Research Article

The Integration of Spiritual Practices in Nursing Care

Sofia Magdalena N. Robles, PhDNEd, RN

Abstract

Image source: http://annualcouncil.dioms.org/

The intent of this study was to describe the integration of spiritual practices in nursing care that could be a basis for developing a framework of nursing care management. The paper utilized a mixed method research design: qualitative approach was used through focused group discussion (FGD) and interviews with staff nurses affiliated with certain tertiary hospitals in Metro Manila selected through purposive sampling. Thematic results from the responses shared by the key informants were processed. These results consisted of the following: (a) Interpersonal relationship with God and personal outlook on values; (b) Caring for the Spirit; (c) Actualization of spiritual care; and, (d) The mission of meaningful service.

A spirituality tool was developed based on the emerging themes and was given to each nurse. The tool revolves around seven elements: general manifestation in rendering spiritual care, specific manifestations in rendering spiritual care, recipients of spiritual care, appropriate time in rendering spiritual care, venue for rendering spiritual care, relevance/meaning of spiritual care and institutional support. The statistical treatment of the spirituality tool shows that nurses practice/concur with the spiritual care at all times.

The framework on the Integration of Spiritual Practices in Nursing Care points to God's presence in the midst of relational presence, integral presence, spaces of presence and moment presence. Hence, this study puts emphasis on the integration in nursing care of spiritual practices where God's presence is visible.

Key words: *Spiritual care, spiritual practices, nursing care*

Introduction

Nursing is a vocation that dwells on rendering holistic care to the patient. Addressing the wholeness of the human dimensions becomes a great challenge to nurses because of the tendency to focus only on what the job description states, namely: monitoring vital signs, giving medications, transcribing doctors' order, attending to the gadgets attached to the patient such as the task of fixing, removing, and, collaborating with other teams, to name a few. These things are necessary but there is a growing need to integrate the spiritual practices in nursing care to realize its holistic imperative. Neuman (in Pesut, 2008) emphasized that "nursing is concerned with the whole person, including the following dimensions: Physiological, Psychological, Socio-cultural, Developmental and Spiritual." Each dimension should be addressed, but oftentimes, the spiritual aspect is neglected.

In 2000, the Joint Commission on Accreditation of Healthcare Organization (JCAHO) mandate**d** that each client admitted to an institution's care must be assessed for spiritual beliefs and practices (Kozier, 2008, p. 1048). In the Philippines, spiritual care is offered as an elective in the

nursing curriculum (CHED, 2009). It is also part of the Nurses' Code of Ethics and the core competency of the Board of Nursing (BON). However, there is no existing standard or guidelines on how to render spiritual care or on how to systematically do it.

Nurses identified patients' spiritual needs as religious beliefs and practices (prayer); absolution; seeking connectedness, comfort and reassurance; and healing or searching for meaning and purpose. The interventions initiated by nurses to meet patients' spiritual needs include: respecting privacy; helping patients to complete unfinished business; listening to patients' concerns; comforting and reassuring; using personal religious beliefs to assist patients; and observing religious beliefs and practices (Narayanasamy et al., 2004 as cited by Barber, 2008). But according to Jenkins (2009), there are nurses who are uncomfortable in providing spiritual care for their patients for several reasons: nursing is too biological; professionalism is synonymous with distancing; more emphasis is placed on technology than holistic care; and, nurses may be uneasy about their own spirituality. Nevertheless, "the neglect of spiritual needs of patients could have serious implications for their overall illness adaptation, particularly in extreme physical conditions" (O'Brien, 2011).

The different spiritual care practices obtained from the nurses during the focused group discussion (FGD) could be the basis for developing a framework for the integration of spiritual practices in nursing care in the Philippine setting. This framework could also enhance the practices in spiritual nursing care.

Research Questions and Objectives

The objectives of this study are: (1) to describe spiritual practices in nursing care; and, (2) to develop a framework on the integration of these practices to nursing in the Philippine context. In order to achieve these objectives, the paper addressed the following questions:

1. How is spirituality perceived by the nurses in the study in relation to nursing practice?
2. How are spiritual practices integrated in the nurses' provision of care to the patients?
3. What are the implications of these practices to the nurses' provision of care to the patients?

Methodology

This study utilized a mixed method research design. The study began with a focused group discussion (FGD) in order to understand the nurses' perception on spirituality in nursing care and how they addressed the spiritual needs of the patient. The development of the spirituality tool was the summary of the nurses' responses from the focused group discussion while the development of the framework was the combination of the emerging themes and the result of the descriptive comparative result of the spirituality tool from the three selected tertiary hospital.

Participants of the Study

The participants of this research were the registered nurses, male and female, ages 22-45 years, have been in the institution for a year to five years and working in selected participating tertiary hospitals in Metro Manila, Philippines. The inclusion criteria were the following: participants are registered staff nurses working in the identified participating tertiary hospitals willing to participate and handle adult medical surgical patients from critical and non critical areas. Only staff nurses doing bedside care were included. Excluded are nurses with managerial position, nurses handling pediatric clients and those assigned in Operating Room, Delivery Room and Out-Patient Department.

For FGD participants, a total of 33 participants were divided according to their respective institutions. There were 431 total respondents on the spirituality tool that was distributed in the three selected tertiary hospital.

Research Instrument and Instrument Validity

The research instrument that was developed by the researcher was generated from the findings of the FGD of the nurses from the three selected tertiary hospitals. The generated findings of the four FGD revolved on the nurses' understanding of spirituality, spiritual care, how spiritual care is being actualized. The significant findings of the FGD were grouped according to the main elements that emerged: what nurses are doing in spiritual care, how exactly nurses are rendering spiritual care, who are the recipients of this spiritual practices, when is spiritual care being rendered, when is the appropriate time in giving spiritual care, why nurses do spiritual care and what is the support offered by the institution in giving

spiritual care. The elements are the main categories around which the content of the spirituality tool revolved while all the statements under each main theme were lifted from the sharing of the participants during the FGD. The spirituality tool is a four - point scale with seven elements that consist of 64 items.

The reliability of the instrument underwent face validity and content validity by 38 experts in the field. The validation of the instrument came from the following: Roman Catholic nun, who is a nurse by profession, currently assigned in the infirmary ward, a lecturer who is a Seventh Day Adventist, teaching spiritual care as a nursing elective in the college of nursing, six (6) clinical instructors assigned in medical surgical adult wards and thirty (30) staff nurses assigned in medical surgical adult wards from both critical and non critical areas coming from an institution which has the same criteria set by the researcher but not included in the study. The six clinical instructors and thirty staff nurses had varied religious affiliation namely, Roman Catholic, 7th Day Adventist, Born Again Christian, Protestant and Jehovah's Witnesses.

The pilot testing results showed between .94 - .99. Reliability and stability of this instrument were established in the developed spirituality tool.

Ethical Consideration

In the observance of ethical principles, anonymity of the participants was protected while a number coding was used to represent the participating hospitals. Informed consent was also gathered before the FGD. Participation was voluntary and did not involve any monetary payment. The participants were also given the right to withdraw anytime the participants felt uncomfortable during the process.

The Internal Review Committee (IRB) of The Medical City granted the approval to conduct the study. The IRB committee required a protocol consent form where it was stated that participants, who were the nurses, could strengthen the spiritual practices in the institutions.

Data Collection and Analysis

The inquiry involved the following:

Phase I: Qualitative focused group discussion (FGD). The first phase aimed to solicit the perception of the participants' views on spirituality and spiritual practices in nursing care. Four FGDs at the three selected hospitals were conducted. Results were analyzed through thematic analysis that resulted to four emergent themes and ten sub themes.

Phase II: Quantitative Instrument Development. The four emergent themes were used for the development of the spirituality tool. The spirituality tool focuses on the actualization of spiritual practices using a four-point Likert scale.

Phase III: Descriptive-Comparative Result. Purposivesampling was used before the spirituality tool was administered to the nurses of the three selected tertiary hospitals. Using weighted mean, standard deviation and ANOVA, data yielded a descriptive - comparative result that described and compared the participants' attitudes and practices on the different spiritual practices in nursing care.

Phase IV: Framework Development. The fourth phase was the development of the framework on spiritual practices in nursing care. The framework was developed from the results of the FGD and the survey using the spirituality tool.

RESULTS AND DISCUSSIONS

Qualitative Results

The FGD yielded four emerging themes and ten sub-themes. It revolved around the following themes: identifying spirituality with God and personal values; defining spiritual care; how spiritual care is practiced; and, the effects of spiritual care.

Theme 1: Interpersonal relationship with God and personal values

The recognition of God in identifying spirituality was evident in the sharing of participants. This shows the belief of nurses on God as a Father and creator. They believed that connectedness with God helped developed good values as God is perceived as the model of goodness. The belief in God and the application of good values in life is closely associated with the perception of spirituality.

1.1 A personal connection with God

The participants perceived God at the core of spirituality and they represented it as connectedness with God, relationship with God, being one with the Lord, respect for the beliefs, faith and belief in the divine power or something greater than the self.

A participant (P6H2) stated, "Spirituality means integrating spiritual things that include faith, beliefs in God and entrusting unseen things that make us strong." "Spirituality, as a personal concept, is generally understood in terms of an individual's attitude and beliefs related to transcendence (God) or the non material forces of life and nature" (Emblen ,1992 as cited by O'brien, 2011, p. 5).

1.2 A personal outlook on values

The participants also associated the understanding of spirituality with their personal outlook on values. According to the participants, spirituality deals with goodness, holiness, guidance to know what is right and wrong as well as having a clean conscience.

According to a participant, "Spirituality means being true to your self and having a clean conscience, doing what is right and what is best" (P7H3)[1]. According to Murray and Zenter (1989), "Spirituality is defined as a quality that goes beyond religious affiliation, that strives for inspirations, reverence, awe, meaning and purpose, even in those who do not believe in any good."

Theme: 2. Caring for the spirit

Participants shared mostly the understanding of spiritual care as an act of doing or practice that respects the faith and beliefs of a person. Caring for the needs of the spirit means that one needs to look after the beliefs, faith, and practices of a patient.

2.1 Unconditional care

Participants viewed the meaning of spiritual care as unconditional care that provides compassion, and wholehearted caring, respect patients as human beings, helping them recover from anxiety and caring for them with a personal touch. One participant noted: "Spiritual care is a personal touch and concern on the spirituality of others" (P6H2).

2.2 Attending to the needs of the spirit

Attending to the needs of the spirit that pertains to faith and beliefs was done by providing time for worship or prayer. In other words, "Attending to the needs of spirit is respecting the belief of each individual no matter what their religion is and acknowledging who and what each believes" (P5H3). According to the participants, caring for the spirit also involves "Care that is based on patients' spiritual relationship, respect for practices, integrating spirituality like prayers, leading patient to Jesus Christ, respecting religious belief of each individual, and introducing a Christ - like character." Lim (2010) in his lecture said that "spiritual nursing includes whatever gives meaning, worth and value to the mind and body, effecting and affecting the healing process".

Theme 3: Actualization of Spiritual Care

The participants gave a comprehensive description on how spiritual care is practiced: how they did it, to whom this care was rendered, when and where was the appropriate time and place to render spiritual care, what was the relevance of spiritual care and what institutional support was obtained in providing spiritual care.

3.1 Bridging the needs of the Spirit

In bridging the needs of the spirit, the nurses serve as a channel through the use of the senses: observing the patients' religious practices, talking to or interviewing patients regarding preferences in relation to cultural practices, and listening to what their spiritual needs are. In particular, "During admission we ask for their religion and their practices to find out if there are special preparation/needs based on their religion" (P1H3).

3.2 Not One Left

Spiritual care is intended for everybody that includes the ill and the well, according to the participants. "Not one left" means that everyone has the opportunity to receive spiritual care, not only the identified patients who are dying, palliative, hospice, terminally ill, depressed, hopeless patient but even patients who are well. Even the "happy and grateful patients like for example patients for discharge, need spiritual care" (P9H2).

This implies that critical, non - critical and well patients including patients who are for discharge from hospital confinement can be recipients of spiritual care. However, researches reveal that majority of patients feel that spirituality or religion

[1] *P (Participant), H (Hospital)*

only becomes more important when a person is ill. They believe that rituals can help people when they are ill or suffering and consider it helpful for health professionals to know their beliefs.

3.3 Best time, time speaks; grounded in a peaceful environment

The generalized preferred place in rendering spiritual care is a quiet and peaceful environment where patients could meditate, pray, and reflect. On the other hand, the best time to give spiritual care is the time when the patients are ready and request it. Nurses can get the cue that patients need spiritual care during nurse patient interaction. One participant said that, "Every time we interact with the patient is the best time to give spiritual care" (P2H1). This implies the importance of nurse - patient interaction that gives nurses an opportunity to assess patients' spiritual needs.

3.4 Supplement the spiritual needs; filling the gap

As described by the nurses, spiritual needs were addressed through prayers, referral to chaplain or minister of choice, serenading with Christian songs, and respecting dietary special request related to religion, to mention some. Meanwhile, hospitals encourage nurses to practice and develop spiritual care by "providing them culture and sensitivity seminar, to help the nurses address the kind of caring for patients with different religions" (P1H1). The provision of sensitive and effective care to persons from cultures that are different from their own requires two things: "1. an awareness of one's own cultural values, beliefs, and recognition of how they influence the attitudes and behaviors; and, 2. understanding of the cultural beliefs and values of others and how they influence them" (Wintz and Cooper, 2009). The respect for patients' culture is important.

Theme 4: The mission of meaningful service

Spiritual care has a great effect on both patients and nurses. The mission of meaningful service is a representation of an evaluation on how the spiritual care impacts nurses and patients.

4.1 A comfort that brings life

Comfort that brings life refers to the effects of spiritual care on patients. As described by the participants, this sub-theme is manifested in various ways: patients look comfortable and relaxed, patients show satisfaction and comfort with the words and actions they made. One participant observed that "my patients in the midst of any circumstances act calmly and hopeful" (P3H1). In addition, "we make sure that we give a conscientious and holistic approach to our patients and *nakikita namin masaya ang itsura nila* (we see that patients are happy)" (P6H1).

This implies that spiritual care brings comfort to the patients, which helps in their recovery. Spiritual health or spiritual well-being "is manifested by a feeling of being generally alive, purposeful, and fulfilled" (Kozier, 2008, p. 1043).

4.2 Meaningful service

The effects of the provision of spiritual care to nurses brought a sense of meaningful service. Generally, the participants felt a sense of personal growth and satisfaction in the practice of spiritual care. The nurses described their experiences as fulfilling as if "it was part of Jesus works" (P3H2); there was "fulfillment in the career, as it was part of nurses' oath" (P5H1); and, satisfaction stems from "the fact that we are doing God's work" (P1H1). Nurses' experiences in giving spiritual care increases their confidence and positive awareness. It gains confidence and understanding that could be a life long learning (Deal, 2009).

Quantitative Findings

Spirituality Tool

The four themes and ten sub themes that surfaced in the discussion became the basis in the development of the instrument. The spirituality tool focuses on how the nurses in the real set - up were practicing spiritual care. As shown in the emerging themes, the spiritual practices in nursing care revolve around what they do in general (general manifestation), how exactly do they do it (specific manifestations), to whom do they do it (recipients of spiritual care), when they do it (appropriate time in rendering spiritual care), where they do it (venue for rendering spiritual care), why they do it (relevance/meaning of spiritual care) and what is the support of the institution (institutional support). *(Please refer to Table 1)*

PHILIPPINE NURSES ASSOCIATION, INC.

Table 1. Spirituality Tool Developed from the Qualitative Data

	SA	A	D	SD
1. General Manifestation in Rendering Spiritual Care				
1.1 During admission, I ask my patients' religious practices.				
1.2 I observe the presence of religious items of my patients such as rosary beads, Buddha beads, bible, etc.				
1.3 I utilize the Checklist/Assessment tool related to spiritual needs.				
1.4 I render spiritual care as an expression of the mission and vision of the hospital.				
2. Specific Manifestation in Rendering Spiritual Care				
2.1 I respond promptly to request on spiritual matters, e.g. Priests/pastors/counselors services (anointing, receiving communion, blessings).				
2.2 I offer silent prayers when at home especially to those terminally ill.				
2.3 I utilize "therapeutic-communication" questions, e.g. "What would you like to talk about?"; "What's bothering you?"				
2.4 I provide privacy by giving space for patients and relative for their prayer.				
2.5 I respect dietary preferences based on one's faith e.g. as a Muslim, Jehovah, Adventist.				
2.6 Part of spiritual care is empathizing with the patient.				
2.7 I maintain an open mind and heart for individual's religious practices.				
2.8 I listen attentively to my patient's stories				
2.9 I anticipate the need for spiritual intervention e.g., anointing, communion, blessing, pray-over.				
2.10 Spiritual care is part of the nurses' daily care.				
2.11 I am sensitive to non-verbal cues, e.g., silence, facial grimaces.				
2.12 I pray before any diagnostic and therapeutic procedure.				
2.13 I am sincere about my patient's concern e.g. request for confession before operation.				
2.14 I document at the nurse's notes the spiritual care I administered.				
3. Recipients of Spiritual Care				
3.1 Patients who are psychologically ill, e.g. depressed, suicidal, confused, needs spiritual attention.				
3.2 The critically ill and dying are those who most frequently need spiritual care.				
3.3 Palliative care and hospice patients need spiritual care.				
3.4 Patient for OR (Operating Room)/ undergoing surgery needs spiritual attention.				
3.5 Patients who received bad laboratory results, e.g., malignant for cancer, needs spiritual care.				
3.6 Patients in pain need spiritual attention.				
3.7 All patients including well patients need spiritual care.				
3.8 Patients who are losing hope e.g., HIV victims, cancer patient need spiritual care.				
3.9 Patients who are happy and grateful, e.g., patient for discharge need spiritual care.				
3.10 Abused patients, e.g., battered wife/child need spiritual attention.				
4. Venue for Rendering Spiritual Care				
4.1 Spiritual care can be given anywhere as long as there is privacy.				
4.2 A silent and peaceful environment for meditation and prayer is a place for spiritual care.				
4.3 Spiritual care can be rendered in a patient's room.				
4.4 Spiritual care is preferably done in the chapel/prayer room of the institution.				
5. Appropriate time in rendering spiritual				
5.1 Spiritual care is rendered when the patients request for it, e.g., to receive anointing.				
5.2 Spiritual care is appropriately done when the patient are calm and willing to listen.				
5.3. Spiritual care is given to patients who are in their lowest moment.				
5.4 Spiritual care is given every time nurses interact with the patients.				
5.5 Spiritual care is given when an emergency procedure is to be done with unknown outcomes.				
5.6 Spiritual care is best given in the morning as part of the daily routine.				
6. Relevance/meaning of spiritual care				
6.1 Spiritual care is based on the patients' religion, beliefs, and faith.				
6.2 Spiritual care is done through counseling and using therapeutic communication.				
6.3 Spiritual care is allowing the patients to practice their faith/beliefs.				
6.4 Spiritual care is a priority aspect of holistic nursing care.				
6.5 Spiritual care prepares patients to accept their illness/condition.				
6.6 Spiritual care is compassion.				
6.7 Spiritual care is respecting patients as human beings with heartedness.				
6.8 Spiritual care is assured when patients have a positive attitude towards their present illness.				
6.9 Integrating spirituality, like saying prayers, is a daily routine of healing in nursing.				
6.10 Taking care of patients with empathy is spiritual care.				
7. Institutional Support				
7.1 The availability of the chapel/prayer room as a place of worship is necessary for spiritual care.				
7.2 Provision of institutional assessment tool is integrated in spiritual care.				
7.3 Daily blessing of patients from religious sisters/priests is a component of spiritual care.				
7.4 A built in speaker place in each room for accessibility of hearing daily mass, is essential for spiritual care.				
7.5 Stipulation of Spiritual Care in FDAR (Focus Data Action Response) documentation is part of spiritual care.				
7.6 Spirituality imparted to all nursing staff through integration in culture and sensitivity seminar given by the HR is crucial in spiritual care.				
7.7 A checklist is utilized in assessing spiritual needs upon admission.				
7.8 The provision of religious leaflets, given to patients, augments spiritual care.				
7.9 Providing spiritual care through visitations and offering of Christian songs helps patients.				
7.10 A chaplain is available to give needs such as anointing the sick, blessing, giving communion, etc.				

The descriptive result of the Spirituality tool and the summary table of the combined result on the different elements of Spirituality Tool administered to staff nurses of the three tertiary hospitals are shown in Table 2 and Table 3 respectively. The highest among the elements is the "relevance/meaning on spiritual care" with a mean of 3.58, and the lowest is the "general manifestation of spiritual care practice" with a mean of 3.33. Overall, the seven elements of the spirituality tool got a verbal interpretation of strongly agree which means that nurses are practicing spiritual care at all times. In totality, all the three hospitals got a positive result in rendering spiritual care, but it varies on how frequently nurses are doing it. It varies because of the different orientation of the three hospitals where the two are faith - based hospitals and the other one is a member of Joint Commission International.

Table 2. Descriptive Result of Spirituality Tool

Likert Scale	Range	Verbal Interpretation	Description
4	3.26- 4.0	Strongly Agree	Practice/concur with the opinion on spiritual care at all times.
3	2.51 - 3.25	Agree	Practice/concur with the opinion on spiritual care most of the time.
2	1.76 - 2.50	Disagree	Hardly ever practice/concur with the opinion on spiritual care.
1	1.0 – 1.75	Strongly Disagree	Never practice/concur with the opinion on spiritual care.

Table 3. Summary Result of Spirituality Tool among the Three Tertiary Hospitals

	Hospital 1			Hospital 2			Hospital 3			Total	
	X	*SD*	*VI*	*X*	*SD*	*VI*	*X*	*SD*	*VI*	*X*	*VI*
1. General manifestation of spiritual care practices.	*3.39*	*0.40*	*SA*	*3.40*	*0.42*	*SA*	*3.22*	*0.45*	*A*	*3.33*	*SA*
2. Specific manifestation of spiritual care practices.	*3.50*	*0.35*	*SA*	*3.62*	*0.27*	*SA*	*3.47*	*0.36*	*SA*	*3.53*	*SA*
3. Recipients of spiritual care practices.	*3.46*	*0.38*	*SA*	*3.64*	*0.27*	*SA*	*3.48*	*0.34*	*SA*	*3.52*	*SA*
4. Venue for rendering spiritual care.	*3.51*	*0.41*	*SA*	*3.58*	*0.33*	*SA*	*3.50*	*0.40*	*SA*	*3.53*	*SA*
5. Appropriate time in rendering spiritual care practices.	*3.38*	*0.45*	*SA*	*3.45*	*0.35*	*SA*	*3.40*	*0.43*	*SA*	*3.41*	*SA*
6. Relevance/ meaning of spiritual care practices	*3.55*	*0.35*	*SA*	*3.65*	*0.29*	*SA*	*3.53*	*0.36*	*SA*	*3.58*	*SA*
7. Institutional Support for spiritual care.	*3.38*	*0.39*	*SA*	*3.48*	*0.34*	*SA*	*3.40*	*0.51*	*SA*	*3.42*	*SA*

Acknowledging the connection between spirituality and health implies that health care professionals should attend to spirituality when they provide care to patients. Waaijman (2002) notes that interest in spiritual issues in today's health care sector are growing from two perspectives. Firstly, from the perspective of the patients: the patients must not be identified with their illness; they should not be medicalized, and isolated. Their personal integrity should be respected. Secondly, from the perspective of care: the spiritual life of the patients must be an explicit part of health care. Nurses must be competently trained to address a patient's spiritual needs (Leeuwen, 2008).

Comparative Result of Spirituality Tool

Table 4 shows that among the seven elements included in the spirituality tool only three had significant differences in the three participating tertiary hospital while the rest showed no significant differences.

Three elements showed significant differences across three hospitals, namely: "General manifestation in rendering spiritual care," Specific manifestation in rendering spiritual care, and "Recipients of spiritual care. The results in element 1 stem from the institutions' different orientations. One is a member of Joint Commission International hospital, and the other two are faith - based hospitals belonging to different religions.

The significant difference in element 2 is due to the individuality of a person and the training provided by the institutions. Each institution has its own orientation. There is also a very significant difference in identifying the patients who are the recipients of spiritual care (element 3). Nurses in the three institutions, though they have similarities in identifying the recipients, vary in the degree of frequency. It means that each institution have their own orientation on how spiritual care is being rendered to the patient. The results for the other elements imply that it is transferrable to different contexts other than the participating hospitals.

Table 4. Comparative Result of Spirituality Tool in the Selected Tertiary Hospitals

	X	SD	F-Value	Significance	Remarks
1. General manifestation of Spiritual Care Practices					
Hospital 1	3.39	0.40	6.870	P = 0.001 < 0.01 Very Significant	Hospital 1 vs Hospital 3 Hospital 2 vs Hospital 3
Hospital 2	3.40	0.42			
Hospital 3	3.22	0.45			
2. Specific manifestation of Spiritual Care Practices					
Hospital 1	3.50	0.35	4.973	P = 0.007 < 0.01 Very Significant	Hospital 1 vs Hospital 2 Hospital 2 vs Hospital 3
Hospital 2	3.62	0.27			
Hospital 3	3.47	0.36			
3. Recipients of Spiritual Care Practices					
Hospital 1	3.46	0.38	7.746	P = 0.000 < 0.01 Very Significant	Hospital 1 vs Hospital 2 Hospital 2 vs Hospital 3
Hospital 2	3.64	0.27			
Hospital 3	3.48	0.34			
4. Venue for Rendering Spiritual Care					
Hospital 1	3.51	0.41	1.239	P = 0.291 > 0.05 Not Significant	
Hospital 2	3.58	0.33			
Hospital 3	3.50	0.40			
5. Appropriate Time in Rendering Spiritual Care Practices					
Hospital 1	3.38	0.45	0.828	P = 0.438 > 0.05 Not Significant	
Hospital 2	3.45	0.35			
Hospital 3	3.40	0.43			
6. Relevance/Meaning of Spiritual Care Practices					
Hospital 1	3.55	0.35	3.145	P = 0.054 > 0.05 Not Significant	
Hospital 2	3.65	0.29			
Hospital 3	3.53	0.35			
7. Institutional Support for Spiritual Care					
Hospital 1	3.38	0.39	1.692	P = 0.185 > 0.05 Not Significant	
Hospital 2	3.48	0.34			
Hospital 3	3.40	0.51			

Framework Development

The framework "The Spiritual Practices in Nursing Care" (Fig. 1),is based on the combined results of the thematic analysis of the FGD and the four elements in the spirituality tool with a verbal interpretation of "strongly agree" and bears "no significant differences" in the spiritual care practices in the three selected hospitals.

The light is the spiritual dimension of nursing care. The active presence of the caregiver for the client could be a source of healing. This is based on a transpersonal relationship, which aims at safeguarding the dignity, humanity, wholeness and inner harmony of both a nurse and the client receiving care (Baldacchino, 2010). The nurse is the instrument in bringing the spiritual care to the patients, which is represented by the smoke where "God's presence" evokes the four circles: relational presence, spaces of presence, moment presence, and integral presence.

God is present in the behavior of the nurse as he/she renders spiritual care through "relational presence", which means the physical presence of a nurse manifested in his/her attitude and behavior in bringing the spiritual dimension through respect, compassion, and empathy, and therapeutic communication. According to Zyblock (2010), presence is transformative when patient care experience has the potential to facilitate the patients' healing process, and when nurses can enhance relationship with their patients.

God is also present in the space provided to the patient. "Spaces of presence" are actualized through the provision of silence that allows faith-experience of a patient. The provided space is important to a patient especially for reflection on what is happening to him/her. The silence that the nurse provides gives an opportunity for the patients to be connected with their God.

God is also present in the "moment presence" when the patients are willing to receive spiritual care and when the patients request spiritual needs. Integral presence means that God is always present in the daily blessings and prayer, the provision of chaplain and the chapel/prayer room, the form of support given by the institution.

God's presence is the core of the spiritual practices in the nursing care and God's presence is visible in the nurses and the institution. God always accompanies nurses especially in attending to the spiritual needs of the patients.

Conclusion

Spiritual care is part of the holistic care that is rendered by the nurses. Spiritual care is a necessity to all patients admitted in the hospital and its provision is a primary role of a nurse. This study showed that the integration of spiritual

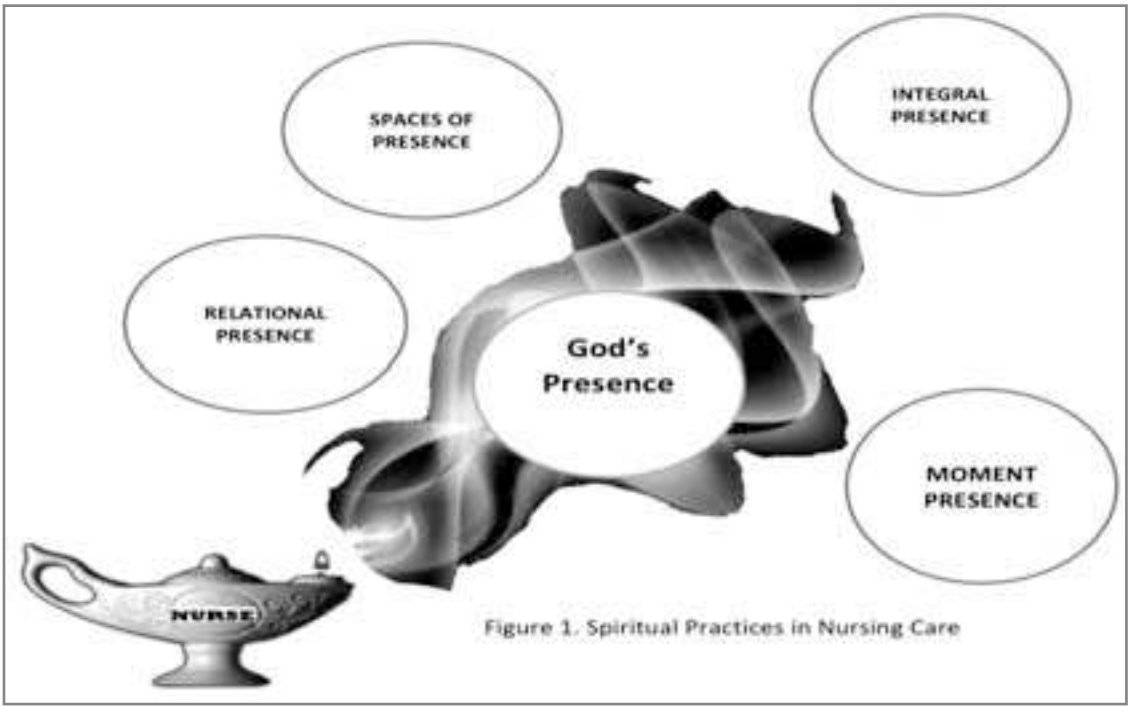

Figure 1. Spiritual Practices in Nursing Care

practices in nursing care creates meaningful experiences to both nurses and the patients. Spirituality is the intimate connectedness to God that reflects on nurses' behavior in taking care of his/her patients. Thus, the role of the nurses' spirituality is important. Nevertheless, spirituality of the nurses goes beyond religion because it speaks about values that include respect, care, compassion, commitment and love to their patient. Finally, the nurse is a channel for providing the spiritual needs of patients. The practice of spiritual caring brings God's presence in each encounter through the relational presence, spaces of presence, moment presence, and integral presence.

Recommendation

A day of recollection or a retreat can be given to staff nurses to be able to renew the relationship with God. Spending a day with the Lord can energize and empower the nurses' capacity to render excellent spiritual practices in nursing care. A value formation could be given to staff nurses for revisiting values in life. The Spirituality Tool that could serve as a guide for the nurses in rendering spiritual care could be recommended to nursing administration of the hospitals. Also, the framework can be shared with the academe, ADPCN (Association of the Deans of the Philippine College of Nursing) where the students can be guided in the actualization of different spiritual care practices in Filipino context. Education can help the future nurses on how to be competent in giving spiritual care. Also it can be shared with nurses' organizations like the Philippine Nurses Association and the Board of Nursing since there is no existing standard for spiritual nursing care. This study can contribute to this aspect.

Implication to Nursing

Spiritual care, together with physical, emotional, social and psychological care is one of the aspects of holistic care. Studies have proven that spiritual care helps in the recovery of the patient. The result of this study strengthens the spiritual dimension in the nursing care of the staff nurses who have the direct access to patients since these nurses do bedside care.

The Spirituality Tool could be useful for the nursing practice. It could serve as a guide in attending to the spiritual needs of the patients. The framework shows how spiritual care practices are being actualized in the Filipino context. Since there is no existing standard on spiritual care, the framework may be used to develop it, which can be a big contribution to the nursing profession.

References

Baldacchino, D. (2010). *Spiritual care: Being in doing*. Marsa Malta: Preca Library.

Barber, J. (2008). *Nursing student's perception of spiritual awareness after participating in spirituality project*. College of St. Mary. Omaha, Nebraska. Proquest, UMI Dissertations Publishing:331514 9

Deal, B. (2008). The Lived Experience of Giving Spiritual Care. Texas Woman's University, ProQuest, UMI Dissertations Publishing,. 3347058.

Jenkins, M. (2009) *The nurse leader's role in spiritual care for hospitalized patients: A grounded theory approach.* University of Phoenix. Arizona USA. Proquest, UMI Dissertations Publishing: 304328201.

Kozier & Erbs. (2008). *Fundamentals of nursing*. 8th edition. vol 2. Prentice Hall: Pearson Education, Inc. Publishing.

Lim , E. (2010). *Embracing Holistic Care through practice, education and research*. 10th regional ASIAN Conference. CICIAMS (Comité International Catholique des Infirmières et Assistantes Médico-Sociales). Retrieved from http://ciciams.org/ ElizebethLim.pdf.

Leeuwen, R. (2008). *Towards nursing competencies in spiritual care*. University of Groningen, The Netherlands.

O'Brien, M. (2011). *Spirituality in nursing. Standing on holy ground*. 4th edition USA: Jones and Barlett Learning.

Pesut B. (2008). Spirituality and spiritual care in nursing fundamentals textbooks. *Journal of Nursing Education*.*47(4)* 167-73.

Swinton, J. (2006).Identity and resistance: why spiritual care needs 'enemies'. *Journal of Clinical Nursing*, *15*, 918–928.

Wintz and Cooper (2009). *Pastoral care leadership and practice group of health care Chaplaincy: Cultural & spiritual sensitivity. A learning module for health care professionals and dictionary of patients' spiritual & cultural values for health care professionals.* New York, Health care chaplaincy.

Zyblock, D.M. (2010). Nursing presence in contemporary nursing practice. *Nursing Forum*. *2*, 120-124. doi:10.1111/j.1744-6198.2010.00173.x.

About the Author: ***Sofia Magdalena Robles*****,** PhDNEd, RN earned her Bachelor of Science in Nursing at University of St. La Salle –Bacolod in 1989. Obtained her Master of Arts in Nursing, major in Nursing Administration from Manila Central University in 1998 and finished her Doctor of Philosophy in Nursing Education major in Leadership and Management at St. Paul University – Manila (SPUM) in 2014. She is currently an Associate Professor and the treasurer of the PNRS Research Cell of the Centro Escolar University, School of Nursing.

Acknowledgement: *This article is derived from the dissertation requirement for PhD in Nursing at SPUM. The author wishes to thank Dr. Gerardo L. Guiuan, Dr. Nieves Medina, Dr. Aida Villanueva and Dr. Teresita I. Barcelo for all the valuable support given in the conduct of the study and in writing the article.*