differentiate between religion and spirituality, and that some of them were not tolerant and accommodating when discussing religions unfamiliar to them. This was especially true

where the researcher happened to adhere to a religion different from their own, which indicated that they may not be able to handle issues related to people of a religion different to their own. The ability to differentiate between religion and spirituality would be of tremendous assistance in cases such as these.

8.12.3. Implications to policy makers

1. Nurses' role in the provision of spiritual care, the spiritual nature of the nurse-patient relationship and the modern-day awareness in religiousness within the nursing profession, must be explored by the nurses for the provision of efficient spiritual nursing care to the patients.
2. Patients may ask their nurses what they believe for a number of reasons. They may want information to aid their search for answers to spiritual questions. They may wish to gain a sense of whether the nurse is someone with whom it would be safe to disclose spiritual beliefs. Thus, nurses must never enforce their personal, religious/spiritual philosophies on their patients.

3. Given that the spirit is the core of a person's being, certainly it is essential to address spiritual care in nursing practice, as spiritual care seeks to affirm the value of each and every person based on non-judgmental love. This is also important because spiritual care is associated with the quality of interpersonal care, as it relates to the expression of love and compassion towards patients by the nurse.

8.12.4 Implications to nursing research

1. One factor that increases the risk of unethical spiritual care is the vulnerability of the clients. Clients as well as their families are usually vulnerable because of an illness or health challenge. Their vulnerability may be physical, psycho-social and/or spiritual. This means that nurses must explore why clients ask nurses about their beliefs and why nurses sometimes share them when it seems that patients may wish to know what the

nurses' spiritual beliefs are. Patients might want to assess whether or not the nurses will impose their own spiritual beliefs on them.

2. Suffering is an ongoing state of distress that affects a person's sense of well-being. It can be physical, emotional, social and/or spiritual in nature. Suffering is a fact of human life and a very difficult one to understand. Inevitably, nurses encounter patients who are suffering. As Donley (2010) indicated, the mission of the nurse includes being with people who are grieving and to provide purpose to the actuality of suffering. As people experience suffering, they begin to ask ''Why me?'' For those who believe in a loving God, unlocking the mystery of why that being would permit suffering in the world becomes paramount, so the essence of spiritual care is to be with patients when they ask this question, and to ''accept with them the mystery of human suffering and…offer no false illusions''. The nurses help the patient to find meaning in their suffering with the aid of the spiritual care rendered to patients.

3. The process of how to provide spiritual care in nursing, include skills, knowledge and attitudes, and these can be achieved expressly if spiritual care in nursing is integrated into both basic and post-basic curricula. If the nursing students are thoroughly taught all aspects of giving spiritual care to their patients, and even exposed to actual and potential cases while in training, this will enhance acquisition of the required competencies.

4. More nurses will need to research this area of spiritual care in nursing. The study has established that this is a grossly neglected area of nursing education and practice. This was indicated by the fact that the researcher could not locate any local (Nigerian) study published in this area, and also by the majority of the participants demonstrating a knowledge deficit in their responses.

5. More research can be conducted, especially locally, in order to evaluate the integration of spiritual care into the nursing curriculum, and to find out about the success and impact of the integration on nurse educators, nurse clinicians, nursing students, the patients and their families.

8.13 CONCLUSION

This section concentrated on summary, inferences, limitation of the study and references, with the implications of the study for nursing development, especially in Nigeria.

The researcher believes that with the integration of spiritual care into the nursing curriculum, nursing education and practice will take a new turn in meeting the bio-psycho-social-spiritual care of the patients and their families, as all stakeholders must necessarily have acquired better skills in holistically meeting the needs of their patients.

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APPENDIX I: PROPORTIONATE SAMPLE FOR THE STUDY

POPULATION GROUP	ESTIMATED NO.	Percentage	Sample
Nurses	154,254	154,254/160,423 = 96.1%	206
Nurse Educators	3621	3621/160,423 = 0.02%	5
Nurse clinicians	432	432/160,423 = 0. 27%	1
Nursing students (400L & 500L)	2116	2116/160,423 = 1.3%	3
Total	**160,423**	**100**	**215**

APPENDIX II: SPIRITUAL CARE COMPETENCE SCALE (SCCS)

1 = completely disagree 2= disagree 3=neither agree or disagree 4=agree 5=fully agree

Attitude towards patient spirituality

1. I show unprejudiced respect for a patient's spiritual/religious beliefs regardless of his or her spiritual/religious background

1 - 2 - 3 - 4 - 5

2. I am open to a patient's spiritual/religious beliefs, even if they differ from my own.

1 - 2 - 3 - 4 - 5

3. I do not try to impose my own spiritual/religious beliefs on a patient

1 - 2 - 3 - 4 - 5

4. I am aware of my personal limitations when dealing with a patient's spiritual/religious beliefs

1 - 2 - 3 - 4 - 5

Communication

5. I can listen actively to a patient's 'life story' in relation to his or her illness/handicap

1 - 2 - 3 - 4 - 5

6. I have an accepting attitude in my dealings with a patient (concerned, sympathetic, inspiring trust and confidence, empathetic, genuine, sensitive, sincere and personal)

1 - 2 - 3 - 4 - 5

Assessment and implementation of spiritual care

7. I can report orally and/or in writing on a patient's spiritual needs

1 - 2 - 3 - 4 - 5

8. I can tailor care to a patient's spiritual needs/problems in consultation with the patient

1 - 2 - 3 - 4 - 5

9. I can tailor care to a patient's spiritual needs/problems through multidisciplinary consultation

1 - 2 - 3 - 4 - 5

10. I can record the nursing component of a patient's spiritual care in the nursing plan

1 - 2 - 3 - 4 - 5

11. I can report in writing on a patient's spiritual functioning

1 - 2 - 3 - 4 - 5

12. I can report orally on a patient's spiritual functioning

1 - 2 - 3 - 4 - 5

Referral

13. I can effectively assign care for a patient's spiritual needs to another care provider/care worker/care discipline

14. At the request of a patient with spiritual needs, I can in a timely and effective manner refer him or her to another care worker (e.g. a chaplain/the patient's own priest/Imam)

15. I know when I should consult a spiritual advisor concerning a patient's spiritual care

1 - 2 - 3 - 4 - 5

Personal support and patient counseling

16. I can provide a patient with spiritual care

1 - 2 - 3 - 4 - 5

17. I can evaluate the spiritual care that I have provided in consultation with the patient and in the disciplinary/multi-disciplinary team.

1 - 2 - 3 - 4 - 5

18. I can give a patient information about spiritual facilities within the care institution (including spiritual care, meditation centre, religious services)

1 - 2 - 3 - 4 - 5

19. I can help a patient continue his or her daily spiritual practices (including providing opportunities for rituals, prayer, meditation, reading the Bible/Koran, listening to music)

1 - 2 - 3 - 4 - 5

20. I can attend to a patient's spirituality during the daily care (e.g. physical care)

1 - 2 - 3 - 4 - 5

21. I can refer members of a patient's family to a spiritual advisor/pastor etc if they ask me and/or if they express spiritual needs

1 - 2 - 3 - 4 - 5

Professionalization and improving the quality of spiritual care

22. Within the department, I can contribute to quality assurance in the area of spiritual care

1 - 2 - 3 - 4 - 5

23. Within the department, I can contribute to professional development in the area of spiritual care

1 - 2 - 3 - 4 - 5

24. Within the department, I can identify problems relating to spiritual care in peer discussions session

1 - 2 - 3 - 4 - 5

25. I can coach other care workers in the area of spiritual care delivery to patients

1 - 2 - 3 - 4 - 5

26. I can make policy recommendations on aspects of spiritual care to the management of the nursing ward

1 - 2 - 3 - 4 - 5

27. I can implement a spiritual care improvement project in the nursing ward

1 - 2 - 3 - 4 - 5

APPENDIX III: THE ROLE OF SPIRITUALITY IN NURSING PRACTICE AND SPIRITUALITY AND SPIRITUAL CARE SCALES

A : THE ROLE OF SPIRITUALITY IN NURSING PRACTICE

The following questions ask your views about the role of spirituality in nursing practice.

Please rate your level of agreement or disagreement with each statement by circling the one number that best reflects your opinion on the 5-point scale

S/N	Items	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
1.	Spirituality is a basic aspect of being human	1	2	3	4	5
2.	Nurses should have more knowledge about spiritual care in nursing	1	2	3	4	5
3.	It is important for nurses to have knowledge about different religious faiths and traditions	1	2	3	4	5
4.	Religious concerns are outside of the scope of nursing practice.	1	2	3	4	5
5.	Spiritual concerns are outside of the scope of nursing practice	1	2	3	4	5
6.	Nursing practice with a spiritual component has a better chance to empower clients than practice without such a component.	1	2	3	4	5
7.	Knowledge of patients' spiritual beliefs is important for effective nursing practice.	1	2	3	4	5
8.	Nurses should be able to assess the positive or beneficial role of spiritual beliefs and practices in their patients' lives	1	2	3	4	5
9.	Nurses should be able to assess the negative or harmful role of spiritual beliefs and practices in their patients' lives	1	2	3	4	5
10.	The use of spiritual language and spiritual concepts in nursing practice are inappropriate	1	2	3	4	5
11.	The spirituals backgrounds of patients do not particularly influence nursing practice	1	2	3	4	5
12.	A nurse's use of scripture or other spiritual texts in nursing practice are appropriate	1	2	3	4	5
13.	It is against nursing ethics to ever pray with a patient	1	2	3	4	5
14.	The use of spiritual concepts in nursing practice is inappropriate	1	2	3	4	5
15.	It is sometimes appropriate for a nurse to share his or her spiritual beliefs with a patient	1	2	3	4	5
16.	Addressing a patient's spiritual beliefs is necessary for holistic nursing care	1	2	3	4	5
17.	Nursing education should include content related to spiritual diversity	1	2	3	4	5
18.	Nursing education should include content on	1	2	3	4	5

	how to deal with spiritual issues in nursing					

B: SPIRITUALITY AND SPIRITUAL CARE

For each question, please circle one answer which best reflects the extent to which you agree or disagree with each statement.

S/N	Items	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
1.	I believe nurses can provide spiritual care by arranging a visit by a hospital priest or the patient's spiritual/religious leader	1	2	3	4	5
2.	I believe nurses can provide spiritual care by showing kindness, genuine concern and cheerfulness when giving care	1	2	3	4	5
3.	I believe spirituality is concerned with a need to forgive and a need to be forgiven	1	2	3	4	5
4.	I believe spirituality involves only going to church/place of worship	1	2	3	4	5
5.	I believe spirituality is not concerned with a belief and faith in a God	1	2	3	4	5
6.	I believe spirituality is about finding meaning in the good and bad events of life	1	2	3	4	5
7.	I believe nurses can provide spiritual care by enabling a patient to find meaning and purpose in their illness	1	2	3	4	5
8.	I believe spirituality is about having a sense of hope in life.	1	2	3	4	5
9.	I believe spirituality has to do with the way one conducts one's life here and now	1	2	3	4	5
10.	I believe nurses can provide spiritual care by spending time with a patient giving support and reassurance in time of need	1	2	3	4	5
11.	I believe nurses can provide spiritual care by listening to and allowing patient time to discuss and explore their fears, anxieties and troubles	1	2	3	4	5
12.	I believe spirituality is a unifying force which enables one to be at peace with oneself and the world	1	2	3	4	5
13.	I believe spirituality does not include areas such as art, creativity and self-expression	1	2	3	4	5
14.	I believe nurses can provide spiritual care by having respect for privacy, dignity and religious and cultural beliefs of a patient	1	2	3	4	5
15.	I believe spirituality involves personal friendships and relationships	1	2	3	4	5
16.	I believe spirituality does not apply to those	1	2	3	4	5

	who are unsure of God or do not believe in God					
17.	I believe spirituality includes people's morals	1	2	3	4	5

APPENDIX IV: INTERVIEW GUIDE FOR THE FOCUS GROUPS I

Focused Group Discussion Guide for nurse educators and nursing students

I am a PhD nursing student from University of the Western Cape, South Africa conducting research study on 'A MODEL FOR INTEGRATION OF SPIRITUAL CARE INTO NURSING CURRICULUM IN NIGERIA'. This Focus Group Discussion will enable me gather the necessary information for the study Kindly express your opinion honestly. All information will be used purely for the research and treated with utmost confidentiality.

Thanks for your co-operation. **Joel Adeleke Afolayan**

3315247

Major Questions

Introduction: Professional qualification, current rank, level

1. What do you understand by the concept of spiritual care within the context of holistic nursing care?

2. Do you teach spiritual nursing care to your student? Or Does your school teach spiritual nursing care? If No, why?

3. Why is the concept of spiritual care essential in nursing education?

4. Have you ever taught or been taught spiritual care? If No, why? If Yes, what does it entail?

5. What are the things to consider when teaching spiritual care in nursing?

6. How will you teach spiritual care to student?

7. Does the current content of the nursing curriculum address spiritual care?

8. What are the competencies a Nurse educator must possess to teach spiritual nursing care to students?

9. What do you think about introducing the concept of spiritual care in nursing education?

10. How can spiritual care be integrated into curriculum of nursing?

11. What are the barriers of teaching spiritual care in nursing?

12. In your own view, what are the possible challenges that we might face if we are to Introduce spiritual care in nursing education?

13. How can these possible challenges be overcome?

14. Do you have any other suggestions on this study that will make it a robust one?

Note: **Always Probe with explain, describe, elaborate, how, why etc**

APPENDIX V: INTERVIEW GUIDE FOR THE FOCUS GROUPS II

Focused Group Discussion Guide for nurse clinicians,

I am a PhD nursing student from University of the Western Cape, South Africa conducting research study on 'A MODEL FOR INTEGRATION OF SPIRITUAL CARE INTO NURSING CURRICULUM IN NIGERIA'. This Focus Group Discussion will enable me gather the necessary information for the study Kindly express your opinion honestly. All information will be used purely for the research and treated with utmost confidentiality.

Thanks for your co-operation. **Joel Adeleke Afolayan**

3315247

Major Questions

Introduction: Professional qualification, unit of work, current rank

The need for inclusion of spiritual care in nursing education and practice is very vital if holistic care is to be achieved with better outcome;

1. What do you understand by the concept of spiritual care within the context of holistic nursing care?
2. Does your institution provide spiritual nursing care? If yes, how? If not, why?
3. Have you ever provided spiritual nursing care to your Clients/Patients? If yes, how was it done?
4. If no, why?
5. What are the things/competencies to consider when providing spiritual care in nursing practice?
6. What do you think about introducing the concept of spiritual care in nursing practice?
7. How can spiritual care be integrated into nursing practice?
8. What are the barriers of practicing spiritual care in nursing?
9. In your own view, what are the possible challenges that clinicians may face if they are to introduce spiritual care in nursing practice?
10. How can these possible challenges be overcome?
11. Do you have any other suggestions on this study?

Note: **Always Probe with explain, describe, elaborate, how, why etc**

APPENDIX VI: ETHICAL APPROVAL I

UNIVERSITY of the
WESTERN CAPE

OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH DEVELOPMENT

26 May 2015

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape approved the methodology and ethics of the following research project by:
Dr J Afolayan (School of Nursing)

Research Project:	A model for integration of spiritual care into nursing curriculum in Nigeria.
Registration no:	15/3/19

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

Private Bag X17, Bellville 7535, South Africa
T: +27 21 959 2988/2948, F: +27 21 959 3170
E: pjosias@uwc.ac.za
www.uwc.ac.za

APPENDIX VII: ETHICAL APPROVAL II

UNIVERSITY OF ILORIN, ILORIN, NIGERIA.

UNIVERSITY ETHICAL REVIEW COMMITTEE

Vice-Chancellor: Prof. A.G. Ambali
DVM (ABU), M.V. Sc., Ph.D (Liverpool, UK),
MVCN, MCVSN, MNVMA, FCVSN
Registrar: Mr. E.D. Obafemi
B.A. (Hons), Cert. Public Information (Kaduna),
MNIPR

E-mail: P.M.B. 1515, Ilorin
uerc@unilorin.edu.ng
unilorin.uerc@gmail.com
Website: ethicalreview.unilorin.edu.ng
www.unilorin.edu.ng

Our Ref: UIL/UERC/2015/CLS 026 **Date:** 13th August, 2015

Protocol Identification Code: UERC/CLS 026
UERC Approval Number: UERC/ASN/2015/134

A MODEL FOR INTEGRATION OF SPIRUTUAL CARE INTO NURSING CURRICULUM IN NIGERIA

Name of applicant/Principal Investigator: **Dr. AFOLAYAN,** Joel Adeleke

Address of Applicant: Department of Nursing Science, Faculty of Clinical Sciences, University of Ilorin, Ilorin.

Type of Review: Full Committee Review
Date of full Committee Decision on Research: 13/08/2015
Date of Approval: 13/08/2015

Notice of Full Committee Approval

I am pleased to inform you that the research described in the submitted proposal has been reviewed by the University Ethical Review Committee (UERC) and given full Committee approval.

This approval dates from 13/08/2015 to 12/08/2018, and there should be no participant accrual or any activity related to this research to be conducted outside these dates.

You are requested to inform the committee at the commencement of the research to enable it appoints its representative who will ensure compliance with the approved protocol. If there is any delay in starting the research, please inform the UERC so that the dates of approval can be adjusted accordingly.

The UERC requires you to comply with all institutional guidelines and regulations and ensure that all adverse events are reported promptly to the UERC. No charges are allowed in the research without prior approval by the UERC. Please note that the UERC reserves the right to conduct monitoring/oversight visit to your research site without prior notification.

Thank you.

Ismaila Isah
For: University Ethical Review Committee

UNIVERSITY ETHICAL REVIEW COMMITTEE
University of Ilorin, Ilorin, Nigeria

" ....if it's not ethical, it's not scientific, if it's not scientific, it's not ethical"

APPENDIX VIII: ETHICAL APPROVAL III

MINISTRY OF HEALTH

OFFICE: P. M. B. 1386, FATE ROAD, ILORIN, KWARA STATE. 031-220349

Our Ref: MOH/KS/EHC/777/94 *Your Ref:* _____ *Date:* 9th June, 2015

Afolayan Joel Adeleke,
Department of Nursing, Faculty of Clinical Science,
College of Health Sciences,
University of Ilorin,
Nigeria.

APPROVAL TO CARRYOUT MEDICAL RESEARCH TITLED: A MODEL FOR INTEGRATION OF SPIRITUAL CARE INTO NURSING CURRICULUM IN NIGERIA.

Sequel to your request and the interest of the State Ministry of Health in Health related research activities to improve the health of the citizens.

I am directed to forward to you the approval of the Ministry of Health to carry out the dissertation as itemized in your Protocol. This approval dates from 9/06/2015 to 9/06/2016 except you seek for extension.

You are mandated to acknowledge the Ministry of Health in your presentations/ publications and deposit a final copy of your project to the Ministry of Health.

Best wishes in your research project.

F. O. P Oyinloye
Secretary Health Ethical Research Committee,
For: Honourable Commissioner.

CC:

- The CMD Sobi Specialist Hospital, Ilorin.
- The CMD General Hospital, Ilorin.
- The CMD Children Specialist Hospital, Centre Igboro, Ilorin.
- The officer In-charge Civil Service Hospital, Ilorin.

APPENDIX IX: ETHICAL APPROVAL IV

STAFFORDSHIRE UNIVERSITY

Faculty of Health Sciences
School of Nursing and Midwifery
Staffordshire University
Blackheath Lane
Stafford
ST18 0AD

Email: wilf.mcsherry@staffs.ac.uk
Direct line: 01785 353630
Fax: 01785 353731

6 May 2015

Dear Joel,

Re: SSCRS Permission – Dr Joel Afolayan

Thank you for the interest you have shown in my research and the Spirituality and Spiritual Care Rating Scale (SSCRS). I hereby give you authorisation and permission to reproduce or use the scale in your research – 'A model for integration of spiritual care into Nursing Curriculum in Nigeria. There is no fee for using the scale or the questionnaire; however I would appreciate if you could forward me a copy of your research findings and report when completed.

The scale was developed as part of descriptive study. If you want to obtain a copy of my original thesis - you should be able to receive through Inter Library Loan the title is - A Descriptive Survey of Nurses' perceptions of Spirituality and Spiritual Care Unpublished Master of Philosophy Thesis, The University of Hull, England.

A summary of how the SSCRS was constructed was published in the International Journal of Nursing Studies 2002:

> McSherry W., Draper P, Kendrick D (2002) Construct Validity of a Rating Scale Designed to Assess Spirituality and Spiritual Care *International Journal of Nursing Studies* 39 (7) 723 - 734

May I take this opportunity to wish you all the best with your studies. If I can be of any assistance in the future then do not hesitate to contact me again.

Yours sincerely,

Professor Wilfred McSherry

Professor in Dignity of Care for Older People
Faculty of Health Sciences

CREATE THE **DIFFERENCE**

APPENDIX X: CONSENT FORM I

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9593024, Fax: 27 21-9592679

Email: 3315247@myuwc.ac.za

PARTICIPANT'S CONSENT FORM

Title of Research Project: A Model for integration of Spiritual Care into Nursing Curriculum in Nigeria

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way. I agree to be audio-taped during my participation in the study.

Participant's name……..

Participant's signature……..

Date……

APPENDIX XI: CONSENT FORM II

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9593024, Fax: 27 21-9592679

e-mail:3315247@myuwc.ac.za

FOCUS GROUP CONFIDENTIALITY BINDING FORM

Title of Research Project: A Model for integration of Spiritual Care into Nursing Curriculum in Nigeria

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way. I agree to be audio-taped during my participation in the study. I also agree not to disclose any information that was discussed during the group discussion to anybody outside of the group.

Participant's name……..

Participant's signature……..

Date……