

**Spirituality in
nursing care:
online resource**

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Spirituality in nursing care: online resource

In 2010 the Royal College of Nursing (RCN) surveyed its members about spirituality and spiritual care (RCN 2011a). Following the survey the RCN established the Spirituality Task and Finish Group. The Group developed the “Spirituality in nursing care: a pocket guide” (RCN 2011b) This online resource expands upon the pocket guide to enable qualified nurses, nursing students and health care assistant/support workers to develop their knowledge and understanding of spirituality and spiritual care. Both resources will be of use to other health care professionals, allowing them to engage with and address important questions about the spiritual part of care.

Media headlines have brought attention to the potential conflict that can exist between personal spiritual values/beliefs of nursing staff and their practice. This online resource will enable nurses to explore these relationships in an interactive and reflective way developing self-awareness and highlighting implications and considerations for nursing practice.

Two nurses from the RCN spirituality survey said:

“Spiritual care is a fundamental part of nursing, currently much neglected through ignorance and misunderstanding. It is distinct from religious care or support for patients / clients faith needs, although these may make up part of spiritual care.”

“I believe that spiritual care is not only an essential component of nursing practice but often the arbiter of how a patient responds to their illness and life experiences. It would appear that when people encounter certain life events like serious trauma and illness, fundamental spiritual issues often emerge that question their very existence. If medicine involves the recovery of the body, then spiritual care as a core component of nursing, involves a recovery of the patient as a person. These areas do not sit in contention, but aim to complement each other and serve to remind us that “there is no profit in curing the body if in the process we destroy the soul”.

Headlines

Recent headlines have raised questions about the overall quality of nursing care provided in some National Health Service (NHS) organisations and the appropriateness of nurses providing spiritual care to patients.

Quality of Care

The following quotations taken from two recent reports raise some serious failings in nursing practice which may account in part for the poor image associated with nursing.

Claire Rayner, the late president of the Patient’s Association and herself a nurse, spoke of nurses in the following terms:

“For far too long now, the Patients Association has been receiving calls on our Helpline from people wanting to talk about the dreadful, neglectful, demeaning, painful and sometimes downright cruel treatment their elderly relatives had experienced at the hands of NHS nurses.” (Patients Association 2009 p3)

If one looks in the summary of the Health Care Commission (2009 pg 6) Investigation into Mid Staffordshire NHS Foundation Trust there is evidence that within nursing and health care there is a lack of basic humanity and older people are treated without dignity and respect.

“The care of patients was unacceptable. For example, patients and relatives told us that when patients rang the call bell because they were in pain or needed to go to the toilet, it was often not answered, or not answered in time. Families claimed that tablets or nutritional supplements were not given on time, if at all, and doses of medication were missed. Some relatives claimed that patients were left, sometimes for hours, in wet or soiled sheets, putting them at increased risk of infection and pressure sores. Wards, bathrooms and commodes were not always clean.”

More recently this theme is explicit within the Parliamentary and Health Service Ombudsman (2011) report “Care and compassion? Report of the Health Service Ombudsman on ten investigations into NHS care of older people”.

The question that must be asked is why patients are being treated with lack of dignity, humanity, care and compassion. Perhaps Rev Professor Stephen Wright (2011 p19) sheds some valuable light on this when he writes:

“Bad nursing does not come down to bad nurses,..., but bad care systems, ‘Nursing is heart-centred work. It is hard to offer care and compassion to others if you are not getting that from your workplace (Wright 2011 p19)”

This quotation implies that the entire organisation of care may have a part to play in nurses not being able to offer the care that patients and their loved ones want and expect.

Spirituality, religion and nursing practice

In 2009 the relationship and role of spirituality and religion within nursing practice were brought to the profession’s attention. The following cases are examples of some of the headlines:

BBC (1 February 2009). “Nurse suspended for prayer offer”

<http://news.bbc.co.uk/1/hi/england/somerset/7863699.stm>

BBC (20 September 2009). “Row over nurse wearing crucifix”

<http://news.bbc.co.uk/1/hi/england/devon/8265321.stm>

Nick Trigg (28 June 2009). “Doctors want right to talk faith”

<http://news.bbc.co.uk/1/hi/health/8116497.stm>

These headlines bring into question some important issues around the role of religious beliefs and spirituality within the health care professions. They also raise some fundamental questions about the role of nurses in supporting patients and clients in meeting their religious and spiritual needs and the relationship between personal belief and professional practice.

In March 2010 the RCN responded to some of the issues raised in the media by commissioning an online survey to ascertain its members' perceptions and understandings of spirituality and spiritual care.

Here are some key findings from the survey:

- 4054 members responded. This is the second largest response by members to any RCN online survey and indicates the importance that members place on the spiritual dimension of care.
- The largest proportion of respondents were from NHS hospitals and community (60.2%) with staff nurses being the largest group represented (25.4%). All levels of RCN membership participated including qualified nurses, nursing students and health care assistants/health care support workers.
- 93.5% felt spiritual care involves the personal attitudes and disposition of the nurse in providing care such as showing kindness, concern and being cheerful.
- 95.5% said that they had encountered patient(s) with spiritual needs with 41.4% doing so on a daily basis. Only 3.5% of nurses said they had not encountered a patient with a spiritual need.
- 92.2% indicated that they are only 'sometimes' able to meet their patients' spiritual needs.
- 83.4% felt that spirituality and spiritual care are fundamental aspects of nursing care.
- 79.3% felt that nurses do not receive sufficient education and training in spirituality and spiritual care.
- 78.8% said that guidance and support should come from the Nursing and Midwifery Council (NMC).
- 78.1% felt that the RCN also has a responsibility in this area.
- 90% agreed that providing spiritual care enhances the overall quality of nursing care.

Fundamental aspect of care

Over the years the World Health Organisation (WHO) has made many statements about the importance of the spiritual part of the person. For example it states:

'Until recently the health professions have largely followed a medical model, which seeks to treat patients by focusing on medicines and surgery, and gives less importance to beliefs and faith. This reductionist or mechanistic view of patients as being only a material body is no longer satisfactory. Patients and physicians have begun to realise the value of elements such as faith, hope and compassion in the healing process. The value of such 'spiritual' elements in health and quality of life has led to research in this field in an attempt to move towards a

more holistic view of health that includes a non-material dimension, emphasising seamless connections between mind and body.’ (Cited in NHS Education for Scotland, 2009, p7).

This sentiment is similarly reflected within nursing and other health care organisations that make reference to the spiritual aspect of care:

Nursing Midwifery Council (2010) Standards for pre registration nursing education

Available from:

<http://standards.nmc-uk.org/PublishedDocuments/Standards%20for%20pre-registration%20nursing%20education%2016082010.pdf>

International Council of Nurses (2006) Code of ethics for nurses

Available from:

http://www.icn.ch/images/stories/documents/about/icncode_english.pdf

Accessed [12-4-2011]

Government health departments:

England: Religion or belief: a practical guide for the NHS Available from:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093133

Accessed 12-4-2010

Scotland: NHS Education for Scotland Spiritual Care:

Available from:

<http://www.nes.scot.nhs.uk/disciplines/spiritual-care>

Accessed 12-4-2011

Wales: Standards for Spiritual Care Services in the NHS in Wales 2010

Available from:

<http://wales.gov.uk/topics/health/publications/health/guidance/spiritualcarestandards/?lang=en>

Accessed [12-4-2011]

Other drivers for the integration of the spiritual dimension within nursing care can be found in models of nursing practice, the philosophy of holistic care and indeed wider society with its diverse religions and belief.

What nurses have asked for

Nurses who responded to the RCN spirituality survey expressed the need for the following:

- more education and guidance
- clarification of personal and professional boundaries
- personal support in dealing with spiritual issues
- further dialogue with United Kingdom (UK) government health departments and the NMC.

Why this resource? Who can use it? How do you use it?

This resource provides an introduction to the concepts of spirituality and spiritual care. It is a site encouraging reflection, both personally and professionally, on the issues of spirituality and spiritual care. It is designed to enable you to explore these concepts at your own pace. If you want to further your knowledge and understanding in this area then you can follow the links to additional resources provided. The resource is presented under three headings:

1. What spirituality is and is not
2. Providing spiritual care: being and doing
3. Personal and Professional Boundaries

Under each heading relevant quotations from the recent RCN survey are given. A limited number of case studies and/ or exercises are then provided to foster further exploration of the topic. **(The case studies are reproduced from McSherry (2006) with kind permission from Jessica Kingsley.)**

1. What spirituality is and is not

What is spirituality?

Spirituality is a difficult concept to define. However this should not diminish its significance or credibility. It is no more complex than other commonly used terms within health care. Think how difficult it is to define everyday health care terms such as care, community, love, attention, affection and so forth. The fact that spirituality is difficult to define and that people tend to define it in different ways is not unusual in terms of the language we use as health care professionals. One way of understanding spirituality is to think of it in this way: *A person's spirituality relates to those core beliefs about reality...the way things are, that enable them to make sense of and cope effectively with their experiences, including their experiences of illness.*

One of the things we often overlook is that all *illnesses are first and foremost deeply meaningful human experiences*. Professionals may offer diagnoses – cancer, schizophrenia, appendicitis, depression, anxiety, influenza – but behind these labels are real people experiencing their illness within particular contexts accompanied by specific emotions and understandings. Illness is always *my* illness. “Illnesses are deeply meaningful events within people’s lives, events that often challenge people to think about their lives quite differently. Spirituality sits at the heart of such experiences. A person’s spirituality, whether religious or non-religious, provides belief structures and ways of coping through which people begin to rebuild and make sense of their lives in times of trauma and distress. It offers ways in which people can explain and cope with their illness experiences and in so doing discover and maintain a sense of hope, inner harmony and peacefulness in the midst of the existential challenges illness inevitably brings. These experiences are not secondary to the ‘real’ process of clinical diagnosis and technical care. Rather they are crucial to the complex dynamics of a person’s movement towards health and fullness of life even in the face of the most traumatic illness.” (Swinton 2005)

Spirituality is about:

- **Hope and strength:** Finding sources of hope and strength in the midst of situations that often appear quite hopeless.
- **Trust:** Learning to trust when all of the things you had previously placed your faith in have been broken by your illness experience.
- **Meaning and purpose:** Illness challenges the way in which we see ourselves and the world. It reminds us of our mortality and forces us to reflect on what life is all about. How can we find meaning and a reason to go on when our lives have been shattered by illness?
- **Forgiveness:** Finding ways to forgive others, one’s self is an important aspect of spirituality. Illness is often accompanied by deep self reflection wherein old wounds are opened up and broken relationships are remembered and grieved for. How can these wounds be healed? If a person has a faith in God, then it may be necessary to explore what it means for them to seek forgiveness or to be able to forgive God for allowing them to get into the situation they are in. reconciliation often takes on great importance in the context of illness.
- **God:** For some people god and/or religion is important. A person’s religion gives them a framework of ideas, stories, narratives, symbols and rituals that they use to make sense of their situation. A person’s illness experience will be deeply affected by what they believe about god, the world and the meaning of their illness. To miss the religious meaning of illness for religious people is to misunderstand the illness experience at a basic level.

- **Confidence:** Spirituality focuses on the things that are most important to the person and to that which provides meaning and value. As such, the spiritual dimension of people's lives is that aspect which gives them confidence and stability; confidence in the fact that they understand the way the world works and their place within it. Illness destroys confidence at this level and as such raises profound spiritual issues relating to people's perception of the world and their confidence of their place within it.
- **Values:** Illness raises issues of what is and what is not valuable. Spirituality relates to that which a person feels is most valuable in their lives and the specific means by which such values are recognized and actualised.
- **Love and relationships:** Human beings are fundamentally relational. We live to love. This is an aspect of humanness that finds verification in sociology, psychology, medicine and theology. Illness may fracture relationships and isolate persons. Spirituality relates to this basic human impulse to relate and raises our consciousness to the centrality of love for care.
- **Creativity and self expression:** Spirituality relates to creativity in that its focus on the hidden meaning filled dimension of people's experience which often cannot be articulated through straight forward language. It is through the arts, painting, poetry and non-verbal modes of expression that people often find ways of expressing these hidden dimensions of human experience. Spirituality reminds us of the centrality of creative and imaginative experience for our understanding of health and illness.

Looked at in this way, a focus on spirituality is a powerful reminder of the importance of looking at all of the dimensions of human beings and not being distracted by the seductive temptation towards a generalised approach to human beings. Spirituality encourages generalist care in the midst of a specialist culture.

Spirituality is not:

- **An idea that has no connection with clinical practice:** From the description above it is clear that spirituality has clinical significance. In order to care for people it is necessary to know what their illness is in a technical medical sense. It is however crucial to know and be able to recognise what the *meaning* of the illness is at the level of the personal. It is not enough to know what an illness is without also recognising what it may or may not *mean* to unique individuals. Meaning matters.
- **Just about religious beliefs and practices:** Spirituality is not only a religious concept. It is something that applies to people of all faiths and none. Within the health care conversations around spirituality, people have come to separate spirituality from religion. Thus people can be spiritual in the sense outlined above, but not necessarily religious. As you will see, the perspective on spirituality outlined above is clearly intended to be open to all people. That is not to say that religious people do not have spirituality. It is simply to point out that it is not necessary to be religious to have the particular needs that are brought together under the term 'spirituality.'
- **Something that is only important for chaplains:** Chaplaincy is a vital and important aspect of spiritual care. However, chaplaincy is not the only discipline that benefits from understanding and recognising what spirituality is and how it functions in the lives of people experiencing illness and distress. Spirituality relates to all of the health care disciplines. However, chaplains do have specific expertise within the area of spirituality and should be perceived both as experts in the field and as vital resources for teaching and educating other health care professionals about spirituality. Spirituality is a multidisciplinary issue.

- **Only important for patients:** While learning to recognise the spiritual is vital for carers, learning to see the importance of the spiritual within carers is equally as important. Carers are spiritual people and learning to work with one's own spirituality within a caring context is a vital tool for holistic care.
- **About imposing your own beliefs and values on another:** To suggest that the spirituality of carers is important is not to suggest that it is in any way appropriate for carers to impose values and beliefs on patients in situations where they are clearly vulnerable. It is however to suggest that carers have a spirituality and spiritual needs which it is important to meet. To care well one needs to be cared for well.

Some nurses who responded to the survey said spirituality is about:

“Looking after patients in a holistic manner respecting their dignity and treating each individual as a separate person with views of their own”

Reflective questions:

- How does spirituality help us to see people as wholes instead of parts?
- What problems might arise when you try to put this into practice? How might they be overcome?

“Spirituality is different from religion. A person can be very spiritual and have spiritual needs without belonging to a religion. Spirituality unites people, whereas religion may cause divisions and conflicts.”

Reflective questions:

- Would you agree with this statement?
- Would religious people agree with what is being said?
- Is there a danger that spirituality in its generic sense, can become exclusive and intolerant?

“I think while some kind of spiritual support is helpful for some patients, it is not necessarily fundamental to nursing, although an awareness of a patients' spiritual needs may help the nurse give the patient more personalised care. As in all areas of nursing, if a nurse feels unable to deal with the spiritual needs of a patient, they should refer the patient to someone who can. As an atheist I almost always find that a caring, respectful and interested attitude towards patients counts for far more than any specific religious beliefs.”

Reflective questions:

- How do you think this person is thinking about spirituality?
- How will their perspective impact upon their dealings with people who have specifically religious beliefs? What might the miss?
- What can be learned from such a response?

“... It is about a sense of personal value and meaning, a sense of being valued for who we are be that by ourselves, by others or by our God. Spirituality transcends all that each of us does or does not do it is what is left when we strip away all material things and all matters worldly that

underlying sense of who we are, how we relate to ourselves, to others and to the universe as a whole.”

Reflective questions:

- What positives and negatives would you draw from this statement?
- What might it mean to relate to the universe?
- Is there a danger that sometimes our understandings of spirituality can be so otherworldly that they make little sense of the present situation?

“Every person is unique and should be treated with dignity and respect. They should be able to express their hopes and expectations of what has deepest meaning for them. In essence, this is recognition of the spiritual dimension of each person.” (DH 2008 p 76)

Reflective questions:

- What might this understanding mean for your area of practice?
- What would need to be changed in order for this to become a realistic possibility?

Case studies

Case study 1: Who knows best?

A young woman is brought into the accident and emergency department with a massive gastrointestinal bleed presumed to be oesophageal varices. Immediately the medical and nursing teams start to resuscitate the woman and the consultant asks for 4 units of blood to be transfused. However, the woman interrupts and states that she does not want the blood transfusion because of her personal beliefs. Therefore other volume-expanding agents have to be used. Unfortunately the woman dies from the haemorrhage several hours later. Talk around the department is, ‘if only the woman had not refused a blood transfusion’. Others say, ‘what a waste of life’. Yet the woman’s husband says, ‘God’s will was done and she approached death as she believed was right’.

Case study reflection:

Whose beliefs are correct in this situation?: The woman’s religious belief that being faithful to her God is more important than saving her life, or the health carers who see saving her life as more important than her belief in God? Why? (Remember, from both perspectives what is being asked for is considered to be the correct and most ethical alternative.)

Some aspects you may have considered:

- The sudden death of a loved one is almost always shattering. Not only might the bereaved experience an emotional crisis, they may experience a spiritual crisis where as one bereaved parent recalled, “everything is smashed, my hopes, my dreams, my future, my faith...”
- Strongly held beliefs may be the only thing that is intact for the woman’s husband. Whilst he comforts himself in the knowledge that she died as her beliefs allowed her to, he is never the less facing bereavement through the traumatic and sudden death of his wife.

- Appropriate and compassionate support in the immediacy of bereavement may well be the best spiritual care that can be offered.

Case study 2

John, aged 75, is admitted into hospital with a chest infection. While admitting John the nurse enquires about his occupation. He replies, 'I'm recently retired. I was a school teacher – and do you know something? I didn't think I'd miss it – all the hassle – when I retired, but I do! Life seems to have lost some of its meaning, now that I don't work.'

Case study reflections:

- Could work be considered an aspect of spirituality? Why?
- If work is deeply tied in with personal identity, worth, value and confidence, how might you help John re-think his spirituality?

Some aspects you may have considered:

John has only recently retired at 75 which suggests that teaching was his life. His identity may well be bound up with his work. It may well be that he has had no one to talk to about this. He might need to get something off his chest! Helping John get back in touch with memorable aspects to his teaching may remind John that he hasn't lost that part of his life.

You could ask John?

"What are your favourite memories from your teaching days?"

"Who are the people that you remember most?"

Exercise/exploration

Exercise: A spiritual person (Reproduced from 'Values in Healthcare: a spiritual approach' with kind permission from The Janki Foundation for Global Health Care 2004, p344)

Individually or as a group:

Think of someone you know that you consider spiritual in some way.

Describe to your partner what qualities they have, or things that person does, that makes them spiritual.

If you cannot think of anyone, use a character from history.

In the same pairs, share with your partner what your special qualities are, and how you express them.

(You may have listed qualities like compassionate, caring, altruistic, kind, listens, is always there for you. The qualities in both lists may be similar indicating that all people, including you, are spiritual. This exercise helps to dispel the misconception that spirituality = only religion).

2. Providing spiritual care: being and doing

Having looked at what spirituality is and is not, in this section spiritual care is explored.

Spiritual care has been defined as:

‘That care which recognises and responds to the needs of the human spirit when faced with trauma, ill health or sadness and can include the need for meaning, for self worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener. Spiritual care begins with encouraging human contact in compassionate relationship, and moves in whatever direction need requires.’ (NHS Education for Scotland 2009)

Quotations

Here is what two nurses who responded to the RCN survey had to say about spiritual care:

“I think that many nurses confuse spirituality with normal compassion and caring. While in practice, I was happy to listen to patients talk about their beliefs, but did not feel it was my place to discuss 'why God was letting this happen to me' etc. Although I am an atheist that would never prevent me from seeking advice from, or referring the patients to, those who would provide the 'spiritual' aspects of care the patient required. Need clarification on terms here though. Spiritual does suggest a 'religious' bent to care, that is, listening to the patient, acting with compassion etc. But as mentioned earlier, such approaches are part and parcel of good nursing care. You listen, empathise, sympathise, know when to talk and when simply not to say anything, you know when to 'be with' the patient and when they might just need time alone. This is not spiritual in any sense other than good nursing.”

“I don't think patients necessarily ask for spiritual care specifically but a nurse provides it in the way she/he gives time to the patient to discuss their illness and in the way she/he treats that patient e.g. with dignity, respect etc. I think spirituality is a fundamental part of a person's make up, whether they practice a particular form of spirituality or not and we all have a spiritual aspect to ourselves.”

Reflective questions

It may be helpful to explore spiritual care further by asking the following questions:

- When does the spiritual come into focus?
- What does spiritual care look like and what does it do?
- What skills are needed?

When does the spiritual come into focus?

Whilst the spiritual is a part of everyday life for many people, it often comes into sharper focus in times of crisis. It has been said that:

Many individuals do not seriously search for meaning and purpose but live as if life will go on forever. Often it is not until a crisis occurs (illness, suffering, death) that the illusion of security is shattered. Illness and suffering, and ultimately death, become spiritual encounters as well as physical and emotional experiences". (Granstrom in Hitchens 1988, p26)

The nurse will often be the health care professional present during such times of crisis and therefore in a position to respond.

The sentiment of the spiritual coming into focus in times of illness is also reflected in the following nurse's statement in the RCN survey:

"Being in hospital is a very anxious time for patients undergoing treatment. If we found out how they coped with anxieties in their life we would be help them to adhere to treatment better and ensure better health outcomes. Nursing is about caring and I think you have to be passionate about providing good quality care to provide the spiritual support people seek out. The DOH are pushing statistics, cures and good results. However, this means the 'essence' of caring for human emotions and lives is being pushed out in the name of statistics and government targets."

What does spiritual care look like and what does it do?

Read this incident from clinical practice (adapted from Ross 1997, p3).

Mrs T was an elderly lady in long term care. She was a tiny bird like creature who had no teeth, had sunken cheeks and never spoke, except to whimper in pain when she had her dressings changed. She was bed bound and had a large pressure sore on her hip which was infected and revealed bone. It required daily dressing and she needed strong pain killers before the dressing could be attempted. She required regular turning and help with feeding (liquidised diet) and drinking. The 4 walls of the ward and the ceiling were her entire world. She stared into space with a glazed, dull lifeless expression. In my view as an 18 year old care assistant, she had very poor quality of life and was more or less waiting to die. One day whilst tidying the lockers I came across an old Bible stuffed at the back of her drawer. Clearly it was well used. I considered asking her if she would like me to read a passage to her, but was fearful that I might get into trouble with the ward sister as I was unsure if this was part of my job. I waited until the ward sister was off duty one weekend and plucked up the courage to ask Mrs T if she would like me to read to her from her Bible. The change in her expression was remarkable. Instead of lying sleeping or staring blankly into space, her eyes widened, she strained to raise her head, smiled and tried to mouth the words with me whilst reaching for my hand. Looking back on it, she had a spiritual need.

Reflections: Reflecting on this example of spiritual care, take a blank piece of paper and divide it into 2 columns. In the first column write down what spiritual care looks like e.g. what does it involve? What action is taken? Then in the second column write down what spiritual care does. What effects does it have? y The following lists are not exhaustive.

- | | |
|------------------------------------------------|-----------------------------------|
| ▶ Picking up a clue | ▶ Enlivens/ 'spark' |
| ▶ Taking a risk | ▶ Changes to expression |
| ▶ Engaging with person | ▶ Interaction/connection |
| ▶ Dialogue/permission | ▶ Emotion |
| ▶ Acting – facilitating a religious/faith need | ▶ Reaction |
| ▶ Religious ritual | ▶ Meaning |
| ▶ Touch | ▶ Hope |
| ▶ 'Being with' | ▶ Reconnection with God |
| | ▶ Feeling of being loved & valued |

What does it look like?

What does it do?

In the previous example attention focused on what action was taken in giving spiritual care by asking the question 'what does it do? However spiritual care is not just about 'doing to' a patient/client; it also involves 'being with' them. This means that our attitudes, behaviours and personal qualities will be important and will influence 'how we are' with people. Although the example included a religious element, spiritual care is not just about religious beliefs and practices. It is not about imposing our own beliefs and values on another or about using our position to convert. It is about meeting people at their point of deepest need. It involves treating spiritual needs with the same level of attention as physical needs. Just as you would assess your patients' physical needs, an initial assessment of their spiritual needs is also important. You may find questions like these helpful in the assessment:

- Do you have a way of making sense of the things that happen to you?
- What sources of support/help do you look to when life is difficult?
- Would you like to see someone who can help you talk or think through the impact of this illness/life event? (you don't have to be religious to talk to them).

Spiritual care can then be planned, implemented and evaluated in the same way as physical care (McSherry & Ross 2010).

So what skills are needed in order to give spiritual care?

What skills are needed?

The following skills may be useful in the delivery of spiritual care:

- Adopting a caring attitude and disposition.
- Recognising and responding appropriately to people's needs.

- Using observation to identify cues that might be indicative of underlying spiritual need e.g. people's disposition (sad/withdrawn), personal artefacts (photographs, religious/meditational books and symbols).
- Giving time to listen and attend to individual need.
- Being aware of when it is appropriate to refer to another source of support e.g. chaplain, counsellor, another staff member, family or friend.
- Looking for the best in the worst.
- Being personally hope-filled, believing that what one does and what one is, is always of some value. Knowing that it is never too late to do good.

You may find the following case studies and exercises helpful in exploring spiritual care further.

Case studies

Case study 3

Mr Singh Bhuller is a practising Sikh. The wearing of religious symbols and prayer are fundamental. Mr Singh is concerned that his customs and daily rituals will not be maintained while in hospital.

Case study reflections: You are the admitting nurse working on a busy, general surgical ward. Can you identify the general principles that would help Mr Singh to continue observing his religious practices while in your care?

You may have considered the following: Don't make assumptions about what Mr Singh might need; ask him or his family. This will require developing a relationship with Mr Singh or his family.

Simply ask for example: *"Mr. Singh, could you tell me about your daily practice? It would interest me to know and it will help me to find ways to enable you to practise it."*

"Is there anything else that you think you might need?"

Also be mindful that the experience of being in hospital and impending surgery may have provoked anxiety for Mr Singh. Daily practice might be one way that he copes with or overcomes those anxieties.

Exploring those anxieties may also be helpful for Mr Singh.

Case study 4

Martha is 56 years old. At the age of 50, she was diagnosed with pre-senile dementia. The signs and symptoms had been associated with stress. However a CT scan confirmed organic changes and the diagnosis. Prior to her diagnosis she had been a highly successful businesswoman. Her final position was director of a large international company. Despite being successful Martha had a strong belief and faith in a God but did not attend any formal religious organisation.

In her spare time Martha had enjoyed a range of activities such as travel, painting and regular cross-country runs in the country. Martha liked to spend time on her own reflecting and keeping in touch with the creative aspects of her personality. The slow progression of the disease meant that Martha

was very much aware of the deteriorative nature of the illness and the result that this might have upon her life. As the disease progressed she was unable to maintain her interests and activities. She became withdrawn and isolated within her own inner world. Familiar faces and locations lost their meaning. Martha's modesty and privacy were lost as she began to become incontinent. Her entire personality changed, resulting in aggressive outbursts, and on several occasions household objects were thrown around the room. Martha had become the complete opposite to everything in which she believed.

Reflections:

- What spiritual needs does Martha have?
- What can be done to try to address these needs?

Possible answers:

Spiritual need	Intervention
Identity	<p>Try and look beyond the appearance of Martha now to see the Martha who once was.</p> <p>The family's story as well as photographs will help the nurse to reconnect with her identity.</p> <p>Helping the family will also be a way of caring for Martha.</p>
Rediscover belief and faith in God	<p>Martha may need to remember old faith experiences. 'Re-membering' through religious activity is a means by which one is reconnected to previous experiences in a way that involves more than 5 senses.</p> <p>Talk to family about what practices were meaningful to Martha prior to her illness and try to facilitate these.</p> <p>Consider involving chaplain with Martha/family's permission. Chaplains have extensive training and experience of praying for, with and alongside others.</p> <p>Establishing whether some religious practice e.g. reading of scripture and/or prayer would be helpful to Martha.</p>
Meaning and purpose	<p>Together with Martha and family, identify activities that could bring meaning and purpose such as art, walking and try to facilitate these. Possibly use photographs of her trips abroad to encourage discussion.</p> <p>Consider displaying some of Martha's paintings by her bedside.</p>
Love and belonging	<p>Encourage visits from old friends and work colleagues.</p>
Maintain dignity and modesty	<p>Consider means of minimising incontinence and deal with this sensitively when it occurs.</p>

Exercises/explorations

Further exercises involving poetry/literature (taken from 'Caring Heart and Soul: Uncovering the path to the heart' and study day for health care professionals run by Dudley Group Healthcare NHS Foundation Trust.)

Exercise: The Space Between

The psychoanalyst, Donald Winnicott, once wrote a book with guidelines for the caring interactions of social workers. In the title, he used the phrase, '*the facilitating environment*' (Winnicott, 1965). The term 'the facilitating environment' refers not just to the room and physical environment, but to the carer through whose presence a person is helped. The writer Michael Jacobs describes this as 'Space Between' (Jacobs, 1985).

Soulful, professionally artistic, practice would be the creation, holding and maintaining of this space between in each of our encounters as carers. Spiritual care is founded on soulful practice.

Reflections

- When do you create a space between for patients and visitors?
- What helps? Time? Setting?
- What hinders?
- What are you doing when it is there the most?
- What does it feel like?

Recognising the Space Between

It is a meeting at the level of humanity. There are many uniforms in health care and especially in the hospital setting: nurse, physiotherapist, doctor, chaplain etc. Each professional group may have a distinctive uniform. Even patients have a kind of uniform, pyjamas and dressing gowns.

Uniforms signify something about our role and what others might expect of us. They are introductory, opening sentences to deeper exchanges.

When we meet at the level of humanity carers reach from behind their uniform and see beyond the surface of the other person.

Reflections

If you really want to help somebody, first of all you must find them where they are and start from there. This is the secret of caring.

If you cannot do that, it is only an illusion, if you think you can help another human being.

First you must understand what the other person understands. If you cannot do that all your understanding (and knowledge) will be of no avail (Kierkegaard, 1856).

The more you think of yourself as therapist/ nurse, the more pressure there is for someone to be a patient (Das & Gorman, 1985).

A meeting is a strange and wonderful thing,

Presence one with another,

Present one to another,

Life flowing one to another

But we can be together and not meet...

Jean Vanier, Tears of Silence (1979)

The space between is a 'safe place' where people can ask the 'slow questions'.

Slow questions are those deeper questions that people are wanting to ask, but are often frightened to ask. Sometimes because they are frightened of the answer or imagine what the answer might be.

The *slow questions* often need the right person, and the right time and the right place.

Sometimes people ask the *slow questions* not to get answers but just to be understood.

Reflections

- When have you responded to a patient's request for some simple need to be met and found that this was a prelude to something deeper?
- What was your response: to the patient? to yourself?

The Slow, Slow Questions

The slow, slow questions wait,
In hiding.
They wait until they perceive that
Once exposed in the open they
Won't be dropped or damaged.
Even a 'space (opened) between will suffice
Only after delicate testing
Emerging from the shadows
The slow, slow questions search for
Somewhere to alight.
A bird flying to a perch

Does it matter that the song
Is not replied to?
The slow, slow questions
Sing as sing they must.
The reply? Ah! The slow, slow, slower answers
Reach and embrace the questions,
Not with words
Not in song
But as dance
The dance of love.

Mark Stobert

The space between can contain and embrace the chaos. Where pain and suffering can exist and find their place.

We suffer because
We suppose that there should
Be no fear or loneliness
No pain or doubt.
The chaos of these
Sufferings
Become creative when we
Understand them as wounds
That are part of being
Human.
If we can embrace
The chaos of pain
With compassion
We will give it space
Within us.
Then liberation starts
And there is a new creation.

Mark Stobert

So at some level, we care with all our heart ...and then we finally let go. We give it all that we have ... and trust the rest to God, to Nature, to the universe. We do everything we can to relieve someone's suffering – our dearest's, our beloved's, anyone's – but we are willing to surrender attachment to how we want things to be, attachment even to the relief of suffering. Our heart may break ... and then we surrender that too. – (Dass and Gorman 1985)

Meetings at the Edge is a book containing a series of conversations that Stephen Levine had with people who were dying, being healed, caring for the dying as carer or friend or relative. They were people who were brought to their edge of what they thought was their capacity for entering into unexplored life and growth. It's a book about the exploration of the unexpected and often unprepared for, and the fear and doubt and courage and faith with which it is faced.

Stephen Levine describes the journey as:

'a high wire act where the heart is kept open in hell, to maintain some loving balance in the face of all our pain and confusion; to allow life in; to heal past our fear of the unknown.' (Levine 1984)

In the space between the search for meaning can be replaced with the experience of it:

'People are searching not so much for a meaning in life, but an experience of being alive, so that our life experiences on the purely physical plane will have resonances within our own innermost being and reality, so that we feel the rapture of being alive.' (Campbell 1988)

It is possible that spiritual care, through the soulful practice of an understanding other, may prove to be transformative for the patient.

"The roots of resilience are to be found in the sense of being understood by and having the sense of existing in the heart of a loving, attuned and self possessed other." (Fosha 2003)

These experiences are not one way. Carers may themselves experience meaning in the same encounter. It may help to sustain them.

And that's OK.

Reflections:

- What have been the most memorable experiences in your work? Have you let them nurture you?
- The Space Between is created, held and maintained by our own inner space, or empathetic space.
- It can be helpful to imagine an inner space set aside and nurtured for the task of caring.
- Creating and maintaining boundaries makes this empathetic space safe for us to be affected by those we care for.

Reflections:

- How do you create an inner space with boundaries for your caring work?

The following illustrates one way of conceiving boundaries that create an empathetic space:



It is important to nurture the space by caring for yourself and developing a ‘*menu of refreshment*’.

Reflections:

What’s on your menu?

The Magic Hour

If you could have an extra hour every week just for you and for your refreshment, how would you spend it?

The top three in one NHS Trust were:

- a relaxing bubble bath.
- reading a good book
- going for a walk

Try and make your own magic hour! Remember, you are worth it!

3 Personal and professional boundaries

At this stage you are probably starting to appreciate that spirituality can have a range of meanings and people may have diverse understandings of the concept depending upon their own world view. One's world view may be shaped and influenced by such things as culture, religion, ethnicity, and race and ultimately the society in which we live.

The UK is no longer a mono-cultural but multi-cultural, meaning that during the course of their practice nurses may encounter and engage with individuals from diverse cultures, religions and ethnic groups. Therefore, it can be said that nurses working across all sectors and with all client groups are in a position of power, influence and ultimately trust.

In recent years nurses have been in the headlines for a whole range of reasons, good and bad but one headline in particular brings into question the relationship between personal belief and professional practice. The Telegraph (2009) reports a nurse who was suspended for offering to pray for an elderly patient's recovery (<http://www.telegraph.co.uk/health/healthnews/4409168/Nurse-suspended-for-offering-to-pray-for-patients-recovery.html>)

Integrating personal belief and professional responsibility

The Nursing and Midwifery Council (NMC) (2008) Code of Ethics outlines the standards, behaviours and practices expected of all registered nurse in the course of their practice. Nurses must study and consider this along with all the other rules, standards, guidance and advice published by the NMC. One central theme within 'The code' is that nurses should not use their privileged position to pursue their own goals or purposes. This is reflected within the following clauses:

"You must not abuse your privileged position for your own ends."

"You must not use your professional status to promote causes that are not related to health."

Not abusing one's privileged position and promoting causes not related to health can be interpreted and applied to the area of personal belief, in that a nurse does not have the right to impose their own personal beliefs, values or opinions on those in their care. This means that nurses must be fully aware of their own personal beliefs and how these might influence their professional practice. For example to impose one's religious beliefs on individuals in one's care and using nursing practice as a vehicle to do this is morally, ethically and professionally wrong.

The remainder of this section will explore the relationships between personal belief and practice providing some guidance on how these can be managed within nursing practice.

Quotations

Here are what three nurses in the RCN survey had to say about personal belief and nursing practice:

'I think that patients should be able to ask nurses about their own faith and for nurses (especially Christians, who have been completely marginalised in today's Britain. You can be any religion except Christian) to tell them what they believe, without consequences. I wouldn't start the conversation with a patient, but feel uncomfortable sharing my faith, especially in the light of recent disciplinary actions taken against Christian nurses.'

"Nurses will always say they need more education, but in the crowded curriculum there will never be enough time for spirituality. It should be embedded in all our teaching, not stowed away in separate sessions."

'I believe that each patient has the right to express their spirituality in an appropriate manner. Staff should be wary of pushing their own beliefs on people that are not ready to accept it, but should recognise when people are asking for spiritual help.'

The following case studies and reflective activity will enable you to consider and explore some of the issues between personal belief and professional practice.

Case studies

If you have not already done so read the following case study which was presented in section 1 and identify what issues this raises between personal belief and professional practice:

Case study 5 Who knows best?

A young woman is brought into the Accident and Emergency department with a massive gastrointestinal bleed presumed to be oesophageal varices. Immediately the medical and nursing teams start to resuscitate the woman and the consultant asks for 4 units of blood to be transfused. However, the woman interrupts and states that she does not want the blood transfusion because of her personal beliefs. Therefore other volume-expanding agents have to be used. Unfortunately the woman dies from the haemorrhage several hours later. Talk around the department is, 'if only the woman had not refused a blood transfusion'. Others say, 'what a waste of life'. Yet the woman's husband says, 'God's will was done and she approached death as she believed was right'.

This case study raises some important issues about the relationship between personal beliefs and professional practice. In this situation the apparent loss of life was deemed a waste. However, this is the health care professional's interpretation of the apparent loss of life from their specific world view and not from that of the individual. We need to be aware of imposing our own world view upon others and strive to be more receptive and sensitive to their needs. This requires self-awareness on our part as carers.

Crucially this case study emphasises the importance of individual choice, consent and the right to refuse treatment. Within nursing and health care we may adopt a paternalistic attitude to care, thinking we know what is best for the individual.

This case study highlights the importance of self-awareness, sensitivity to individual need and the dangers of imposing our own world view upon others.

Case Study 6 will enable you to explore these issues further

Case study 6

In whose interest?

Mr Francis was admitted to the ward having suffered a very dense left-sided CVA (cerebrovascular accident, or stroke). For two days he was deeply unconscious and unresponsive, and was given intravenous fluids for hydration. Several days passed and slowly Mr Francis gained consciousness and became more alert. Prior to admission he had been a very active man who had had an excellent quality of life, free of any major illness or hospitalization. Mr Francis' wife and family stayed with him and supported him throughout the acute phase of the illness. Mr Francis' condition improved, and the process of rehabilitation was initiated. It soon became apparent that Mr Francis was aphasic, having a marked dysphagia. It was decided by the medical and nursing staff, in consultation with Mr Francis and his family, to pass a fine bore nasogastric tube and to commence enteral feeding. However, Mr Francis showed dissatisfaction with this by pulling out the tube. Again the tube was passed, and again Mr Francis pulled out the tube, to the displeasure of his family.

The nurses and consultant caring for Mr Francis discussed the matter with him, and it emerged that he did not want to be fed. However, when his family were present he would change his mind in an attempt to keep the peace. Mr Francis' family was rightly concerned that he would possibly starve to death, and asked for a gastrostomy tube to be inserted. Mr Francis agreed and consented to have the procedure performed. Several days later he pulled out the gastrostomy tube, and categorically refused to have it reinserted. Again when approached by the consultant and nursing staff Mr Francis indicated non-verbally that he did not want the gastrostomy tube reinserting. The consultant explained, in detail, informing him of the consequences of his decision, and that he would die if he were left without nutritional support. Mr Francis was adamant in his decision, and even persuasion from his family failed. Consequently Mr Francis died some days later.

This is a very complex and demanding situation ethically, morally, professionally and spiritually. It demands health care professionals to use advanced communication skills such as empathy to listen to more than just the spoken word.

The major challenge is doing what is in the best interests of the patient (Mr Francis) while providing support to the family and listening to their concerns and wishes. It is clear that Mr Francis has the mental capacity to make decisions and to consent to or refuse treatment.

The nurse must stay impartial and non-judgmental and their own personal beliefs about life, death and continuation of treatment must not be used to influence the decisions of Mr Francis or his family.

A further challenge is supporting individuals with questions of mortality and meaning in life. It is clear that Mr Francis has decided that he wants to die because his life had been so significantly affected by the stroke.

The nurse may be the mediator between Mr Francis and his family. The dynamics of this relationship will draw upon all the nurse's knowledge, skills and expertise in dealing with very emotionally charged situations. Other health care professionals such as chaplains, psychologists (the psychosocial team) may help support the nursing team and provide further clinical expertise. Some considerations for integrating personal belief and professional responsibility

It may become apparent that the individual for whom the nurse is caring requires some intervention to support them with their spiritual or religious beliefs, before taking any action you should consider the following:

- Has the intervention been initiated by the patient/client?
- Has clear consent been given?
- Does it comply with your professional codes of practice?
- Does it comply with your employer's codes of practice?
- Is it safe and appropriate?
- Is it likely to cause offence?
- Do you feel comfortable?
- Do you have sufficient knowledge and skills?
- Is there adequate support and supervision for you and your patient/client?

Reflective exercise: What should I do?

The Nursing Times Survey reported by Mooney (2009) asked participants 'Has a patient ever asked you to pray for them? Responses were Yes 48% No 57%. This finding demonstrates that nurses are encountering requests for prayer from patients. Read the following scenario and, using the above guidance, consider how you would respond:

While providing personal care for a patient the conversation moves to the question of personal belief and religious practice. The patient asks you to pray with/for them.

In this instance the request has been initiated by the patient. In responding you would need to consider the following:

- How comfortable do you feel with carrying out the request?
- Could this request for prayer cause offence to you or anyone else?
- Do you share the same religious belief as the individual?
- You may need to explore with the patient ways to respond? This may include referring elsewhere?
- You may wish to consult the chaplaincy department for advice and support?
- It is important to recognise who we are and what we do are not inseparable?

When integrating personal beliefs and professional practice you may sometimes feel that you are out of your depth in terms of your knowledge, skills and expertise (out of your comfort zone). In such situations you should acknowledge these limitations and then consider asking for help and support from different sources depending upon the situation. Some suggestions are given below.

- Where do I go when I feel out of my depth?

It is about knowing your strengths, limitations and when to seek help. You may consider the following:

- another colleague, someone you trust (mentor or preceptor)
- the Chaplaincy team (who are there for staff and patients of all faiths and none)
- local contacts specific to your workplace
- psychosocial team (e.g. social worker, counsellor, psychologist)
- your own faith groups and/or other support networks.

Exercise/exploration

Read the following taken from the 'Department of Health Religion or Belief A practical guide for the NHS' (2009 p 22) and consider the implications of this for integrating personal belief and professional practice.

"Members of some religions, including Mormons, Jehovah's Witnesses, evangelical Christians and Muslims, are expected to preach and to try to convert other people. In a workplace environment this can cause many problems, as non-religious people and those from other religions or beliefs could feel harassed and intimidated by this behaviour. This is especially the case when particular views on matters such as sexual orientation, gender and single parents are aired in a workplace environment, potentially causing great offence to other workers or indeed patients or visitors who are within hearing. To avoid misunderstandings and complaints on this issue, it should be made clear to everyone from the first day of training and/or employment, and regularly restated, that such behaviour, notwithstanding religious beliefs, could be construed as harassment under the disciplinary and grievance procedures. Where one or more people from the same religion are working in the same environment, an individual could be pressured to conform to certain religious practices, which is again a form of harassment. There may also be differences of opinion on conformity within groups, for example between orthodox and reformed branches of certain religions, which could cause tensions and make an individual feel under pressure because of his or her religious beliefs."

Reflective questions:

- What are the implications of this for the organisation in which you provide nursing care?
- How can the fears spoken about be prevented?
- If you observed a colleague or patient trying to convert a patient to a particular religious belief what action would you take?

The extract highlights the importance of self-awareness and sensitivity regarding the areas of spiritual and religious practice. Everyone working within nursing must acknowledge the boundaries that exist

between personal belief and professional practice. The potential to cause, offense, intimidation and harassment are evident. This extract highlights that any form of evangelisation or proselytising (seeking to convert another person to your beliefs by whatever means or persuasion) within any nursing environment or context is prohibited.

However, this does not preclude nurses from asking patients if they require assistance in maintaining their religious beliefs or practices. Nor should it prevent nurses from assessing, planning, implementing and evaluating the person's holistic needs and providing person centred care. Crucially, by developing awareness into the fundamental and deeply personal aspects of the individual's life, nurses will be in a stronger position to safeguard vulnerable patients in their care and challenge inappropriate practices.

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Additional resources

Looking after yourself

Janki Foundation: www.jankifoundation.org

Sacred Space Foundation: www.sacredspace.org.uk

Health care chaplaincy

Local Chaplaincy Department

College of Healthcare Chaplains: www.healthcarechaplains.org

UK Board of Health Care Chaplaincy: www.ukbhc.org.uk

Scottish Association of Chaplains in Healthcare: www.sach.org.uk

Association of Hospice and Palliative Care Chaplains: www.ahpcc.org.uk

Multi Faith Group for Health Care Chaplaincy: www.mfghc.com

Faith and belief

Nurses Christian Fellowship International: www.ncfi.org

Health Care Christian Fellowship International: www.hcfi.givengain.org

Hospital Christian Fellowship: www.hcfusa.com

Christian Medical Fellowship: www.cmf.org.uk

The British Humanist Association: www.humanism.org.uk

Personal faith and religious communities

Personal religious/spiritual leader

Professional

Royal College of Nursing Direct: www.rcn.org.uk

RCN (2011a) The RCN spirituality survey 2010. A report by the RCN on members' views on spirituality and spiritual care in nursing practice. London, RCN

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Nursing and Midwifery Council (2008) The Code. London, NMC

Other Allied Professionals codes of professional practice

Employer related codes of practice

Organisations and societies

British Association for the Study of Spirituality: www.basspirituality.org.uk

Research Institute for Spirituality and Health: www.rish.ch

World Health Organisation: www.who.int

The Association for Children's Spirituality: www.childrenspirituality.org

Centre for Spirituality, Health & Disability: www.abdn.ac.uk/cshad

Foundation for Workplace Spirituality: www.workplacespirituality.org.uk/

Autism Spectrum People and Religion Research Group:
www.cardiff.ac.uk/.../research/religion/researchgroups/.../asparrg-autism-spectrum-people-and-religion-research-group.html

European Society for the Study of Theology of Disability: esstd.org

[Spirituality and Psychiatry Special Interest Group: www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)

National Secular Society: www.secularism.org.uk

Government health documents

Religion or belief: a practical guide for the NHS:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093133

NHS Education for Scotland Spiritual Care: <http://www.nes.scot.nhs.uk/disciplines/spiritual-care>

Standards for Spiritual Care Services in the NHS in Wales 2010:

<http://wales.gov.uk/topics/health/publications/health/guidance/spiritualcarestandards/?lang=en>

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Some useful journals

Journal for the Study of Spirituality <http://www.equinoxpub.com/JSS>

Journal of Religion, Disability and Health <http://www.tandf.co.uk/journals/WRDH>

Journal of Spirituality in Mental Health <http://www.informaworld.com/smpp/title~db=all~content=t792306967>

Scottish Journal of Healthcare chaplaincy <http://www.sach.org.uk/journal/journal.htm>

Journal of Health Care Chaplaincy <http://www.tandf.co.uk/journals/WHCC>

International Journal of Children's Spirituality <http://www.tandf.co.uk/journals/cijc>

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