Hospice nurses' perspectives of spirituality

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Hospice Nurses' Perspectives of Spirituality

Abstract

Aim

To explore Singaporean hospice nurses' perspectives of spirituality and spiritual care.

Design

A descriptive, cross sectional design was used.

Background:

Spiritual care is integral to providing quality end-of-life (EOL) care. However, patients often report that this aspect of care is lacking. Previous studies suggest that nurses' neglect of this aspect of care could be attributed to poor understanding of what spirituality is and what such care entails. This study aimed to explore Singapore's hospice nurses' perspectives about spirituality and spiritual care.

Method:

A convenience sample of hospice nurses was recruited from the eight hospices in Singapore. The survey comprised two parts: the Participant Demographic Details and the Spirituality Care Giving Scale (SCGS). This 35-item validated instrument measures participants' perspectives about spirituality and spiritual care.

Results:

Sixty-six nurses participated (response rate of 65%). Overall, participants agreed with items in the Spiritual Care Giving Scale related to Attributes of Spiritual Care; Spiritual Perspectives; Spiritual Care Attitudes and Spiritual Care Values. Results from General Linear Model analysis

showed statistically significant main effects between race, spiritual affiliation, and type of hospice setting, with the total SCGS score and four factor scores.

Conclusions:

Spirituality was perceived to be universal, holistic and existential in nature. Spiritual care was perceived to be relational, and centred on respecting patients' differing faiths and beliefs. Participants highly regarded the importance of spiritual care in the care of patients at EOL. Factors that significantly affected participants' perspectives of spirituality and spiritual care included race, spiritual affiliation and hospice type.

Relevance to Clinical Practice:

Surveying staff can clarify values and the importance of spirituality and care concepts in EOL care. Accordingly, spirituality and care issues can be incorporated in multi-disciplinary team discussions. Explicit guidelines regarding spiritual care and resources can be developed.

Key words: hospice nurses, spirituality, spiritual care; end-of-life; perspectives; perceptions

INTRODUCTION

Caring for individuals at end-of-life (EOL) is demanding and requires nurses to meet the physical, emotional, psychological and spiritual needs of individuals in order to alleviate their suffering and maximize quality of life during their final days (Singapore Hospice Council 2008). The World Health Organization (WHO) (2002) recognizes spiritual care as a fundamental aspect of palliative care – defining it as "an approach that improves the quality of life of patients and their families facing problems associated with life-threatening illness…". However, implementing spiritual care in practice is fraught with difficulties and considered a much neglected area of practice (McSherry & Jamieson 2011, Highfield *et al.* 2000, Noble & Jones 2010, Kale 2011).

BACKGROUND

Translating Spirituality into Practice

Several factors can hinder the provision of spiritual care in the hospice setting. These include personal characteristics of nurses and patients, a lack of understanding about spirituality and spiritual care; differing views of spirituality by nurses and patients; and organizational issues such as setting and time constraints.

According to Chism and Magnan (2009) views about spirituality are influenced by nurses' demographic characteristics such as gender, race and age, as well as their personal religious and spiritual affiliations. Spirituality is also experienced and interpreted differently by each individual (Milligan, 2011; Paley, 2008). Furthermore, definitions of spirituality, spiritual health, and spiritual well-being are often culturally bound (Ellis *et. al*, 1999). These factors may contribute to different perspectives about-spirituality in end of life care.

Nurses' neglect of spirituality in hospice care could be attributed to poor understanding of the concepts concerning spirituality and ~~of~~ its integration in practice (Puchalski 2007, McSherry & Jamieson 2011).One study regarding Singapore nurses' perceptions towards caring for the dying reported nurses were fearful, anxious and unprepared to care for the dying (Ooi *et.al* 2007). Difficulties may relate to their fear of misunderstanding patients' needs due to differing beliefs, and perceptions of spirituality as a taboo, contentious, and highly sensitive subject (McSherry & Jamieson 2011; Lind *et al.* 2011).

Nurses' own spiritual awareness and attitudes toward spirituality could also affect their provision of spiritual care (Sheldon 2000, Chan *et al.* 2006, Stranahan 2001). One study reported that nurses commonly associated spirituality with religion, and described a sense of vagueness and ambiguity regarding its meaning (McBrien 2006). Furthermore, some nurses may perceive that the role of spiritual caregiving resides with experts such as the pastoral team rather than by nurses.

Organisational factors may also hinder spiritual care. Results of two studies conducted with hospice and oncology nurses found that hospice nurses held more positive attitudes and greater spiritual preparation than oncology nurses even though both are required to provide a high level of spiritual care (Highfield *et al.* 2000, Taylor *et al.* 1999). Time constraints have also been cited by nurses as a barrier in spiritual care provision (Noble & Jones 2010). Having time to provide holistic care for the terminally ill or dying patient is critical to spiritual care (Evans & Hallett 2007). Spending quality time with patients is invariably linked to the positive value of 'being with' as an integral part of spiritual care. Patients value nurses' presence during their moments of emotional crisis and point of death (Evans & Hallett 2007).

Spiritual care by Hospice Nurses

There has been little research on the attitudes of hospice nurses towards spirituality and spiritual care. A literature review of studies published from 1994 to 2011 retrieved four studies. Three studies involved qualitative methods (Carroll 2001, Belcher & Griffiths 2005, Kale 2011), were conducted in religious organisations (Judeo-Christian), and had small samples ranging from 7 to 15. Most respondents had positive attitudes towards spiritual care. In one study, nurses acknowledged the collaborative nature of spiritual caregiving and highlighted the significance of the pastoral team (Belcher & Griffiths 2005). Similarly, Carroll (2001) reported that hospice nurses perceived their role as collaborators and sought help from other healthcare professionals to meet patients' specific spiritual needs. In another study hospice nurses identified shorter patient stays, fewer admissions to inpatient units, inadequate manpower, lack of commitment and other nursing responsibilities as factors hindering spiritual caregiving (Evans & Hallett 2007). Some hospice nurses perceived themselves as lacking knowledge in spiritual care. Some also attributed their role conflict and discomfort due to differing faith or belief systems of their patients (Carroll 2001, Belcher & Griffiths 2005, Kale 2011). The quantitative study in the review used the Spiritual Care Perspective Scale to assess nurses' attitudes to spiritual care. Highfield et al. (2000) found 51% of hospice nurses felt prepared for spiritual caregiving and attributed this to (1) supportive employers; (2) adequate spiritual caregiving training; (3) greater ability and comfort with spiritual caregiving, and (4) patient influence.

Although there is growing interest in spirituality and spiritual care, few studies have explored hospice nurses' spiritual and spiritual care perspectives. To date, most studies have been conducted in North America and Western Europe where the nursing population are relatively homogenous in regards to religious beliefs. We know little about the extent to which information from these studies can be generalized to Asian countries. It is timely to explore nurses' spiritual perspectives from different cultures, ethnicities, religions and socio-political backgrounds. The proposed study is multi-site, conducted in diverse ethno cultural-religious settings and may provide useful insights about the role of spirituality in end of life care in other cultures.

Aim

To explore Singaporean hospice nurses' perspectives of spirituality and spiritual care.

Objectives

- Describe nurses' perspectives of spirituality and spiritual care
- Examine the relationship between nurses' socio-demographic characteristics and their perspectives of spirituality and spiritual care

METHOD

Design

A descriptive, cross sectional design was used.

Participants

Convenience sampling was used to recruit nurses from five hospice settings offering inpatient, outpatient and home hospice care in Singapore. Target sample population was 101 hospice nurses. Given this total population size, to achieve a confidence level of 95% with a margin error set at 5% set, and alpha level at $\alpha = 0.05$ to control the risk of incurring a Type 1 and Type 2 error [23], the desirable sample size was 67. The inclusion criterion was Registered and Enrolled Nurses working in participating hospices.

Setting

All participating sites provide terminal palliative and end of life care to patients (as inpatients or outpatients) suffering from cancer and / or end-stage chronic diseases. Most of these hospices are operated by charitable welfare organisations with a bed capacity ranging from 30 to 200 beds.

Instrument

A two part questionnaire was used. The participant demographic details form sought information such as age, gender, nationality, marital status, nursing level, years of experience, specialisation in palliative care, duration of experience in hospice / palliative care, spiritual affiliation (defined as participants' association with religions and / or other faith-based groups) and religious practices (defined as participation in certain religious customs or activities). The Spiritual Care-Giving Scale (SCGS) is a self-report 35-item multi-dimensional instrument to assess nurses' spirituality and spiritual care perspectives using a 6-point Likert scale with responses ranging from one (strongly disagree) to six (strongly agree) (Tiew & Creedy 2012). The SCGS was developed from a critical review of the literature, review by an expert panel, a pilot study, and a final survey with 745 final-year nursing students. Participants also completed the Spirituality and Spiritual Care Rating Scale (McSherry *et al.* 2002) and Student Survey of Spiritual Care (Meyer 2003) to assess construct validity. In that study good internal consistency (r=0.81) and reliability (Cronbach's alpha = 0.96) were reported. Principal component analysis (PCA) was used to evaluate, and reduce the SCGS from 68-items to 35-items. All corrected item-total correlations were 100% positive, with corrected item-total correlations between 0.51 and 0.72. Factor analysis of the SCGS reported a five-factor structure: attributes for spirituality; spirituality perspectives; defining spiritual care; spiritual care attitudes; spiritual care values (Tiew & Creedy 2012).

Attributes for Spiritual Care (Factor 1) comprised eight items that defined the pre-requisites for spiritual care such as spiritual awareness, empathy, and establishing trust. Spirituality Perspectives (Factor 2) defined the constructs of spirituality, such as "Everyone has spirituality". Defining Spiritual Care (Factor 3) identified key aspects of spiritual care such as respect, listening, being sensitive and intuitive to patients' anxieties and fears. Spiritual Care Attitudes

(Factor 4) explored ~~participants'~~ attitudes towards spiritual care-giving; e.g. "Spiritual care is important because it gives a patient hope". Spiritual Care Values (Factor 5) measured beliefs about spiritual care and the importance of a multidisciplinary team approach (Tiew & Creedy, 2011).

Data Collection

All ~~hospices~~ facilities offering inpatient and outpatient hospice care in Singapore were approached regarding the study. Arrangements were made to meet and brief all potential participants about the study. They were informed of their right not to participate and withdraw at any time without prejudice. Consent was implied with the return of the completed survey form. After each briefing, attendees were given a Participant Information Sheet (PIS) as well as a copy of the survey form. Completed survey forms were placed into a locked box located at their nursing administration office for collection. Additional information sheets and survey forms were left at each facility for staff who were unable to attend the briefing. The study was conducted from September to November 2011.

Ethics approval

Ethics approval was obtained from the National University of Singapore (NUS) Institutional Review Board (IRB) and permission was obtained from the respective hospices prior to data collection.

Approach to analysis

Data analysis was conducted using the Statistical Package for the Social Sciences (SPSS) version 19.0 (2009) personal computer version. Descriptive statistics was used to describe categorical data with frequencies and percentages, while numerical data was described with means and standard deviations. Pearson's product-moment correlation was used to test any correlations

between participants' age, their total SCGS score and sub-factor scores. General Linear Model Analysis was used to investigate main effects and/or interaction effects between participants' socio-demographic factors, total SCGS score and factor scores. Post-hoc analysis using Least Significant Difference (LSD) test, a post-hoc test with equal variance assumptions, was employed to determine significant differences between groups.

RESULTS

Sample

The survey response rate from participants at the five sites was 65% (n=66). Respondents were classified according to two settings – inpatient hospice (n=30, 45.5%) and home hospice (n=36, 54.5%). Of the 66 participants, the majority were Registered Nurses (n=60, 90.9%) and remainder were Enrolled Nurses (n=6, 9.1%). The mean age was 44 years (SD=9.53), and many were Singaporean (n=45, 68.2%), female (n=63, 95.5%) and married (n=39, 59.1%). Most were Chinese (n=39, 59.1%), followed by Indian (n=8, 12.1%), Malay (n=5, 7.6%) and other races (n=14, 21.2%) which is representative of Singapore's ethnic population profile.

Around half of the participants considered themselves to be both spiritual and religious people (n=36, 54.5%). A third had worked in their current institution for 5-10 years (n=23, 34.8%). The extent of work experience in palliative care settings was around1-5 years (n=34, 51.5%), while a third of participants had more than 5 years (n=22, 33.3%), and the remainder had more than 10 years (n=10, 15.2%). Around two-thirds of participants had specialized in palliative care (n=40, 60.6%) (refer to Table 1).

SCGS responses

The overall SCGS score for this sample was178 out of a possible 210, indicating high agreement with descriptors of spirituality and spiritual care in the SCGS. The item mean score (5.07±0.89)

indicated that most were agreeable to statements in the SCGS. The highest mean value was in response to Factor 2: Spiritual Perspectives (5.24±0.78), followed by Factor 3: Defining Spiritual Care (5.16±0.85), Factor 1: Attributes for Spiritual Care (5.16±0.71), Factor 4: Spiritual Care Attitudes (4.93±0.96) and lastly, Factor 5: Spiritual Care Values (4.69±1.16). The overall mean value for the SCGS was 5.07, with the highest mean at 5.47 and lowest mean of 4.18, indicating that most participants agreed with statements in the SCGS. The item with the lowest mean was item 9**, "**Without spirituality, a person is not considered whole." (4.18**±**1.45). The item with the highest mean was item 2, "Spirituality is an important aspect of human beings" (5.47±0.64) (refer to Table 2).

The SCGS demonstrated good reliability with a Cronbach alpha of 0.869 for this sample of practicing nurses.

Relationship between participant characteristics and SCGS

Results from the General Linear Model analysis showed statistical significant main effects between race, spiritual affiliation, hospice setting, and the overall SCGS (see Table 3) and four factors namely: Factor One (Attributes of Spiritual Care) (see Table 4); Factor Two (Spiritual Perspectives) (see Table 5); Factor Three (Spiritual Care Attitudes) (see Table 6) and Factor Four (Spiritual Care Values) (see Table 7). There was no statistical significant correlation between age and SCGS.

DISCUSSION

This is the first study regarding spiritual perspectives of Singaporean nurses working with people at end of life (EOL). Overall, participants reported positive attitudes toward spirituality and spiritual care. The positive views expressed by participants are similar to those of hospice nurses

from studies in other countries (Carroll 2001, Belcher & Griffiths 2005, Bailey *et al.* 2009, Kale 2011). As with most nurses in previous studies, most participants in the current study had specialized in palliative care with at least five years or more experience. It is likely that respondents' palliative care knowledge and extensive clinical experience enabled them to identify and effectively attend to patients' spiritual needs (Wong *et al.* 2008). In Singapore, palliative care nurses work within an extended scope of practice especially in regards to symptomatic management of pain. Accordingly, understanding that spiritual care enhances and promotes quality EOL care may have contributed to participants' positive attitudes towards spirituality and spiritual care. The close care of patients over an extended period of time could have also enhanced nurses' ability to recognize and attend to their spiritual needs.

Hospice nurses' views of spirituality and spiritual care

Hospice nurses' perceptions of spirituality and spiritual care were reflected in the four factors of the SCGS. . Attributes for Spiritual Care (Factor 1) defined prerequisites for spiritual care such as spiritual awareness; empathy; and establishing trust. Two items scoring the highest means (5.39±0.55 and 5.39±0.61 respectively), indicated that participants recognized empathy and establishing a trusting nurse-patient relationship as imperative attributes to spiritual care. Their views are similar to those of hospice nurses in Ireland and other Western-countries (Belcher & Griffiths 2005, Tiew & Creedy 2012).

However, participants indicated less agreement about spiritual awareness as an attribute essential for spiritual caregiving (4.89±0.95). This suggests that participants may not have viewed spiritual awareness as a vital attribute for spiritual care. Spiritual awareness, referred to as "an awareness of the existential, religious and universal nature of spirituality" (Carroll 2001, p. 95), denotes an awareness of transcendence. Sawatzky & Pesut (2005), however, argued that spiritual

care could still occur without nurses being spiritually aware. Patients could still benefit spiritually from sensitive care rendered by the nurse who does not place particular importance on their own spiritual awareness (Wong *et al.* 2008). In the current study, participants may have felt that their ability to deliver spiritual care was more contingent on experience (5.14±0.70). Many nurses in previous studies have espoused the role of experience in developing preparedness for spiritual caregiving (Taylor *et al.* 1999, Highfield *et al.* 2000, Noble & Jones 2010). Results of the current study identified that senior nurses possessed greater spiritual understanding and a sense of responsibility towards spiritual care. These nurses were aware of the difficulties in accurately assessing patients' spiritual needs and reported greater ease and comfort in spiritual caregiving.

Spiritual Perspectives (Factor 2) defined spirituality using three central concepts: 1) universality; 2) holistic; and 3) existential nature of spirituality. Overall, participants agreed with these descriptors and this mirrors similar results in other studies (Taylor *et al.* 1999, McSherry *et al* 2004). Participants were also more likely to agree with descriptors of spirituality as 'helping one to be at peace' and 'providing emotional benefits'. It could be that caring for the terminally ill may have sensitized participants to the role of spirituality in helping the dying cope with the imminence of death.

Responses about Defining Spiritual Care (Factor 3) revealed general agreement that spiritual care involved respecting patients' religious or personal beliefs. This concurs with a North American study with oncology nurse clinicians who described spiritual care as respecting and supporting patients' beliefs and as a means to promote well-being (Taylor *et al.* 1994). As Singapore is a multi-religious, multiracial and multicultural society, such displays of respect may be reflective of the imbued religious sensitivity in the local community.

In the current study, hospice nurses were less likely to agree that "being with a patient" was a form of spiritual care. This was unexpected, given that nurses in previous studies embraced the act of "being" as the basis of spiritual care (Carroll 2001, Bailey *et al.* 2009, Noble & Jones 2010). The therapeutic use of self in being with a patient has been valued as part of spiritual care, as it allows the nurse to fully engage in a caring-healing relationship with the patient (Cumbie 2001). As the current participants had identified empathy and a therapeutic relationship as ~~a~~ vital attributes to spiritual care, it is interesting to note that they gave less regard to the act of "being". One possible reason could be that half the participants were from home care hospice services and on a day to day basis may not have had the opportunity to spend extended time with patients. Also, it could be that participants perceived this aspect of spiritual care as more relevant for the patient's family who are constantly at the patients' side in the home. Participants did however view spiritual care as a process, which could be interpreted as an act of being with and journeying with the patient. Although participants engaged in home hospice care were not able to be with patients most of the time, they recognized spiritual care as a process instead of episodic.

It could also be that hospice nurses in Singapore may have a different understanding of 'being with' the patient. Participants may have perceived "being with" negatively, portraying the role of the nurse in a passive way. A lack of "doing" is frowned upon in the Singaporean work culture which is driven by productivity. Respondents may not be aware that 'being with' a terminally ill patient affirms the person's search for meaning and purpose (Campion 2011).

Singaporean hospice nurses were less likely to agree with the notion that good nursing care was in itself spiritual care (4.59±1.20). This finding could be because most of the participating nurses viewed religious care as a key aspect of spiritual care. Participants tended to view spiritual care

as meeting the person's religious needs or "doing" something that supported or enabled the person to meet their religious obligations.

Enabling the patient to find meaning and purpose in the course of their illness elicited the highest mean score in this domain (5.27±0.74). Such consideration is consistent with the views of hospice nurses reported previously (Highfield *et al.* 2000, Carroll 2001, Belcher & Griffiths 2005, Bailey *et al.* 2009). Hospice nurses in Singapore reported that finding meaning and purpose was a common and important spiritual need of dying patients (Hermann 2001).

It was interesting to note that although participants perceived religious care as one aspect of spiritual care, they were ambivalent about helping patients to observe their religious beliefs (4.59±1.18). Respondents may have perceived a conflict of interest or an ethical dilemma in providing religious care as part of spiritual care despite their belief in respecting patients of differing beliefs and faith (Belcher & Griffiths 2005). The possible discomfort in supporting religious beliefs, as part of spiritual care, may be a reflection of nurses' knowledge and experience of providing care in a society characterized by multiple races, cultures and religious beliefs which they may not fully understand.

Participants supported the integration of spiritual education in undergraduate nursing curricula and this finding is consistent with other reports advocating for changes in education to improve nurses' understanding of spirituality and spiritual care (Dorff 1993, Narayanasamy 1993, McSherry & Jamieson 2011). Participants also agreed that spiritual care could be positively reinforced in practice. Clinical experience, guidance and coaching in practice settings, as well as in-service sessions and continuing education programmes can all contribute to nurses' professional development in spirituality and spiritual care (Belcher & Griffiths 2005).

The participants viewed spiritual care as an integral component of holistic nursing care (5.30±0.58), which is also consistent with the literature (Belcher & Griffiths 2005; Noble & Jones 2010; McSherry & Jamieson 2011). They believed that a patient's well-being is multifaceted, constituting not just the physical and emotional, but also spiritual dimensions.

Factors affecting spiritual perspectives

Previous research identified the contribution of personal, cultural and professional factors on spirituality. In the current study, participants came from diverse racial and cultural backgrounds, including Chinese, Malay, Indian and Other ethnicities. Chinese hospice nurses (which formed the largest ethnic group reported positive spirituality and spiritual care attitudes in comparison to respondents from other ethnic groups. According to Wong *et al* (2008), the traditional Chinese belief that doing good deeds begets good luck may explain this phenomenon. Additionally, Chinese people believe that spirituality is about "maintaining harmony and balance in humanistic relationships… [and] the wholesome life is asserted by maintaining harmony with all the spiritual forces" (Wong *et al.* 2008, p. 338). Participating Chinese hospice nurses may have similarly perceived spirituality to be a "force" that enables peace, and is holistic in nature.

Participating Malay nurses were more likely to agree with items about spiritual perspectives (Factor 2) and this could be due to their. Islamic faith which does not distinguish religion and spirituality from each other. According to Rassool (2000), Muslims believe that "there is no spirituality without religious thoughts and practices, and religion provides the spiritual path" (p. 1479).

Indian hospice nurses, relative to nurses of other races, did not indicate stronger spiritual perspectives and values. This may be attributed to the doctrine of karma, a basic tenet of Hinduism prevalent in Indian culture that emphasizes individual responsibility for one's actions,

well-being and misfortunes (Anand 2009). There was a significant interaction effect between race and spiritual affiliation. It is possible that participants' spiritual affiliations may be shaped by their racial and cultural identity, as affirmed by other authors (Lemmer 2002, Belcher & Griffiths 2005, Tiew & Drury 2012). Indeed, in contemporary society, individuals may have a wider view of spirituality than just their traditional religions and cultural beliefs (Holloway 2006). Individuals may subscribe to a particular religion but be flexible in the way they pursue it and not exclude the beliefs of others (Holloway 2006). Participants reported a high level of transcultural spiritual awareness, but this might not necessarily translate to transcultural spiritual competency, especially in light of the complex multicultural terrain of Singapore.

The current study did not collect data on participants' religious affiliations. It may be helpful to further explore whether the findings can be explained from a non-religious point of view. It would also be important to establish if the dominant religions of different races are significant in explaining the differences in spiritual attitudes and perspectives.

It was also found that the type of hospice setting (inpatient versus home) influenced spiritual care attitudes. Inpatient hospice nurses had slightly higher overall spiritual scores than home-based nurses. There appears to be no existing literature on the influence of setting on spiritual care attitudes and highlights the need further research.

Home hospice nurses face challenges which differ from inpatient care and may contribute to the disparity in spiritual attitudes. For example, in a qualitative study of Singapore's palliative home care nurses, Chong & Poon (2011) highlighted that "going on call and providing out-of-hours coverage" (p. 53) were some of the difficulties that arose for home hospice nurses. High caseloads and geographical coverage that home hospice nurses must accomplish in a day invariably meant that they did not have as much time to spend with terminally ill patients.

Additionally, caring for home patients seemed to be focused on the more routine technical aspects of care such as carrying out doctor's orders in dispensing pain medication instead of the spiritual aspects of palliative care (Chong & Poon 2011). Significant differences between inpatient and homecare hospice nurses' practice may have negatively influenced spiritual care attitudes.

Results showed that age did not have a direct linear relationship with total SCGS and factor scores. Although it is commonly believed that spirituality develops with maturity and experience Lundmark (2006) and Taylor et al. (1994) supported the notion that age had no bearing on spirituality. As the participants' age range was wide (21-66), this result suggests that spirituality is universal and not constrained by age. Other authors have reported similar findings (Meyer 2003, Tiew & Drury 2012, Tiew *et al.* 2012) and highlight that spirituality can be nurtured at any age through thoughtful reflection and self-awareness

Limitations of Study

Several limitations associated with the study must be considered. The study recruited a sample size of 66 participants, yielding a 65% response rate. Although Portney & Watkins (2009) consider a response rate of 60-80% excellent for survey studies, the current findings may not reflect the views of all hospice nurses in Singapore, especially considering that one major hospice did not participate. The refusal to participate in the study was attributed to "subject-fatigue" of staff by a management representative from one of the facilities.

The possibility of social desirability response bias by participants cannot be discounted, especially with the use of a self-reported questionnaire. Although the researcher assured anonymity and endeavored to create a permissive atmosphere to encourage frankness, the problem of response bias remains a challenge in Asian-based studies.

Lastly, employing a quantitative method (survey) to explore nurses' attitudes and perspectives invariably limits the ability to glean more in-depth findings from participants' responses. Mixed-methods research may allow in-depth exploration and better access to richer and meaningful findings.

RELEVANCE TO CLINICAL PRACTICE

Currently, spirituality education in Singapore's undergraduate nursing curricula largely emphasizes being sensitive and respectful of patients' religious and personal beliefs. In part, this could be related to the multi-racial and cultural context of the country, whereby the government emphasizes racial and religious harmony. However, by emphasizing religion during class may create an impression that religion is synonymous to spirituality, particularly if other important tenets of spirituality such as sense of belonging, meaning and purpose in life are not effectively addressed. An alternative option could be to offer inter-cultural and religious awareness activities to nurses, such as cultural nights and plays which depict concepts important and debunk misperceptions for those who render EOL care to patients.

The recruitment of a multi-cultural nursing sample enhances the generalizability of findings to other countries. Globally, care settings need to promote holistic palliative care and a workplace culture that visibly translates dedication to spirituality and spiritual care into action. One measure of commitment could be the provision of adequate human resources especially for home hospice nurses to allow them to spend quality time with a patient at end of life. Additionally, spiritual assistance and support should be made easily available to assist hospice nurses who face ethical challenges when delivering spiritual care to their dying patients. To ensure spiritual care is carried out consistently regardless of hospice setting, explicit guidelines regarding spiritual care and spiritual resources need to be established. Additionally, spiritual care could be included as one topic of

care discussion in the multi-disciplinary team rounds. This encourages open discussions, guidance and sharing of spiritual perspectives and clarity of spiritual issues.

CONCLUSION

This study contributes to our understanding of nurses' perspectives on the nature and importance of spirituality and spiritual care. Spirituality characteristics were perceived to be universal, holistic and existential in nature. Spiritual care was perceived to be relational in nature, holistic and centered on respecting patients' differing faiths and beliefs. Participants regarded the importance of spirituality in the care of terminally ill patients highly. Factors that significantly affected participants' spiritual perspectives included race, spiritual affiliation and hospice type. The interplay amongst these factors may be a reflection of Singapore's multi-racial and multicultural society. The findings have implications for nursing education and practice, which will help improve integration of spiritual care into practice.

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Table 1: Socio-demography of Participants

	n	%
Job Title		
Registered Nurse	60	90.9
Enrolled Nurse	6	9.1
Age (Years)		
Mean±SD	44±9.53	
Range = 21-66	21-26	
Nationality		
Singaporean	45	68.2
Non-Singaporean	21	31.8
Gender		
Male	3	4.5
Female	63	95.5
Race		
Chinese	39	59.1
Malay	5	7.6
Indian	8	12.1
Others	14	21.2
Marital Status		
Single	27	40.9
Married	39	59.1
Attend Religious Practices		
Yes	53	80.3
No	13	19.7
Spiritual Affiliations		
Religious	15	22.7
Spiritual	15	22.7
Both	36	54.5
Number of Years in Current Institution		
1-2 years	22	33.3
>2-5 years	12	18.2
>5-10 years	23	34.8
>10 years	9	13.6
Specialized in Palliative		

Care		
Yes	40	60.6
No	26	39.4
Duration of Experience in Palliative/Hospice Care		
1-5 years	34	51.5
>5-10 years	22	33.3
>10 years	10	15.2
Hospice setting		
In-patient	30	45.5
Home	36	54.5

Table 2: Participants' SCGS Results

	Mean±SD
Factor 1:	
Attributes for Spiritual care	**5.16±0.71**
Item 24 Spiritual care should take into account of what patients think about spirituality.	5.12±0.62
Item 25 Nurses who are spiritual aware are more likely to provide spiritual care.	4.89±0.95
Item 26 Spiritual care requires awareness of one's spirituality.	5.02±0.77
Item 29 The ability to provide spiritual care develops through experience.	5.12±0.83
Item 31 Spirituality is influenced by individual's life experiences.	5.14±0.70
Item 32 Spirituality helps when facing life's difficulties and problems.	5.24±0.68
Item 33 Spiritual care requires the nurse to be empathetic towards the patient.	5.39±0.55
Item 34 A trusting nurse-patient relationship is needed to provide spiritual care.	5.39±0.61
Factor 2:	
Spiritual Perspectives	**5.24±0.78**
Item 1 Everyone has spirituality.	5.12±1.09
Item 2 Spirituality is an important aspect of human beings	5.47±0.64
Item 3 Spirituality is part of a unifying force which enables individuals to be at peace.	5.36±0.60
Item 4 Spirituality is an expression of one's inner feelings that affect behaviour	5.20±0.79
Item 5 Spirituality is part of our inner being.	5.29±0.72
Item 6 Spirituality is about finding meaning in the good and bad events in life.	4.97±0.99
Item 7 Spiritual well-being is important for one's emotional well-being.	5.36±0.60
Item 8 Spirituality drives individuals to search for answers about meaning and purpose in life.	5.17±0.78
Factor 3: Defining Spiritual Care	**5.16±0.85**
Item 14 Spiritual care is a process and not a one-time event or activity	5.36±0.57
Item 15 Spiritual care is respecting a patient's religious or personal beliefs.	5.36±0.82
Item 16 Sensitivity and intuition help the nurse to provide spiritual care.	5.02±1.00

Item 17 Being with a patient is a form of spiritual care.	4.71±1.09
Item 18 Nurses provide spiritual care by respecting the religious and cultural beliefs of patients.	5.18±0.89
Item 19 Nurses provide spiritual care by giving patients time to discuss and explore their fears, anxieties and troubles.	5.27±0.74
Item 23 Nurses provide spiritual care by respecting the dignity of patients.	5.20±0.81
Factor 4: Spiritual Care Attitudes	**4.93±0.96**
Item 20 Spiritual care enables the patient to find meaning and purpose in their illness	5.27±0.74
Item 21 Spiritual care includes support to help patients observe their religious beliefs.	4.59±1.18
Item 22 Nurses provide spiritual care by respecting the dignity of patients.	4.76±0.88
Item 27 Spiritual care should be instilled throughout a nursing education programme	4.86±0.99
Item 28 Spiritual care should be positively reinforced in nursing practice	5.06±0.84
Item 30 Spiritual care is important because it gives patient hope.	4.73±1.16
Item 35 A team approach is important for spiritual care.	5.21±0.94
Factor 5: Spiritual Care Values	**4.69±1.16**
Item 9 Without spirituality, a person is not considered whole.	4.18±1.45
Item 10 Spiritual needs are met by connecting oneself with other people, higher power or nature.	4.29±1.43
Item 11 Spiritual care is an integral component of holistic nursing care.	5.30±0.58
Item 12 Spiritual care is more than religious care.	5.11±1.15
Item 13 Nursing care, when performed well, is itself, spiritual care.	4.59±1.20
Total n = 66	**5.07±0.89**

Table 3: General Linear Model Analysis of Socio-demographic Characteristics and Total SCGS Score

	n	Mean ± SD	Statistics (F)	*p*-value
Socio-demographic Characteristics				
Spiritual Affiliations				
Religious	15	170.80±16.11		
Spiritual	15	183.73±13.00	3.416	0.040*[a]
Both	36	178.75±13.69		
Spiritual Affiliations*Hospice			3.490	0.038*[b]

**significant at p<0.05; [a] LSD Post-hoc Analysis: Spiritual versus Religious, p=0.013; [b] Significant interaction effect between Spiritual Affiliations*Hospice, p=0.038*

Table 4: General Linear Model Analysis of Socio-demographic Characteristics and Factor One (Attributes of Spiritual Care)

	n	Mean ± SD	Statistics (F)	*p*-value
Socio-demographic Characteristics				
Spiritual Affiliations				
Religious	15	39.53±4.17		
Spiritual	15	42.87±2.95	3.916	0.026*[a]
Both	36	41.42±3.05		

**significant at p<0.05; [a] LSD Post-hoc Analysis: Spiritual versus Religious, p=0.01, and Both vs Religious, p=0.028; Interaction effects on the different combinations have showed that results are not significant, therefore only presenting main effect results*

Table 5: General Linear Model Analysis of Socio-demographic Characteristics and Factor Two (Spiritual Perspectives)

	n	Mean ± SD	Statistics (F)	*p*-value
Socio-demographic Characteristics				
Race				
Chinese	39	42.82±3.42		
Malay	5	43.00±3.74	4.645	0.006*[a]
Indian	8	38.88±6.71		
Others	14	40.86±3.86		
Spiritual Affiliations				
Religious	15	39.80±5.06		
Spiritual	15	43.20±4.41	8.870	0.001*[b]
Both	36	42.31±3.41		
Spiritual Affiliations*Hospice			10.596	<0.001*[c]
Race*Spiritual Affiliations			10.336	<0.001*[d]

**significant at p<0.05; [a] LSD Post-hoc Analysis: Chinese versus Indian, p=0.002, and Others versus Indian, p=0.002; [b] LSD Post-hoc Analysis: Both versus Religious, p<0.001; [c] Significant interaction effect between Spiritual Affiliations*Hospice, p<0.001; [d] Significant interaction effect between Race*Spiritual Affiliations, p<0.001*

Table 6: General Linear Model Analysis of Socio-demographic Characteristics and Factor Four (Spiritual Care Attitudes)

	n	Mean ± SD	Statistics (F)	*p*-value
Socio-demographic Characteristics				
Hospice				
Inpatient	30	35.43±4.07	6.357	0.015*
Home	36	33.69±3.50		

**significant at p<0.05; Interaction effects on the different combinations have showed that results are not significant, therefore only presenting main effect results*

Table 7: General Linear Model Analysis of Socio-demographic Characteristics and Factor Five (Spiritual Care Values)

	n	Mean ± SD	Statistics (F)	*p*-value
Socio-demographic Characteristics				
Race				
Chinese	39	24.15±3.62		
Malay	5	20.20±5.07	3.201	0.031*[a]
Indian	8	20.50±3.55		
Others	14	24.43±3.78		
Spiritual Affiliations*Hospice			4.529	0.015*[b]

** significant at p<0.05 ; [a] LSD Post-hoc Analysis: Chinese versus Malay, p=0.030, and Chinese versus Indian, p=0.020; [b] Significant interaction effect between Spiritual Affiliations*Hospice, p=0.015.*