

Providing Holistic and Spiritual Nursing Care

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Abstract

Holistic nursing is care of the whole person, which addresses physical, mental, emotional, spiritual, and relational aspects of health. Historically, nursing has always integrated these aspects into providing care. Nursing developed out of religious orders and was predominantly a way to serve God by serving the poor and the sick. Florence Nightingale believed that nursing was her calling from God and her faith and spirituality influenced every aspect of her care. Nurses today are often fearful of addressing the spiritual needs of their patients, despite research that demonstrates the importance of providing care in these areas. Nurses can use interventions such as prayer, Scripture, active listening and presence, as well as referral to meet the spiritual needs of their patients.

Providing Holistic and Spiritual Nursing Care

An Overview of Holistic Care

The American Holistic Nurses Association defines holistic nursing as “all nursing practice that has healing the whole person as its goal” (Thornton, 2012, What is Holistic Nursing?, para. 1). Holistic nursing is a specialty practice that recognizes the interconnectedness of the body, mind, spirit, emotions, environment, relationships, and social and cultural aspects of life. The holistic nurse focuses on becoming a partner in the patient’s healing process and may use nursing knowledge, theories, expertise, and intuition to provide care for the person as a whole. In addition to conventional and modern medical therapies and treatments, nurses may incorporate complementary or alternative modalities (CAM) into their practice for the purpose of broadening and enriching their care and helping their patients reach optimal levels of healing (Thornton).

The term “complementary medicine” refers to other modalities used along with conventional medicines and treatments, such as using acupuncture alongside the usual treatments for pain relief. “Alternative medicine” involves using CAM instead of using conventional medicines and treatments. “Integrative medicine” involves the combined use of CAM and conventional medicine into one treatment (National Center for Complementary and Alternative Medicine, 2011). Complementary or alternative modalities are often described in broad categories including natural products, mind and body medicine, and manipulative or body-based practices. Natural products can include a variety of herbal products, vitamins, minerals, and probiotics. The 2007 National Health Interview Survey found that the most commonly used natural product by adults in

the United States was omega 3 fatty acids in the form of fish oil (National Center for Complementary and Alternative Medicine).

Another category of CAM is mind and body medicine, which is concerned with the interactions between the brain, mind, body, and behavior. This can include meditation, acupuncture, yoga, deep-breathing exercises, guided imagery, hypnotherapy, progressive relaxation, and tai chi. Mind and body techniques are among the most popular CAM practices for adults (National Center for Complementary and Alternative Medicine, 2011). Manipulative and body-based practices make up another category of CAM and focus primarily on body structures and systems. Two common types of this practice are spinal manipulation and massage therapy. Other types of CAM include movement and energy manipulation therapies (National Center for Complementary and Alternative Medicine). All of these types of CAM may be utilized by the holistic nurse in seeking to address the physiological, psychological, and spiritual needs of patients.

Holistic nursing focuses on healing the whole person and considers every aspect of life and its effect on a person's wellbeing. A holistic nurse is considered to be an instrument and facilitator in this process. The practice of these nurses will often lead to more self-reflection, improved self-care and responsibility, and spirituality in their own lives. This increased self-awareness will affect how the nurse views himself or herself in the healing process. Florence Nightingale, considered to be the founder of modern nursing, is also considered a pioneer for holistic nursing (Dossey, 2005).

Florence Nightingale

Florence Nightingale was born into a wealthy family in England in the 1820s. Even from a young age, Florence was already thinking about what would become her

life's work. In a note written when she was nine years of age, she mentioned her desire to "pray regularly" and "to visit the people and take care of those who are sick" (Dossey, 2010, p. 54). The time period in which Nightingale grew up was deeply rooted in religion, and as many of her letters and journals have revealed, her faith was an integral part of her pioneer work in nursing. Her caring and maternal instincts emerged at a very young age, and she helped raise her younger cousin and would assist her grandmother with walking daily. Florence Nightingale's father, William Nightingale had very high academic standards for his family; though at the time universities were only available for men. Florence's father took over as her tutor and taught her Greek, Latin, French, German, Italian, history, philosophy, and mathematics (Dossey, 2010).

Letters written by Florence reveal that she often thought about the meaning and purpose of life. In a letter written to her mother, Florence described a sermon she had listened to about the cholera pandemic: "It was a sort of Cholera sermon, I think, talking about the uncertainty of [and] the only use of life being to prepare for heaven, a very good sermon" (Dossey, 2010, p. 26). Even from the time she was a teenager, Florence loved to visit the poor in their homes. Florence longed to live like and among the poor and in one of her letters noted that simply giving money to the poor is not acting like Christ "who made Himself like His brethren" (Dossey, 2010, p. 30). Florence's attitude towards poverty and charity were strikingly different than her family; her mother and sister were content with occasional visits to the poor to distribute food and offer advice. Social success, which included finding suitable husbands for her daughters and tending the family estate, was her mother's priority. When she was 16, Florence felt that she had a divine calling on her life, though she wasn't sure quite what this calling entailed. Much

to her family's dismay, Florence refused several marriage proposals and told her parents at the age of 25 that she wanted to become a nurse. Her parents did not like the idea of Florence becoming a nurse at all, because the idea of nursing was associated with the working class, with "nurses" often coming from among the poor and unskilled. Nurses at this time also had a reputation of drunkenness and immorality (Dossey, 2010).

During one of the Nightingale's family travels, Florence befriended Elizabeth Blackwell, the first female medical doctor to graduate in the United States. Blackwell encouraged Florence in her hope of becoming a nurse, and eventually, Florence's parents agreed to allow her to spend some time training as a nurse. In 1851, she spent three months training at the Institution of Deaconesses at Kaiserwerth. The time she spent training was deeply impactful on Florence's life and she learned how to connect mind, body, and soul in caring for the sick. During this three-month period, Florence wrote over 100 pages of notes about her observations and interactions with those for whom she was caring. These notes also contained Florence's reflections on the sacredness of her work and records of patients' physical, mental, and spiritual progress and responses (Dossey, 2010).

In the spring of 1853, Florence was given a chance to utilize the skills she had learned and was offered a position as the superintendent of the Institution for the Care of Sick Gentlewomen in Harley Street, London. Florence noted in her writings during this time that mercy, kindness, and comfort were just as important in providing care for the sick and dying as the actual medical treatments being utilized. It was also at this time that Florence realized her passion for training others to become nurses, but she never felt like her full potential was realized and she informed her employer that at the end of her

year of service, she would leave and find something more “analogous to the formation of a nursing school” (Dossey, 2010, p. 96). Florence dreamed of recruiting farmers’ daughters for training that would be structured similarly to the training she received at the institution in Kaiserwerth (Dossey, 2010).

In March of 1853, Russia invaded Turkey. Britain and France allied with Turkey in a conflict that became known as the Crimean War. When doctors were sent to find suitable locations for hospitals and other facilities for injured troops, the buildings they found were in low altitude, swampy areas and were filled with rodents and other vermin. In spite of the conditions, their reports were ignored by the government and these were the buildings that were used. Huge outbreaks of cholera, malaria, and dysentery occurred and thousands of lives were lost before the first shot was even fired. Florence Nightingale took notice of how many casualties were caused by wounds from battle, preventable diseases, and other causes, and compiled a data chart of her information, which she referred to as a coxcomb. An example of this data chart is pictured in chart 1 of the appendix. In her charts, areas shaded in red measured from the center of the graph represent deaths that could be directly contributed to wounds from battle; areas shaded in blue measured from the center of the graph represent deaths that could be directly contributed to preventable and treatable diseases; areas shaded in black measured from the center of the graph represent deaths contributed to other causes (Lienhard, 2002).

During this time, women were discriminated against in medicine. The government initially denied women the privilege to help out in providing health care service to wounded troops; however, when the public found out about the conditions of the facilities and hospitals for the injured troops, the government was forced to take

action. Florence Nightingale was summoned to lead a volunteer group of nurses into a hospital in Scutari, Turkey. Thirty-eight women went with Florence and became the first group of female nurses to ever be used in British military hospitals (Dossey, 2010). Florence was alarmed and appalled at the conditions within the hospital. Wounded soldiers were packed into the rooms of the hospitals, the hospital's water supply was visibly contaminated, and the sick soldiers desperately retained their own blankets despite how filthy they were because the hospital's blankets were so coarse or went without bedding altogether. The men were often left to lie "in their uniforms, stiff with gore and covered with filth to a degree and of a kind no one could write about" (Richards, 1941, p. 77).

Nightingale would often work 20 hours a day and quickly made progress in improving the conditions of the hospital. One occasion is recorded during which the physicians determined that five of the soldiers in the hospital did not have a chance for recovery and were laid aside to await death. Nightingale and a few of her students got permission to care for these men overnight and by morning all five were fit for surgery. Nightingale quickly gained the reputation of a "ministering angel" among the soldiers in the hospital and was named by some "the lady with the lamp" (Dossey, 2010, p. 210) because she would make her rounds at night after many had already gone to bed. Nightingale believed that the crux of the healing environment of nursing was to provide touch, kindness, and other comfort measures while also attending to the patient's physical needs (Frisch, 2007).

Nursing History

Though often viewed as a unit, medicine and nursing are two separate professions with entirely different histories. The study of medicine developed from a Greek understanding of body-mind dualism that viewed the body as an object. Later, the field of nursing grew out of the Christian worldview that believes the human person is created in the image and likeness of God. Nursing viewed the body as a living unity and dwelling place of the Holy Spirit. Nursing, even from its beginnings has always been about the health of the whole person (Shelly & Miller, 2006). Nurse theorist Patricia Benner states, “nurses deal with not only normality and pathophysiology but also with the lived social and skilled body in promoting health, growth, and development and in caring for the sick and dying” (Benner, 2006, p. 17).

Though some forms of healthcare were available in ancient cultures, the first organized group of nurses came about because of the teachings of Christ to love and serve one another. First-century Christians taught that all believers were to be ministers who were to care for the poor, sick, and the lowly. As churches grew, deacons were appointed to care for the sick and needy within the church. Phoebe, the deaconess mentioned in Romans, is often considered to be the first visiting nurse (Shelly & Miller, 2006).

Nursing continued to center around the church for centuries. In the third century, groups of deaconesses were responsible for the care of the physically and mentally ill of the community. In the fourth century, hospitals were established that were almost entirely staffed by nurses. At this time, the church viewed the practice of medicine as a

pagan art, and thus did not include physicians into providing care for the sick (Shelley & Miller, 2006).

In the Middle Ages, those who wanted to serve God by caring for the sick gathered together in monasteries. The Knights Hospitallers of St. John, a military nursing organization, built hospitals along the path of the Crusades, one of which was in Jerusalem. This hospital provided care for those traveling on the way to Jerusalem, including people of various religious backgrounds including Muslims, Jews, and Christians (Shelley & Miller, 2006).

The Renaissance proved to be a dismal time in nursing history, which coincided with religious organizations being disbanded and suppressed. With the restraint of religion, hospitals collapsed and nursing moved from a public role to a private, home-centered role. Nursing care deteriorated worldwide; nuns were prohibited from touching any part of the body besides the head and extremities and were made to work 24-hour days (Shelley & Miller, 2006).

The Christian church brought along reform for nursing. The Widow's Society was established by Elizabeth Seton in New York in 1797 with the purpose of nursing and caring for poor women in their homes. Similar establishments were beginning all over the world. Mother Mary Catherine McAuley founded the Sisters of Mercy, an organization that focused on ministry to the sick and poor in Dublin, Ireland, and would eventually spread to other countries, including the United States. Elizabeth Fry helped to found the organization, which would later be known as the Society of Protestant Sisters of Charity, which began as a prison ministry and developed into a group of nurses resolved to provide care for the sick in all socioeconomic classes in their homes. Fry's

compassion for the sick inspired Theodor Fliedner, a German pastor, and his wife, Frederika, to address the needs of the poor and sick in their own community. The Fliedners determined that it should be a duty of the church to care for those who are ill and cannot care for themselves, and they turned an outdoor garden house to provide shelter for outcast girls. The Fliedners decided that they needed to organize a group of people who would be assigned the task of visiting and nursing the sick in their homes, and what they established eventually became the Kaiserwerth Institute for the Training of Deaconesses, where Florence Nightingale would later end up training to become a nurse (Shelly & Miller, 2006).

Despite the local religious movements to help the poor and sick, nursing remained largely corrupt and disorganized until the Florence Nightingale reform of nursing, which brought nursing back to its Christian roots and established definite educational and practice standards. Florence Nightingale paved the way for professional nursing, and many church-owned hospitals in both Europe and the United States began establishing nursing schools. As the field of nursing grew more popular, a division grew between those who wanted to be known as professionals and those who viewed their work as a call from God. Florence Nightingale did not see these two things as distinguishable from one another, and used the theological influences in her past to shape her practice of professional nursing (Shelley & Miller, 2006). William Passavant (1903), a pastor and pioneer in hospital establishment, took notice of the divide between the deaconesses and those who wanted to be known as professional nurses and described it in an address given in 1899:

The deaconess has a Biblical office, the nurse a worldly vocation. The one serves through love; the other for her support. In the one case we have an exercise of charity as wide in extent as the sufferings and misery of mankind; in the other, a usefulness circumscribed by the narrow circle of obedient help given to the physicians and surgeons. Above all, the deaconess cares for the body in order to reach the soul. She works for eternity. The trained nurse, like the man whose vocation brings him to the sick-bed, is, as a rule, quite content to pass by unnoticed the possibilities of an eternal future in the demands of the present welfare of the patient. (p. 585)

As the profession of nursing began to grow and develop, influential leaders of the movement sought to ensure that nursing should not be considered as a religious call. The British philosophy of empiricism, which ascertains that a person cannot have knowledge apart from his or her own experiences, led many people to question the spirituality of the church and instead put their trust in science. The poor working conditions, chronic fatigue, and subsequent high mortality rate led to the decline of nurses who were a part of religious orders or deaconess communities. Prior to the establishment of baccalaureate nursing programs, there was a great divide in nursing philosophy between those who viewed nursing as religious service and those who viewed it as secular professionalism (Shelley & Miller, 2006). Today, the United States Department of Labor estimates that the employment of registered nurses is expected to grow 26 percent from 2010 to 2020, which is faster than the average for all other occupations (Bureau of Labor Statistics, U.S. Department of Labor, 2012). As nursing continues to grow and change, its roots will always be traced back to Florence Nightingale and the Christian faith.

The Importance of Addressing Spiritual Health

The World Health Organization defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (2013). This definition includes addressing spiritual health to maximize mental and social wellness. In seeking to provide the best possible patient care, nurses have the responsibility to plan both preventative and restorative interventions that address all three areas highlighted by the World Health Organization's definition. Historically, nursing theorists have nearly always addressed the necessity of meeting a patient's spiritual needs. Many professional organizations also endorse the need for spiritual care. The North American Nursing Diagnosis Association (NANDA) acknowledges a diagnosis of spiritual distress, for which they offer nursing interventions that include performing a spiritual assessment that includes the client's relationship with God, meaning and purpose in life, religious affiliation, and any other significant beliefs; encouraging the client to pray, setting the example by praying with and for the client; and validating the client's spiritual concerns and conveying respect for his or her beliefs (Ackley & Ladwig, 2011). In the code of ethics for nurses, the American Nurses Association asserts that nurses should strive to "maximize the values that the patient has treasured in life" and that "the measures nurses take to care for the patient enable the patient to live with as much physical, emotional, social, and spiritual well-being as possible" (2010, p. 4). The Joint Commission on Accreditation for Healthcare Organizations (JCAHO) also recognizes the importance of spiritual care and requires that all patients be assessed for spiritual beliefs and have spiritual support offered to them. In regards to education, the American Association of Colleges of Nursing advises that nursing students should be taught how to

understand the implications that spirituality has on health and healing. Even though so many renowned professional organizations address the importance of providing spiritual care, most nursing textbooks contain very little about this subject. As patients and their families deal with stress, loss, suffering, challenges, and even death, they may attempt to find meaning and purpose for their illness or they may try to define causalities. The time surrounding hospitalization may result in spiritual strengthening or total loss of hope and faith. How the nurse responds during this time is of indispensable value (Frisch, 2007).

Assessment of Spiritual Needs

In seeking to address the spiritual needs of patients, nurses must always begin with an assessment. This may be done in a formal manner through nursing research or an informal manner, which simply involves interaction with the patient and his or her family; however the nurse must always remain respectful and non-biased. Some nurses have admitted to feeling uncomfortable or unprepared to talk with their patients about religious or spiritual topics; however, it is recommended to approach the issue of spiritual care in a systematic manner. Some nurses suggest incorporating a spiritual assessment into the initial assessment at the beginning of every shift, others advocated waiting for spiritual assessment until the nurse and patient have established a relationship. Either technique may be appropriate and the nurse should use her own discretion to determine which to use on a patient-to-patient basis. The goal of the spiritual assessment should be to shed light on the patient's beliefs that may affect his or her care (Loustalot, 2008).

There are many methods of conducting a spiritual assessment that a nurse may utilize. Gowri Anadarajah and Ellen Hight of the Brown University Department of Family Medicine developed a screening tool called HOPE. The HOPE tool utilizes open-

ended questions to explore the individual's spiritual resources and concerns; this is easily incorporated into discussion of the patient's support systems. In the mnemonic, H stands for the patients' sources of hope, including the spiritual resources that they already have in their lives that help them to find meaning, comfort, strength, peace, and love. These initial questions do not focus immediately on religion or spirituality, as this may be a barrier for patients whose spirituality is outside those of traditional religion or who may have been disconnected for some reason from their own religion (Anandarajah & Hight, 2001).

The next letters of the mnemonic are O, which assesses the patient's involvement in organized religion, and P, which assesses the patient's personal spirituality and practices. To begin addressing these issues, the nurse may say, "For many people, religion and spiritual beliefs can be a source of comfort and peace during hard times, is this true for you?" These questions will help the nurse identify any practices that may be useful during the patient's hospital stay or specific chaplaincy services that the patient may find helpful. These questions open the door for discussion about any spiritual matters that may be of concern during medical care (Anandarajah & Hight, 2001).

The last letter of the mnemonic, E, addresses the effects of the patient's spirituality and beliefs on his or her medical care and end-of-life issues. These questions redirect the discussion back to specific ways the nurse and other members of the health care team can provide the spiritual care the patient wants and needs. The nurse may assess for the presence of barriers that may prohibit the patient from spiritual resources, fears or concerns related to the patient's current illness or treatment, or effects of the patient's beliefs on his or her medical care. Spiritual care of the dying patient should also

include addressing fears concerning death or separation from loved ones, and the need for making peace with the life they have lived and the death that is approaching (Anandarajah & Hight, 2001). If the nurse ever feels that a situation is beyond her ability to assist, collaboration with the hospital's chaplain services may be the next step in ensuring the patient's spiritual needs are met.

There are many other spiritual assessment tools available for nurses and other health care professionals. Tools such as the HOPE screening are good to use for initial assessments; however, ongoing assessments made by nurses who have established relationship and rapport with the patient are thought to most accurately identify a patient's spiritual needs. Simple, open-ended questions indicate the nurse's willingness to help the patient and give the patient an opportunity to express any areas of concern. Some patients perceive that nurses and physicians are only focused on providing physical care and will not approach the subject of spirituality with hospital personnel outside of the chaplaincy. The initiation of spiritual discussion may open the door for the patient to feel comfortable talking to nurses about this important area of their health. A study of 15 chronically ill patients in the United Kingdom revealed that some patients feel they have to avoid the discussion of spiritual matters to avoid becoming an object of ridicule among health care workers. The problem may prevail particularly with patients who perceive their spirituality and beliefs as differing from the mainstream community (Frisch, 2007). Any information gathered from the spiritual assessment may then be used to support, encourage, and lead the patient into connecting and utilizing spirituality to promote their health and wellbeing.

In a geriatric unit in Edinburgh, Scotland, ten patients were asked to describe their spiritual needs. The most common needs identified by the patients were religious needs such as being able to attend church, pray, and read the Bible. Patients also identified the need to make sense or find meaning in life and feel a sense of love and belonging. This study also recognized that spiritual needs arise related to death and dying. This may include addressing questions about life after death, reflecting on moral standing and doing the right thing, and fulfilling perceived duties to one's family. None of the patients in this study felt like they had received any help from the nurses in meeting their spiritual needs; however almost 75% of nurses working in a similar setting admitted to identifying spiritual needs. The interviewer conducting this study noted that the patients frequently talked about emotional experiences from their past that they had never talked about or hadn't talked about in years. If the patients seemed to get upset, the interviewer would give them the option to move on to the next question, however, all of the patients elected to keep talking about the painful event, indicating that they found the process of talking to be therapeutic. The conclusion of this study identified enabling patients to attend chapel services at the hospital, providing a quiet room for prayer and meditation, and improving the patient's link with hospital chaplain services as ways to address and provide spiritual care (Ross, 1997). Hermann (2001) assessed the spiritual needs of elderly patients with terminal cancer. This study grouped identified spiritual needs into six categories including religious practices, companionship, involvement and control, experiencing nature, having a positive outlook, and finishing business.

Interventions to Meet Spiritual Needs

Research concerning the spiritual care of patients seems to identify three different categories of interventions to meet identified needs. The most frequently suggested interventions were directed towards improving or facilitating the process of communication between the patient and other people in his or her life or communication between the patient and a higher being. Interventions in this area include active listening, therapeutic touch, building trust, and being present. The next category of frequently mentioned interventions was aimed at assisting the process of religious and spiritual activities, including prayer, meditation, and arranging for ritualistic needs such as the administration of sacraments, and special dietary considerations. Another intervention in this category involves connecting the patient to the hospital's chaplain services and providing education about what other spiritual resources are available. The third category of interventions focuses on providing physical care. The patient's physical needs must be met, particularly regarding sufficient pain management. This category also recognizes therapeutic touch as an intervention for connecting with the patient and providing spiritual care. As the nurse involves these interventions in the care of the patient, the nurse must take special care to ensure he or she is being supportive of the patient and responding in ways that convey sensitivity (Frisch, 2007).

Frisch (2007) compared the needs and interventions by patients, nurses, and chaplains and identified five nursing actions that help to meet patients spiritual needs. These actions include prayer, scripture, presence, listening, and referral. Oncology, hospice, and parish nurses confirmed the helpfulness of these interventions and also identified conveying acceptance and instilling hope in their patients as essential.

Prayer is usually understood to be the act of asking or petitioning a Higher Being to obtain some sort of positive outcome. Prayer can take on many different forms, but healing prayer has been described as “bringing oneself and a situation of disease before God with at least one other person to listen, discern, speak and respond, so that healing in relation to or with God can take place” (O’Brien, 2003, p. 135). The nurse may encourage the patient to pray individually, but often some aspect of the patient’s illness or treatment may create a barrier for solitary prayer. In these cases, the prayers of the nurse, both with and for the patient, can become an intervention in spiritual care. If the nurse uses this intervention, prayer should reflect what the patient would pray for himself or herself. A therapeutic prayer will likely include simple statements about the patient’s hopes, fears, and needs, and a recognition and request of God’s ability to intervene in the situation and meet the needs of the patient. For many patients, prayer can provide peace and comfort in a variety of different situations. The nurse should always ask the patient’s permission before using prayer as an intervention in the plan of care (O’Brien, 2003).

Scripture is generally understood to be the word of God and is adored and revered as instruction to live by for religious communities. For followers of Judaism, this is the Torah; for Christians this is both the Old and New Testaments. The term scripture may also be taken broadly to represent any sacred writings of a religion, including the Qur’an for Muslims, or the Book of Mormon for members of the Church of Jesus Christ of Latter Day Saints. The nurse should use this intervention with discretion; if the nurse attempts to encourage the patient with Scripture at a time when the patient is depressed, angry, or experiencing severe pain, it may actually be harmful rather than therapeutic. If the nurse is unsure about whether or not to use this intervention, he or she may politely ask the

patient's permission. When a nurse feels comfortable reading a passage of Scripture with a patient or a family and when this intervention is timed appropriately, this intervention can be very spiritually therapeutic (O'Brien, 2003).

Other nursing actions that can help meet patient's spiritual needs are the nurse's simply being there as caring presence and active listener. Many patients describe their time in the hospital as a period of loneliness. When the nurse is present in the room, attuned to the patient's needs, and is willing to stop and listen to the patient, this can be a great holistic intervention. With modern medical technology, the nurse can do most of the necessary monitoring from the doorway without ever being a caring presence for the patient. Nurses should be taught that quality patient care treats the patient, not just the monitor. By being present with the patient, and demonstrating a willingness to actively listen, nurses can meet some of the spiritual needs of their patients and open the door of communication to find other spiritual needs that the patient might have (O'Brien, 2003).

At times, it may be necessary to refer the patient for various types of pastoral care. It is recommended that the spiritual care given by nurses and that given by the pastoral caregiver be complimentary. When the nurse utilizes this resource, communication is vital to ensure that there are mutual goals in the care giving process and delineation of role responsibilities. When the nurse makes a pastoral care referral, this may involve a priest, minister, rabbi, imam, or some other type of spiritual advisor from the patient's religious or spiritual background. The nurse may also refer the patient to the hospital's chaplain services. In preparing for a visit with pastoral care, the nurse should plan to allow for as much privacy as the setting allows and should ensure that there is a place for the pastoral caregiver to sit close to the patient. The nurse may also

cover the bedside table with a white cloth if necessary for any religious rituals or sacraments (O'Brien, 2003).

Barriers to Spiritual Care

One measure that could drastically impact the spiritual care of patients is how nurses are educated about this aspect of care. Research has indicated that only about 15 percent of nurses studied spiritual care in their nursing education. Nurses are comfortable attending to the physical needs of their patients but are uncomfortable addressing the spiritual needs. Two of the most important factors in whether or not nurses felt capable of providing spiritual care to their patients were the nurse's personal spirituality and the nurse's knowledge about this aspect of care. Other barriers for nurses providing spiritual care include the nurse's belief that spirituality is a private, pastoral responsibility, insufficient time related to being responsible for multiple other care interventions, or the belief that needs cannot be addressed if the nurse and the patient have different belief systems. Not only are there barriers to spiritual care on the nurse's side; many patients do not recognize the provision of spiritual care to be a nursing responsibility beyond calling for a chaplain (Frisch, 2007).

Parish Nursing

A parish nurse, also known as a faith community nurse, is "a registered nurse with a minimum of two years experience that works in a faith community to address health issues of its members as well as those in the broader community or neighborhood" (International Parish Nurse Resource Center, 2011, para. 1). Parish nursing is grounded in the relationship between spirituality and caring for the sick. Parish nursing focuses on healing the whole person, with particular emphasis on the spiritual aspect of care. The

philosophy of parish nursing is rooted in promoting health in a faith community by working closely with the pastoral staff to integrate theological, sociological, and physiological aspects of health and healing to serve the congregation. The parish nurse must have strong clinical and communication skills, a strong personal faith, and a desire or perceived calling to serve the needs of the faith community through nursing. Parish nursing is fundamentally built on the philosophy of caring that already exists in nursing; however, it adds that this caring should come from a deeper purpose of serving God and serving others. The role of a parish nurse is similar to that of a community nurse but the parish nurse operates specifically in a faith community (O'Brien, 2003).

Parish nursing is becoming increasingly recognized and popular; there are currently parish nurses in all 50 states. In 1998, the Practice and Education Committee of the Health Ministries Association (HMA) issued a document that identified the scope and standards of practice for parish nurses. This document was acknowledged by the American Nurses Association later that year. Among the roles of the parish nurse described in the scope and standards of practice are: collecting data related to the client health, diagnosing based on collected data, identifying health outcomes, health promotion and planning, and implementing and evaluating responses (O'Brien, 2003).

Parish nursing was started in the 1980s in Chicago by Lutheran pastor Granger Westberg as an attempt to take nursing back to its roots in faith, when nursing outreach was conducted through religious orders, such as the "Parish Deaconesses" (International Parish Nurse Resource Center, 2011). Westburg advocated fervently for the re-integration of spirituality into health care and began several holistic health centers within religious congregations. Westburg encouraged his local hospital to begin a program

within local faith communities to provide nurses who would reach out and provide connections to healing and hope. Pastor Westburg's interest in holistic care and parish nursing was noticed by the larger nursing community and the first parish nursing program was established at Lutheran General Hospital in Park Ridge, Illinois. The International Parish Nurse Resource Center (IPNRC) was developed out of this local movement, and together with the counsel of other nurses, a curriculum was created for parish nursing education. "Westburg Symposiums" began taking place annually and would serve as a meeting place for parish nurses across the nation to take part in the discussion of the emerging practice of parish nursing (O'Brien, 2003).

Today, parish nurses may operate within churches or other institutions and may be volunteers or paid employees. Hospitals and other health care institutions may also employ a parish nurse as a way of reaching out and promoting health to the faith community. Educational training for parish nursing varies from weekend or weeklong continuing education programs, to full academic courses ranging from three to six credit hours. There are also post-baccalaureate and graduate programs that focus on practice within a faith community (O'Brien, 2003).

Implications for Future Research

Upon completion of the literature review, a number of gaps in the research were identified. While much research was conducted about the subject of spiritual care in the early 2000s, there has been a lack of adequate study about this subject in more recent years. With the new healthcare reforms that are currently taking place, it will be important to reevaluate the topic of spiritual care to meet the changing needs of patients in all healthcare settings. Another area where research was lacking were studies

comparing various assessment tools to determine where patients have spiritual needs. If research could identify a certain tool that seems to be effective in multiple clinical settings, this could be integrated into the curriculum of nursing schools to better prepare nurses for meeting the spiritual needs of their patients. Another area that seems to be lacking in current research is nurse's perspective of providing spiritual care and their concerns in addressing this need in their patients. Collecting and examining this data may also reveal needs and gaps in nursing education.

Conclusion

All nurses must be informed about the importance of addressing the spiritual needs of their patients and providing more holistic and comprehensive care. Though nursing has seen many changes throughout its history, it must never be forgotten that the central premise of this field is caring. Nurses must not be fearful of approaching spiritual topics with their patients. Interventions such as prayer, Scripture, presence and active listening, as well as referral, can improve patient outcomes and should regularly be integrated into patients' plans of care. Future research should be conducted into the topic of providing spiritual care and changes made in nursing and nursing education accordingly. This patient need must be regarded as highly as any other physical or emotional need.

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Appendix

Chart 1. Florence Nightingale Coxcomb Chart. This chart shows the number of deaths by month and their causes (Lienhard, 2002).

