

**NURSING STUDENT'S PERSPECTIVES ON SPIRITUAL CARE IN CLINICAL
NURSING PRACTICE IN A SELECTED SCHOOL OF NURSING AT
UMKHANYAKUDE DISTRICT IN KZN PROVINCE**

By

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**Submitted in accordance with the requirements
for the degree of**

MASTER OF ARTS

In the subject

Health Studies

at the

UNIVERSITY OF SOUTH AFRICA

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Dedication:

I dedicate this dissertation to:

My late mother, Faith Nomazizi Mazwi, for her unconditional love for me, may her soul rest in peace.

My husband Bongani Nkala, for love and support and my children Sanqa, Khule, Thobeka, Ndumiso and Sibusiso my grandson, for your support and understanding of all the time I spent pursuing my dream.

All the student nurses who took part in this study, my colleagues who supported my course and my sister Bongiwe Ngcobo for being the pillar of strength and comfort.

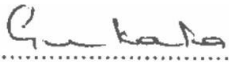
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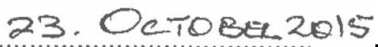
DECLARATION

I declare that **NURSING STUDENT'S PERSPECTIVES ON SPIRITUAL CARE IN CLINICAL NURSING PRACTICE IN A SELECTED SCHOOL OF NURSING AT UMKHANYAKUDE DISTRICT IN KZN PROVINCE**

is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

GC Nkala


.....


.....

.08.... February 2018.....

SIGNATURE

DATE

(Gugulethu Cynthia Nkala)

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ABSTRACT

A qualitative, non-experimental, explorative and descriptive research design based on the phenomenological philosophical tradition by Heidegger to broaden hermeneutics was conducted. The study was conducted at Umkhanyakude District to investigate the perspectives of eligible nursing students relating to the provision of spiritual care to patients. A purposive sample of 9 participants was recruited and consent form obtained. An unstructured interview guide, with a grand tour question, was used to conduct face to face individual interviews. The Thematic analysis and interpretative phenomenological method of analysis were employed until three themes, six categories and eleven subcategories emerged from the data. Data analysis revealed that nurses had difficulty to differentiate spiritual care from religious care. Commonly cited methods

of providing spiritual care were prayer, reading sacred text and singing spiritual songs. Nurses still felt inadequately prepared educationally on how to provide spiritual care in nursing practice. Most of the participants provided spiritual care out of their own interest and not as part of their professional responsibility. Recommendations proposed that the matter be taken up by nurse managers to conduct related in-service education and mentoring programs and nurse educators to guide curriculum planning which evidently include spiritual care.

Key concepts:

Clinical practice, holistic care, nursing, perspective, spiritual care, student.

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LIST OF ABBREVIATIONS

DoH Department of Health

ENs Enrolled nurses

KZNCN KwaZulu Natal college of Nursing

PNs Professional Nurses

SA South Africa

SANC South African Nursing Council

UNISA University of South Africa

WHO

CHAPTER 1

ORIENTATION TO THE STUDY

“We want to provide more holistic, spiritual care, part of providing good health care is spiritual care” (Jennifer Williams).

1.1 INTRODUCTION

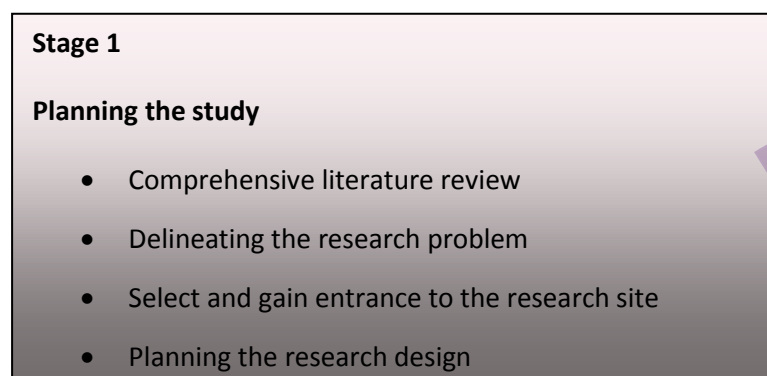
In view of the fact that nurses are professionally and ethically responsible for providing holistic care that is inclusive of spiritual care, their educational preparation should

therefore empower them to fulfil this moral obligation of care (Yilmaz & Gurler 2014: 929). Nursing educational programmes are designed to train nurses to be empowered to optimally address the health needs of society. These programmes are reviewed periodically by curriculum developers to keep pace with the rapid advances in disease management (Yilmaz & Gurler 2014: 929). According to Wallace, Campbell, Grossman, Shea, Lange and Quel (2008:1), it is the nursing curricula that should enable nursing students to understand spirituality in a broader context that goes beyond religious beliefs. The view that considers the fact that some nurses do not have any religious affiliation, but are however equally charged with a responsibility of providing holistic care to patients is paradoxical (Wu, Liao & Yeh 2012:1). The nursing education system that embraces teaching on holistic nursing should evidently address the content on spiritual care in the context of teaching and assessment in that regard. Nursing students need to be exposed to comprehensive assessment of patient's needs as they participate at all levels of disease interception to be able to provide effective patient care appreciating the role spiritual care has in management of illness and disease

Students require a strong foundation or understanding also of their own spirituality to be able to provide spiritual care to others (Wallace et al 2008:1). Findings from a study conducted by Tiew, Kwee, Creedy and Chan (2013:574) contend that provision of spiritual care to patients is not adequately addressed or understood in the health care environment. This could be due to lack of a clear definition of what spiritual care is. According to Swinton and McSherry (2006:801), spiritual care is an interpersonal, a systemic and political concept that needs to be addressed at all these levels for it to have a positive impact on quality of patient care. In view of Swinton and McSherry (2006:801)'s assertion, the political climate sets the tone for the priorities that the system adheres to, and nursing as part of a health care system cannot escape political control, as such non-practice of spiritual care cannot be attributed to nurses nor nursing education only (Swinton & McSherry 2006:801). Guidelines such as Batho Pele principles and the six priority areas of the National Core Standards to name a few have received much focus and attention emanating from the political influence to have them implemented (Khoza & DuToit 2011: 8)

Patient's spiritual needs are viewed by O'Brien (2014:119) as a dimension of holistic health care as such nurses including nursing students have an obligation to identify and be sensitive towards them. Conceptualisation of spiritual care will benefit nursing students when they give health education on prevention of diseases focussing on practices such as meditation, prayer, sacred text and mind focus to deal with stress, insomnia and psoriasis (Gottlieb 2013:129- 130). Therefore, as student nurses make a contribution to the day to day patient care their perspectives and views on this phenomenon will share valuable light on the phenomena.

The research design for this study was a qualitative, explorative and descriptive approach based on the phenomenological philosophy. The study was conducted in stages. The schematic presentation of these stages is displayed in Figure 1.1 which has been adapted from Polit and Beck (2012:61).



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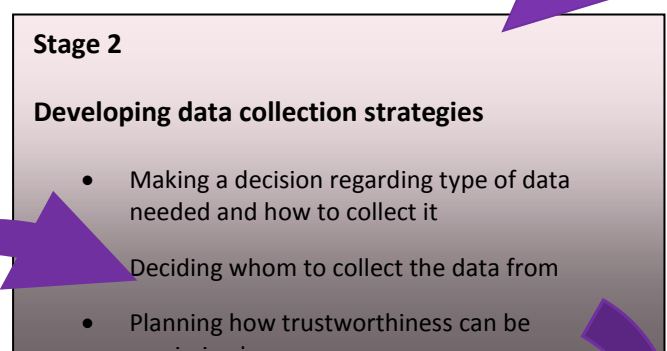
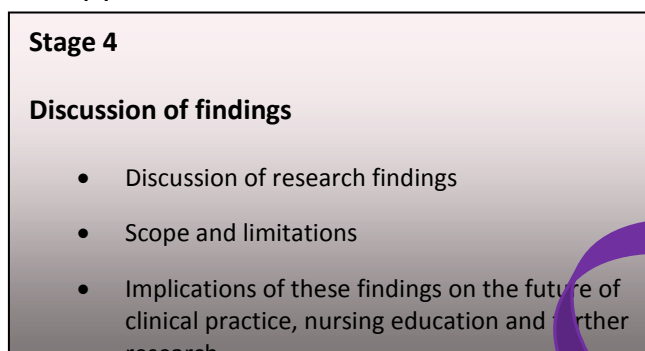


Figure 1.1 Flow of research activities for the qualitative study (Adapted from Polit & Beck 2012: 61)

The *first stage of the research involved* conceptualising and planning. A comprehensive review of the literature using sources such as journal articles from various data bases, research and discipline books, and the internet were undertaken for contextual understanding of the nursing student's perspectives on spiritual care in clinical practice.

The *second stage* involved constructing the research methodology, which focused on a qualitative non-experimental, explorative research design, theoretical framework and

the research methods. The process of stage two overlapped to stage three due the concurrent collection of data and analysis.

During the *third stage*, the researcher was engaged in data collection, analysis and discussion of the research findings.

At the *fourth stage*, the researcher summarised the findings, presented the discussions, limitations and scope and implications of the study.

1.2 BACKGROUND TO THE RESEARCH PROBLEM

A research problem refers to a troubling condition and implies a phenomenon a researcher is interested in (Polit & Beck 2012:73). Provision of quality holistic nursing care to patients is one of the areas of focus and importance in the nursing profession. In a study conducted on the effective factors in providing holistic care reference is made to the fact that holistic care is the heart of the science of nursing (Zamanzadeh, Jasemi, Valizadeh, Keogh & Taleghani 2015:218). As much as health care professionals represent art and science in their practice of caring for body and mind, caring for the spirit is part of the area of great need that cannot be ignored (Savel & Munro 2014:2). Quality care implies embracing the idea of holism or wholeness which is inclusive of body, mind and spirit. Monareng (2013:3) states that nurses need to appreciate the interconnectedness of the dimensions of a human being in order to provide holistic care to their patients. Providers of holistic care consider a patient as a whole acknowledging existence of a body, mind and spirit in a person (Zamanzadeh et al., 2015:218) and giving attention to a person's spirituality is an inherent aspect to meeting patient care needs. The inadequacy in provision of spiritual care is attributed to the manner of preparing nursing students for their role as nurse practitioners. According to Zamanzadeh et al (2015:220), evidence points at the biomedical allopathic focus during training hence the neglect of spiritual and social needs as consideration is on corporeal and medical needs only. Further, the Scope of Practice of Professional Nurses (Regulation R2598, 1984, paragraph 3(1) (a) see SANC) excludes the spiritual

dimension when directing professional nurses (PNs) on acts or procedures applicable to health care practice.

The exclusion of the spiritual dimension by such an important statutory body as credible as the South African Nursing Council (SANC) with its mandate to monitor and control the practice of nursing in the country is a threat to the effective provision of spiritual nursing care, as it gives the impression that spiritual nursing care is not essential (Monareng 2013: 17). Nursing students have a need to be taught how to integrate spiritual care in clinical practice to develop their ability to provide such care with competence. However, the spiritual aspect of care has received far less attention in the classroom and in the clinical environment (Wallace et al 2008:1). Integration of spiritual care will be possible if the concept is taught during the early formative years of nursing students who enter the profession. Nurse educators should therefore explore the student's level of understanding and their spiritual views in order to empower them on how to respect individual beliefs of patients (Shores 2010:8). Role modelling of the right attitude and behaviour forms part of the grooming of a student hence the need to socialise them to recognise and respond to the needs of the human spirit especially when people are faced with illness and trauma (Giske 2012:1050).

The nursing process is used as a framework to guide the provision of patient care and thus the assessment tool gives direction on what data to collect (Berman & Snyder 2012:180). Questions to ask on spiritual wellbeing must be made simple and clear so that they are not skipped, omitted or ignored. Most nurses come from family backgrounds that have like-minded spiritual values that only need to be re-enforced into professional practice. Swinton and McSherry (2006:802) attest that spiritual care is seemingly not a priority in clinical practice as some nurses claim to see its importance but have no time to focus on it whilst others shy away avoiding to offend the patient particularly if the patient's beliefs are contrary to those of the nurse (Alpert 2010: 140). Hoffert, Henshaw and Mvudud (2007:66) mention that if student nurses are to be taught how to fulfil their function of promoting health care, then spiritual nursing care is not an optional extra. However, according to Hoffert et al (2007:66), majority of nurses do not include spiritual care as a routine part of their nursing care role. This has implications on

how student nurses are accompanied, mentored and socialised in the clinical environment with regard to spiritual care.

1.3 STATEMENT OF THE RESEARCH PROBLEM

As much as nurses subscribe to the concept of spiritual care but there is still lack of understanding of its characteristics and their role in providing such care (Biro 2012:1003). The emphasis in the art of caring for patients is on respecting patient's beliefs and nurses may be afraid of imposing their own beliefs as such refrain from providing spiritual care that is related to their professional practice. They may also find it difficult to engage in spiritual dialogue with patients whose faith they do not know or understand (Monareng 2009:30). One of the ethical responsibilities of the nurse is to alleviate suffering and protect the vulnerable but negative reports are re- appearing in the media of nurses who are insensitive, incompetent and abusive to patients (Meehan 2012:991). The South African National Health Minister expressed a concern regarding money spent by the Department of Health (DoH) on litigations (Etv news, 2015; News at seven, 09 March 2015, 19h00) related to professional malpractice. The regulation laying down acts of misconduct or omission (Regulation R387, 1985, paragraph 4) for PNs does not refer to omission of spiritual care as an act of misconduct despite the emphasis on provision of holistic care, it only refers to the physiological responses of the body to disease conditions, trauma and stress. The World Health Organisation (WHO) defines health as a state of physical, psychological, social and spiritual wellbeing and not merely the absence of disease or infirmity (Vasuthevan & Mthembu 2016:1). Quality and effectiveness of health care have advanced owing to advances in science and technology; however, this overshadows concerns for humane personal care for patients that is embedded in spirituality (Monareng 2013:2). Provision of patient care is a collaborated effort of the multidisciplinary team with nurses being in a better position to provide spiritual care seeing that they are in the clinical practice area providing comprehensive care to patients around the clock. This aspect of care is

seemingly not well understood or implemented in clinical practice because of the confusion between religion and spirituality (Monareng 2013:2).

This study seeks to investigate the nursing student's perspectives on spiritual care especially as neophyte stakeholders of patient care provision and future policy influencers. Nursing students are the future of the nursing profession as clinicians, educators, decision and policy makers and researchers. Their exposure to this phenomenon competes with influences from the medical model of care, the professional expectations from management, culture and climate that prevails in institutions and their social environment. Understanding their position in this regard needs support and guidance by relevant influential stakeholders such as the nurse educators, managers in clinical practice, the SANC, Department of higher education and training, DoH and the WHO.

This study is conducted with an assumption that provision of quality holistic care is still a challenge facing the nursing profession, and nursing students are the hope for the future as such investing in them ensures a secured future for the profession. They still experience some uncertainty concerning the nurse's role in providing spiritual care related to spiritual content not adequately addressed during the classroom engagements or curriculum development. There is therefore a need for both educators and nurse managers to teach spirituality and role model spiritual care both in the classroom and in clinical practice.

Therefore, the central theoretical statement for this study is that "What are the perspectives of nursing students on spiritual care in clinical practice?"

1.4 THEORETICAL GROUNDING OF THE RESEARCH

A theory is defined in Burns et al (2013: 45), as a combination of related concepts and relational statements that presents a view of a phenomenon to describe and explain or control that phenomenon. It is a set of interrelated concepts that provides a systematic view of a phenomenon (Wood & Haber 2014: 78). Qualitative studies do not usually use

a theoretical framework to guide data collection and analysis, but in this study inductive reasoning will be used to approach the conceptualisation of the construct and the meta – theoretical assumptions. No particular theoretical framework will be used to guide data collection and analysis.

1.4.1 Inductive reasoning

Parahoo (2014:408) defines inductive reasoning as a method of reasoning from a particular to a general premise and implies a mental process involved in creating generalisations based on observed phenomena. According to Maltby, Williams, McGarry and Day (2010:53), inductive reasoning refers to the process of making generalisations based on specific observations made out of facts (Brink, Van der Walt & Van Rensburg 2012: 5). Inductive reasoning in this study assisted the researcher in drawing conclusions about the phenomena under study.

The meta-theoretical assumptions as proposed by Mouton and Marais (1990:11 -16) as a classic source, which are the ontological, teleological, epistemological and methodological dimensions were utilised.

1.4.2. Meta-theoretical assumptions

Assumptions are basic principles that are assumed to be true based on logic and reason, without proof or verification (Mouton & Marais 1990:11; Polit & Beck 2012:720). Sources of assumptions include universally accepted truths such as theories, previous research and nursing practice experiences. Assumptions influence the logic of a study and their recognition leads to more rigorous study development. The assumptions focussed on in this study were:

Ontological assumptions refer to the human nature, society and the nature of reality (Mouton & Marais 1990:11). The ontological assumptions underlying this study were:

- Man is multidimensional and all dimensions are equally important in determining the quality of life of an individual whose dimensions are body, mind and spirit.

- Spiritual nursing care is an important component of holistic care which the nursing practice aspires to provide to ensure optimal quality patient care.

Teleological assumptions are about the aim or goal of understanding reality it comes from the Greek word telos, meaning goal or end which describes an ethical perspective which describe the wrongness or rightness of people's actions (Mouton & Marais 1990: 11-12). The teleological assumptions underlying this study were:

- Exclusion of spiritual care has adverse outcomes on the quality of patient care
- Lack of proper definition of what spiritual care is makes nurses to ignore this aspect of care or treat patients contrary to their beliefs.
- It is ethically not acceptable to impose one's belief system that will be harmful to a patient.

Epistemological assumptions are about the content of truth and related ideas that reflects the nature of knowledge (Mouton & Marais 1990:14). In this study epistemological assumptions were posited as follows:

- Multiple realities exist with regard to spiritual nursing care and this can be captured by means of qualitative research.
- Narrative data can elicit an understanding of the meanings that nurses attach to spiritual nursing care.
- Although it is difficult to ascertain when the truth has been attained, it is, however, necessary to strive for reality as close as possible.
- Theories inductively generated from data are likely to offer insight, knowledge, enhance understanding and provide a meaningful guide to action, including nursing practice.

According to Mouton and Marais (1990: 15 – 16), methodological assumptions provide how the research is planned, structured and executed to comply with the criteria of

science. It refers to the logic of implementing scientific methods in the study of reality. Methodological assumptions regarding this study were:

- Qualitative research supports naturalistic inquiry to collect qualitative data on reality which is constructed by people.
- In-depth interviews are ideal as human beings use language to attach meaning to phenomena and communicate the meaning to others.

Burns et al (2013:158) conclude that assumptions are embedded in thinking and behaviour, uncovering these assumptions requires introspection and a strong knowledge base in the particular field of study.

1.5 DEFINITION OF CONCEPTS

The conceptual and operational definitions of this study were:

Clinical practice

Clinical practice refers to the interaction that takes place in a clinical environment where legal and ethical aspects of practice are implemented to observe and treat sick, ill or injured persons as distinguished from theory taught in the classroom (Freshwater & Prothero-Maslin 2005:132). This is the environment where a group of health care professionals including nurses work together co-operatively with understanding of illness diversities of suffering (Monareng 2013:1).

In this study, clinical practice refers to provision of appropriate health care activities by nurses with an intention to optimise patient care to be holistic by focussing on the spiritual, physical, psychological and social needs of an individual in order to optimally address specific health needs in a hospital or clinic setting.

Holistic care

Holistic care is a system of total or comprehensive care that includes the physical, emotional, economic, social and spiritual needs of the person, his or her response to

illness disease and trauma as well as the effect of illness on his ability to meet self – care needs.

In this study, holistic care refers to care given to patients in other aspects such as emotional, psychological, physical in addition to the spiritual care in an evident way,

Nursing

Nursing is a caring profession practised by a person registered under section 31(1) (a) of the Nursing Act, Act No. 33 of 2005 as amended, which supports, cares for and treats health care users to achieve or maintain health and where this is not possible, cares for a health care user so as to live in comfort and with dignity until death (South Africa 2005: s5). Nursing is the blending of art, science and devotion to help those who are physically, mentally and spiritually unwell or ill. According to Virginia Henderson (George 2011: 90), Nursing is a unique function of a nurse to assist the individual, sick or well in performance of those activities contributing to health or its recovery or to peaceful death, that he would perform unaided if he had the necessary strength, will or knowledge. This is done to help him gain independence as rapidly as possible (George 2011: 90).

A nurse is a qualified individual in terms of the nursing education program undertaken as guided in R683 or R425 as the case may be, who is registered as such in terms of section 31 (1) (a) of the Nursing act (South Africa 2005: s5).

In this study, the concept *nursing* refers to an interactive process by a nurse who is a student in the Bridging course programme in a nursing college as guided by Regulation R683, 1989, Paragraph 4(1) (a), (2). This regulation and its teaching guide stipulates that the duration of the course shall be two academic years, the subjects comprises of Applied Social Sciences (including Communication and Mental Health), Ethos and Professional Practice (including Ward Management and Clinical Teaching) and Integrated General Nursing Science (SANC 1989. Par 6.1 & 7.2).

Historically the bridging programme in South Africa (SA) was established in 1988 to address career- pathing needs for Enrolled nurses (E/Ns) to become P/Ns thus opening

avenues for them to grow in the profession (Mellish 2012: 51). This programme provided some relief on the shortage of P/Ns especially in rural areas which are mostly affected. The setting in which this study was undertaken is in a rural health care facility and qualifiers of this program forms about 70% of the total population of P/Ns in the institution. According to Naranjee (2012: 20), health care services in these areas are mostly staffed by nursing graduates of the Bridging Programme hence the interest to understand their perspective on spiritual nursing care.

Perspective

Streubert and Carpenter (2011:20) defines perspective as multiple realities which are the frame of mind that reflects the opinions or views an individual hold on a specific issue and may be indicative of conclusive idea emanating from one's experience. Perspective is defined as the art of representing three-dimensional objects on a two-dimensional surface so as to give the right impression of their height, width, depth, and position in relation to each other. It is a particular attitude towards or way of regarding something; a point of view or an apparent spatial distribution in perceived sound (Oxford *Advanced Learner's Dictionary* 2013: 1020).

In this study, the concept perspective refers to the viewpoints and opinions that nursing students have about spiritual care as applied in clinical practice. It also refers to the impressions they have concerning the provision of holistic care to patients and particularly the provision of spiritual care as learned from the classroom with reference to caring for the body, mind and spirit. It refers to multiple realities and meanings to consider when trying understanding spiritual nursing care as is viewed by the Bridging course nursing students.

Care

Care is a procedure whereby the caregiver commits to look after the patient's needs by making an effort to do something correctly, safely or without causing damage; to keep someone healthy, safe or to keep something in good condition (Freshwater & Maslin-Prothero 2005:108 sv "care").

Care is the provision of what is necessary for the health, welfare, maintenance and protection of someone or something (Oxford English Dictionary 2012: 102 sv “care”).

Spiritual care

Spiritual care is a process that nurtures the essence of a person’s being, the identification of one’s inner resources and an awareness of who and what one is, the purpose of being and what shapes one’s journey during illness (Wallace et al 2008:1). According to Monareng (2013:2), spiritual care refers to the support and engagement with patients in a compassionate relationship; assisting them to find meaning and purpose in life in relation to the presenting health condition of trauma, sickness, injury or pain which may be a need for faith support in a form of prayer, sacrament or sacred scriptures. In a study conducted by Alpert (2010: 141), spiritual care is viewed as any act that nourishes the soul and nurses are the right people to provide this nourishment as people who spend most of the time with patients than other members of the multidisciplinary team.

In this study, spiritual care denotes a perspective on deliberate and motivating engagement by Bridging course nursing students with patients presenting with a spiritual need which can be spiritual pain, sadness, and suffering, questions about purpose, hope and meaning of life and competently meet those needs.

Student

A student refers to a person who attends an educational institution for the purpose of studying (*Oxford English Dictionary* 2012: 724 “context”).

In this study, student refers to a Bridging course learner nurse who is registered as such under section 32 of the Nursing Act, (Act No 33 of 2005 as amended) which describes a student as a person undergoing education and training and specific professional socialisation in nursing. The word student is used to refer to learners of the

Bridging course programme which is offered over a period of two academic years (SANC 1989. Par 6.1) to transit them from an ENs position to the P/Ns status.

1.6. SIGNIFICANCE OF THE STUDY

The findings from this study will help all stakeholders who have interest in the provision of holistic care to patients; to gain knowledge that will assist to modify current practices on how to implement the nursing process inclusive of spiritual care. Some of the findings will guide both educators and clinicians on the formulation of nursing care plans that shows evidence that the spiritual needs of patients are met. Recommendations made and formulated guidelines will provide some insights for stakeholders involved in educating, training and supporting students on how to provide basic spiritual care in order to improve the quality of patient care. Valuable in-service education will be provided for nurses in practice on the findings of the study to create a clinical environment that is inclusive of spiritual care. Suggestions based on the findings, will be made to nurse educators to consider making spiritual care to be evidenced in the teaching and assessment strategies.

1.7. PURPOSE OF THE STUDY

Research purpose is a concise, clear statement of the aim of the study which establishes and captures its essence by giving an overall summary of the goal of the study (Polit & Beck 2012:92). It refers to a determination as to what the researcher intends to do (Wood & Haber 2014:34).

The purpose of this study was to explore and describe the perspectives of Bridging course nursing students regarding spiritual care as experienced in clinical practice.

1.7.1. Objectives of the study

Objectives are the declarative clear concise statements of accomplishments to be achieved by conducting a study (Polit & Beck 2012:73).

The objectives of this study were to:

- Explore and describe the perspective of Bridging course nursing students on spiritual care in clinical practice
- Identify factors underlying the perspective of Bridging course nursing students on spiritual care in clinical practice

1.7.2. Central theoretical statement

- This is an interrogative statement of the purpose of the study (Burns et al 2013: 158). It is a statement of the specific query the researcher wants to answer or address as a research problem which is similar to a research question in quantitative studies (Polit & Beck 2012:741). The theoretical statement guiding this study was:
- “What are the perspectives of nursing students on spiritual care in clinical practice?”

1.8 CONTEXT OF THE STUDY

The study was conducted in one of the sub-campuses in the KwaZulu-Natal College of Nursing (KZNCN) situated in one of the districts which offers a two-year Bridging course programme for E/Ns leading to registration as a general nurse (SANC 1989, Par 3(1)). The sub- campus is attached to a sub- district hospital with a capacity of 296 beds which is staffed by approximately 300 nurses of different categories and 16 doctors. The details of this section are in chapter 2.

1.9 RESEARCH METHODOLOGY

Research methodology refers to techniques and procedures used to structure a study, gather and analyse information in a systematic manner (Polit & Beck 2012:741). It offers opportunities such as gaining insight into the overall research process, creating awareness of the choices that are available in research methods and assisting in enabling evaluation of research (Bryman, Bell, Hirschsohn, Dos Santos, Du Toit, 27

Masenge, Van Aardt & Wagner 2014: xxi). In this study, research methodology referred to the research design and method that was used to conduct the research. The research design for this study was a qualitative, explorative and descriptive approach based on the phenomenological philosophy. The Heideggerian phenomenological philosophy was utilised to guide data collection and analysis. The research method included aspects such as population, sample and sampling, sampling technique, sample size, data collection and data analysis methods. Trustworthiness and ethical consideration were ensured.

1.9.1 Research design

Research design is a detailed outline of how an investigation will take place, a description of how the researcher plans to go about to address the research problem (Wood & Haber 2014:100). Parahoo (2014:412), defines it as a plan of how, when and where data collection and analysis will take place. According to Burns et al (2013:36) it is a blue print of how the researcher intends to conduct the research and the focus is on the logic of research outlining the kind of evidence required to adequately address the research question. It is explained in Polit & Beck (2012: 741) as the overall plan which specifies how the research question will be addressed and further indicates specifications for enhancing the study's integrity and credibility.

The research design for this study was a qualitative, explorative and descriptive approach that enabled the researcher to examine nursing student's perspectives on spiritual care in the context of clinical practice.

1.9.2 Research method

Research method refers to the techniques or processes used to structure a study and to gather and analyse information in a systematic and objective manner (Polit & Beck 2012:741). The methods followed in this study were population and sample selection, sampling technique, sample size, data collection and data analysis.

Population and sampling

Population refers to the entire aggregation of cases in which a researcher is interested. It may be broadly defined to involve a large number of people or narrowed to specific targets (Polit & Beck 2012:273). Parahoo (2014:259) defines population as the units from which data can potentially be collected which according to Wood and Haber (2014:232) the units must have specified properties.

There are three types of population which are universal, target and accessible population. The universal population for this study was all the nursing students registered for the Bridging course in South Africa (SA). Target population refers to the entire set of cases about which the researcher would like to contextualise the findings (Wood & Haber 2014:233). In qualitative study's findings are not generalised but applied in context. In this study, target population referred to all participants at the study context who met the inclusion criteria. The accessible population is defined by Burns et al (2013: 351) as the portion of the target population that the researcher has a reasonable access to. In this study the accessible population was all the Bridging course nursing students who were available on the days of data collection and were recruited to participate in the study.

The inclusion criteria refer to the characteristics determined to be essential for membership or participation in the study as it reflects distinguishing descriptors (Brink et al 2012: 131). The *inclusion criteria* in this study was two or more years of clinical experience, aged between 25 and 50, both males and females who were registered in the Bridging course programme. The *exclusion criteria* as explained in Polit and Beck (2012:275) refer to the characteristics that people must not possess to be part of a study. In this study all those who do not have two years of clinical experience or were younger than 25 years even though they were undergoing training of the same programme were excluded.

Sample

A sample is defined as a portion of the population to represent the entire population (Polit & Beck 2012: 742). In this study, nursing students of the Bridging course

programme between the ages 25 – 50 both males and females who were willing to participate in the study and were available during data collection formed the sample.

Sampling technique

The *purposive sampling* method was used to recruit participants in this study. Purposive sampling is a non-probability form of sampling done in a strategic way so that those sampled are rich with information relevant to answer the grand tour question (Bryman et al 2014:186). Purposive sampling was found ideal for this study as the inquiry was specific to the Bridging course nursing students who were the rich source to answer the research question compared to any other student in the study context.

The *sample size* was not predetermined as data was collected until saturation occurred. Data saturation occurred at the ninth interview; that is at the stage when information was redundant and no new information was obtained and data collection ceased (Polit & Beck 2012: 521).

Data collection

Data collection is defined by Polit and Beck (2012:7250) as the gathering of information needed to address a research problem. In this study, an interview guide was used to collect data from individuals through in-depth face to face interviews. These interviews entailed, according to Burns et al (2013: 698), conducting an unstructured verbal communication between the researcher and the participants. A grand tour question that was asked was “Tell me, what do you understand by spiritual care and how do you implement it during patient care in clinical practice?” Subsequent probing questions were guided by responses of participants for further exploration and clarification on a study phenomenon. Data was captured on a recorder, transcribed verbatim and typed by the researcher. All collected data was kept under lock and key and only authorised people had access to it. Data collection occurred simultaneously with data analysis.

Data analysis

A thematic analysis method was used to describe, analyse and interpret the findings. Thematic analysis is a flexible method that is not tied to a specific philosophical orientation whose goal is to identify, analyse and describe patterns or themes across the data set (Bryman et al 2014:351). The transcripts were read intensely and recurrent themes and categories were identified. The Heideggerian interpretative analysis based on the major construct of Being and Time (Polit & Beck 2012: 496) was incorporated as a method of data analysis to elicit the meaning that students attach to the construct under study. Heidegger's interpretive analysis was based on the research and probing questions that were posed to the nursing students' to elicit interpretations of their perspective of "being in" nurse/patient interactions with intent to provide spiritual care. This process was done under expert supervision of a colleague who is knowledgeable with qualitative studies.

Bracketing

Bracketing was applied which is a process whereby preconceived beliefs and opinions about the phenomena under study are identified and held in abeyance by conducting a bracketing interview (Polit & Beck 2012: 589). This method helped the researcher to put the researchers' own experience and understanding of the study phenomena aside and ensure that the study findings were purely the perspectives of the study participants.

1.10 ENSURING TRUSTWORTHINESS

Trustworthiness according to Lincoln and Guba (1985:290) refers to the quality value of the final results and conclusions reached in a qualitative research. In qualitative research rigor is measured by its trustworthiness or the extent to which the findings are true to the data collected and analysed (Polit & Beck 2012:583). Lincoln and Guba (1985:290) identified criteria of credibility, transferability, confirmability and dependability to encompass trustworthiness.

This section is discussed in detail in chapter 2.

1.11 ETHICAL CONSIDERATION

Ethics is the moral philosophy that addresses issues of human conduct and is concerned about right, wrong, good, bad, ought and duty of researchers (Pera & Van Tonder 2011:5). Ethics in this study was ensured by protecting the rights of the study institution, the rights of the participants and ensuring scientific integrity.

This section is discussed in detail in Chapter 2.

1.12 SCOPE AND LIMITATIONS OF THE STUDY

Limitations in a study may be theoretical or methodological and are defined as the restrictions or challenges that decrease the generalisability or contextualisation of the findings in a study (Burns et al 2013: 598).

The main limitations in this study were that the sample was relatively small and the application of the findings was only to a single setting. The purposive selection of participants could have eliminated students that have desirable characteristics for the study with probable rich information to answer the research question.

1.13 STRUCTURE OF THE DISSERTATION

The dissertation was structured in a logical flow of arguments and activities as described in the stages of the study section and organised into chapters.

Table 1.1 Structure of the dissertation

Chapter	Title	Content description
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1	Orientation to the study	An overview of the research problem, purpose and significance of the study, research design and methodology, theoretical grounding, definition of key concepts measures to ensure trustworthiness and ethical considerations was presented.
2	Research design and method	Description of the research design and method with reference to data- collection and analysis techniques with detailed description of trustworthiness and ethical considerations was presented.
3	Data analysis and interpretation	Analysis, presentation and interpretation of findings.
4	Discussions, conclusion and recommendations	Discussion of findings, conclusion and recommendations. Presentation of the nursing care plan on spiritual nursing care based on the application of the nursing process as guided by the findings of the study and literature. Implications of the findings on clinical practice, education and further research were presented.

1.14 CONCLUSION

In this chapter, an introduction on the study problem, a background to the research problem, a statement of the research problem and a theoretical grounding was introduced. Key concepts were conceptually and operationally defined. Highlights of the purpose, objectives and a central theoretical statement were given. The research design and method were clarified. A brief explanation on how trustworthiness and

ethical consideration will be ensured was given, and the possible scope and limitations were indicated.

Chapter 2 presented the research design and method.

CHAPTER 2

RESEARCH METHODOLOGY

“Every discourse even a poetic or oracular sentence with it is a system of rules for producing analogous things and thus an outline of methodology”

2.1 INTRODUCTION

The research methodology of this study comprised of the research design and the different research methods and techniques that were used to investigate the research problem for empirical evidence. A guide, a recipe or a map is needed in order to reach a destination. The research design and method in this study were the guide or recipe which was used to draw conclusions about the study phenomenon. The implementation of a good research study requires a clear research question, a fitting method to answer the query and the availability of people with rich information to answer the question or grand tour question in qualitative studies (Streubert & Carpenter 2011:33). The methodology offered the researcher opportunities such as gaining insight into the overall research process, creating awareness of the choices that are available in research methods and assisting in enabling evaluation of research (Bryman et al 2014: xxi). The study was conducted at a selected KZN CN Sub- Campus in one of the districts of KwaZulu- Natal (KZN).

The research design of this study was a qualitative, explorative and descriptive design that was based on the phenomenological philosophy. The grand tour question asked was "Tell me, what do you understand by spiritual nursing care and how do you implement it during patient care in clinical practice?" The research techniques and procedures used were population, sampling and sampling techniques, sampling size, data collection and analysis. Trustworthiness measures and ethical considerations were ensured (Polit & Beck 2012:741).

This chapter was at the second stage of the research process and involved constructing the research methodology, which focused on a qualitative, non-experimental, explorative research design, theoretical grounding of the research and the research methods. The aim of this chapter was also to discuss the where, when and how data collection and data analysis will be undertaken. At this stage, the researcher obtained permission from DOH and KZN CN who were the gate keepers (Polit & Beck 2012:67).

The process of stage two overlapped to stage three due the concurrent collection of data and analysis.

2.2. OBJECTIVES OF THE STUDY

Objectives are the declarative clear concise statements of accomplishments to be achieved by conducting a study (Polit & Beck 2012:73).

The objectives of this study were to:

- Explore and describe the perspective of Bridging course nursing students on spiritual care in clinical practice
- Identify the factors underlying the perspective of Bridging course nursing students on spiritual care in clinical practice

2.3 RESEARCH SETTING

According to Brink et al (2012:59), setting refers to the field where the research will be undertaken. The identified setting in this study depended on the nature of the research question, objectives and the information required to address the research problem.

The study was conducted in one of the sub-campus in the KwaZulu-Natal College of Nursing (KZNCN) situated in one of the districts (as shown in Figure 2. 1) which offers a two-year Bridging course programme for E/Ns leading to registration as a general nurse (SANC 1989, Par 3(1)). A two-year Enrolment programme leading to registration as an Enrolled nurse (Regulation, R2175, 1993) is also offered. A one-year Enrolment programme leading to enrolment as a nursing auxiliary (Regulation, R2176, 1993) is offered as well. The capacity of the nursing school was one hundred and twenty (120) students of whom sixty (60)

were enrolled in the Bridging programme and sixty (60) in the enrolment programme with eight nursing lecturers (2 males and 6 females).

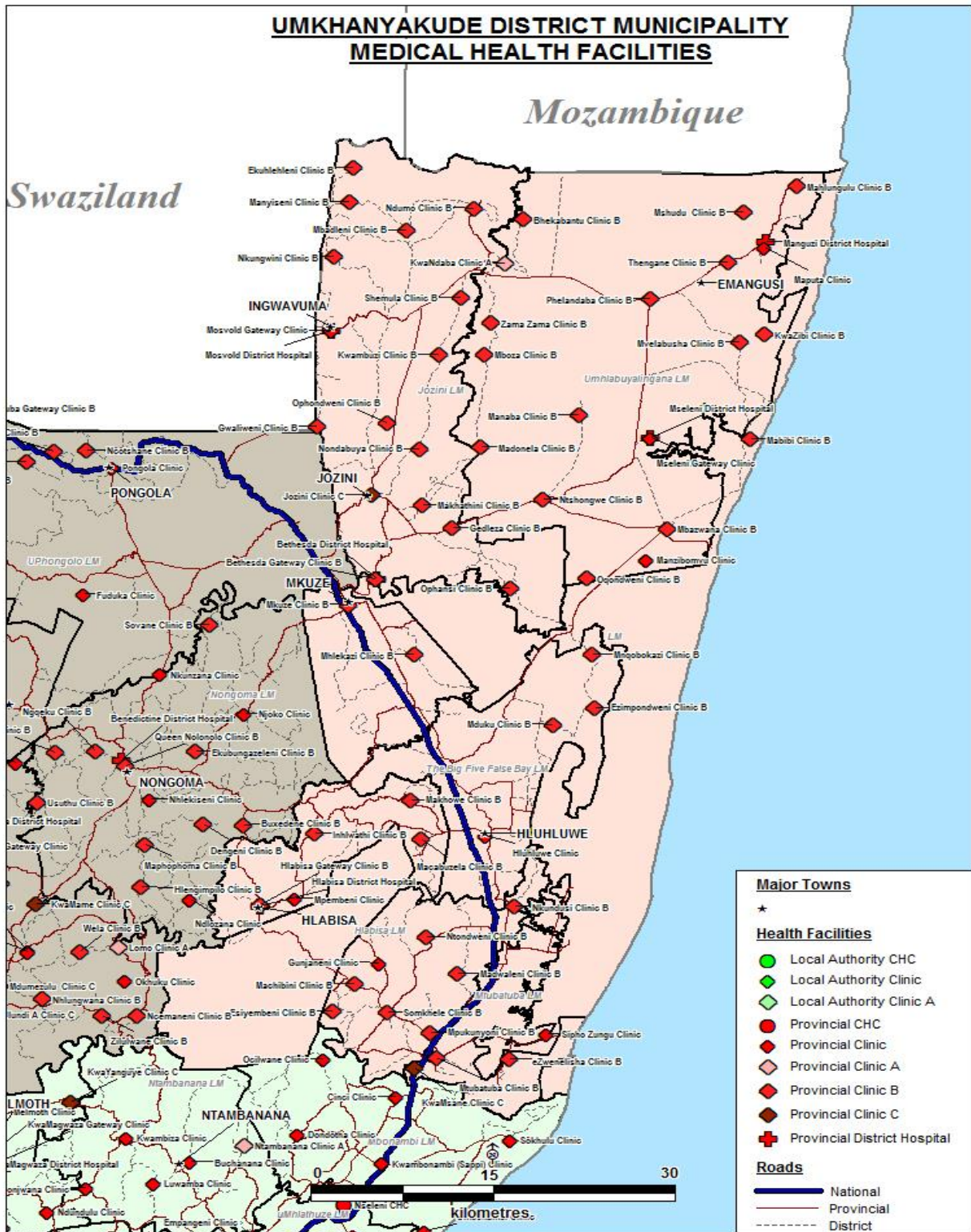


Fig. 2.1 Map of UMKhanyakude District (ARC MAP GIS)

Figure 2.1 is the map that shows the boundaries of the selected district (pinkish in colour) which is a deep rural district with five municipalities and five sub- district hospitals. The sub- campus is attached to a sub- district hospital with a capacity of 296 beds which is staffed by approximately 300 nurses of different categories and 16 doctors. It is linked to provincial hospitals by means of a referral system. The population served is estimated to be 71 925 with 13 184 households. There are various practices in terms of religion that are predominant in the area, Christianity is growing significantly even though many families practice both African religion and Christianity. Nazareth Baptist is also a very popular religion within the chosen catchment area served by the sub- district hospital with an influential belief system of traditional practices (Municipality integrated development plan 2013- 2014).

2.4 RESEARCH METHODOLOGY

Research methodology refers to the composite elements of the research design and the research method.

2.4.1 Research design

Research design is defined as a detailed outline of how an investigation will take place, a description of how the researcher plans to go about to address the research problem (Wood & Haber 2014:100). Parahoo (2014:412), defines it as a plan of how, when and where data collection and analysis will take place. According to Burns et al (2013: 37), it is a blue print of how the researcher intends conducting the research and the focus is on the logic of research outlining the kind of evidence required to adequately address the research question, whereas de Vos, Strydom, Fouche' and Delport (2011: 142), describe it as the process which focuses on the end product and the steps necessary to achieve the expected outcome. In this study, it is explained based on Polit and Beck

(2012: 741) as the overall plan which specifies how the research question will be addressed and further indicates specifications for enhancing the study's integrity.

The research design for this study was a qualitative, explorative, descriptive and **non – experimental** approach based on the phenomenological philosophy that enabled the researcher to examine the study phenomenon.

2.4.1.1 Qualitative Paradigm

A paradigm is defined as a way of looking at natural phenomena, a worldview that encompasses a set of philosophical assumptions and that guides one's approach of inquiry (Polit & Beck 2017:738). It is an overall philosophical framework that was applied in this study to assist the researcher to produce credible findings (Holloway & Wheeler 2010:341). The qualitative research paradigm was used to allow participants to freely express themselves as to what their perspectives were concerning the study phenomena and the meaning attached to them (Brink et al 2012:120). Qualitative research allowed the subjective views of the participants to be expressed, captured on the digital audio recorder and reflected on by the inquirer. The approach was used as a form of social inquiry that focused on the way people make sense of their world in which they live (Holloway & Wheeler 2010:3).

Qualitative research focused on the emic perspective of the participants, which was enhanced by the use of the local language, common concepts or means of expression to characterise and describe their perspectives meaningfully (Polit & Beck 2017:468).

Characteristics of qualitative research

A number of key characteristics are described such as a belief in multiple realities, the researcher as an instrument and that research settings are natural.

A belief in multiple realities

Individuals are active participants of creating meaning of the world, and the meanings created differ as they come to know and understand phenomena differently, hence the need to explore meanings until data saturation is reached (Streubert & Carpenter 2011: 20). This approach is flexible, and capable of adjusting to new information during the course of data collection. Multiple ways of understanding are used as the researcher may add new probing questions since data is analysed as it is gathered if new insights are brought up. (Burns et al 2013: 264)

The researcher is an instrument

The researcher was directly involved in the data collection process as an interviewer and observer that implies that she was part of the study an addition to the richness of data collection (Tappen 2016: 55).

Settings are natural

The research was conducted in real situations which were experienced by the participants and not in artificial settings. The researcher was able to understand the context of what was researched (Tappen 2016: 55).

There were a number of advantages that the researcher experienced when using qualitative research.

Advantages of qualitative paradigm

- The method was useful for exploring the full nature of a little understood phenomenon as the one undertaken (Polit & Beck 2012:14).

- Enabled the researcher to search for explanations about how or why the phenomenon exists or what a phenomenon means as a basis for developing a theory that is grounded in rich, in-depth, experiential and empirical evidence. This mode of enquiry aimed at examining the nuances and complexities of the phenomenon that was studied (Polit & Beck 2012:14).
- The selected participants and the kind of data that was generated became focused and purposeful as the conceptualisation was developed and refined (Polit & Beck 2012:15). The focus of qualitative research is usually broad and the intent is to give meaning to the whole as the qualitative researcher has an active part in the study (Burns et al 2013:23).
- Qualitative research is cost effective as it requires smaller scales and number of participants (Polit & Beck 2012:14-15).
- As much as generalisation of findings is not possible due to a smaller number of subjects, the findings can however be transferred to another similar setting

The design was suitable for gaining insight into the perspectives of nursing students for provision of spiritual care and what reality they attached to their world. However, there were some disadvantages experienced in the use of the qualitative paradigm.

Disadvantages

- Usually fewer people are studied thus making it impossible to generalise findings.
- It is often difficult to prevent or detect researcher bias, which can easily have influence on the quality of the research; an element that is heavily dependent on the skills and expertise of the researcher.
- The huge quantity of data makes interpretation and analysis time-consuming (Tappen 2016: 395).
- The presence of the researcher in the process of gathering data can influence the responses of subjects (Streubert & Carpenter 2011: 22).

Most researchers regard this approach as subjective and seem to violate the rule of objectivity. However, in this study bracketing was used to hold in abeyance any preconceived beliefs, opinions, views and the experience of the researcher especially as this is a phenomenological study (Polit & Beck 2012: 471). Bracketing per se is discussed under the section on phenomenology.

Other research designs used were the explorative, descriptive and non- experimental approaches based on phenomenological philosophy.

2.4.1.2 Exploratory Research Design

Exploratory research is defined as a study that explores the dimensions of a phenomenon or develops or that refines hypothesis about relationships between phenomenon (Polit & Beck 2012:727). Exploratory research looks at specific fields or topics that have been partly researched or has not been adequately addressed empirically. It considers the “what” of a matter and although it seldom gives the final conclusions, it does signify whether further research pertaining to a problematic issue or about specific topics is indicated (Polit & Beck 2012:18). An explorative design is relevant for this study as the researcher is interested in understanding how this important component of holistic care is implemented in clinical practice. Engaging with nursing students shed light on various ways used in clinical practice to address the spiritual needs of patients. Exploratory research in this study was conducted in order to satisfy the researcher’s curiosity and desire for a better understanding and to explicate the central concepts and constructs of the study phenomena (Polit & Beck 2012:18). It was used to respond to the research theoretical statement of this study which was “What are the perspectives of Bridging course nursing students on spiritual care in clinical practice?” In this study, the perspectives of nursing students relating to the study phenomenon were explored using qualitative unstructured and individual in-depth interviews

2.4.1.3 Descriptive Research Design

The objective of this descriptive design was to portray the characteristics of a study phenomenon as it occurred or was being experienced by participants who were involved in it. Descriptive research is aimed at providing specific details of a situation and frequently follows exploratory research in that describing a situation, the researcher has to be clear about what the main aspects are, the ‘how’ and ‘who’ is involved in a situation (Brink et al 2012:112). This form of a design is used where more information is required in a specific area by providing a picture of a study phenomenon as it occurs naturally (Brink et al 2012: 112).

The purpose of this descriptive design was used to obtain complete and accurate information about the phenomenon. The descriptive research assisted the researcher to provide a thick and detailed description of the perspectives of the participants for the purpose of audit trail.

2.4.1.4 Phenomenological research philosophy

Phenomenology is defined classically by Streubert and Carpenter (2011:74) as a system of interpretation that helps individuals to perceive and conceive themselves. Holloway and Wheeler (2010:213) concur with this definition by defining phenomenology as a philosophy which explores the meaning of individuals’ experiences through their own personal reports. The concept is further explained as a way of viewing ourselves, others and everything else whom or with which we come into contact in life (Holloway & Wheeler 2010:213).

The phenomenological tradition was used in this study to understand the meaning that nursing students attached to their perceptions about spiritual care (Brink et al 2012:121). Phenomenological design was the desired philosophy because it assisted the researcher to examine the perspectives of nursing students who answered the study question (Brink et al 2012:121); Polit & Beck 2012:490).

Phenomenology emphasises that people’s actions should be explained with reference to their conscious intentions. Intentionality means that consciousness is always being

conscious of something (Streubert & Carpenter 2011:74). The researcher maintained that phenomenological research is suitable to capture the essence of how nursing students perceived provision of spiritual care to patients by themselves or others in the clinical environment. Use of this tradition involved application of the descriptive and interpretive phenomenological research during data collection and analysis which incorporated elements of bracketing, intuiting, analysing and describing.

Descriptive phenomenology

The researcher employed both the descriptive and interpretive phenomenological research to describe and interpret nursing student's perspectives on the study phenomenon. The researcher implemented basic phenomenological actions that included *bracketing*, *intuiting*, *describing* and *analysis* during the descriptive phenomenology enquiry process (Brink et al 2012:122); Polit & Beck 2017:471).

Bracketing

Bracketing in this study required the researcher to be neutral with respect to beliefs or disbeliefs in the existence of the phenomena. It was however impossible to achieve total bracketing. The researcher tried to set aside previous knowledge or personal belief about the phenomenon under study to prevent the information from interfering with the recovery of a pure description of the phenomenon and the findings (Streubert & Carpenter 2011:77). The researcher maintained a reflective journal in ensuring bracketing as guided by the tips for qualitative researchers (Polit & Beck 2017:471)

Intuiting

Intuiting illustrates eidetic comprehension or accurate interpretation of what is meant in the description of the phenomenon under investigation. In this study, it occurred when the researcher tried to develop an awareness of the perspectives without forcing prior expectation or knowledge in the process (Brink et al 2012:122); Streubert & Carpenter 2011:76). Intuiting occurred when the researcher remained open to the meaning attributed to the phenomenon by those who have experience it (Polit & Beck 2017:472).

Intuition required the researcher to become totally embedded in the phenomenon of interest (Brink et al 2012:122)

Analysing

Analysing in phenomenology research is defined as a process that involves identifying the essence of the phenomenon under investigation based on data obtained and how they are presented (Streubert & Carpenter 2011:80). Whereas, Polit and Beck (2017:530) outline that analysis of qualitative data is an active and interactive process. In this study, the researcher scrutinised the data carefully and deliberately, often read and reread data in search of meaning and understanding (Brink et al 2012:122). While Polit and Beck (2017: 531) note that qualitative data analysis is a “process of fitting data together, of making the invisible obvious and of linking and attributing consequences to antecedents. The major data source in this study was qualitative interviews that were tape recorded. Then the collected data was transcribed verbatim to enable data analysis. Data analysis was done using the thematic analysis method which included inductive, descriptive and open coding technique of qualitative analysis (Creswell 2014:198-199).

Describing

Describing in phenomenological research is a process developed by Husserl (Polit & Beck 2017:471) who was interested in answering the question: What do we know as persons? His philosophy emphasised descriptions of human experiences. Descriptive phenomenologists insist on the careful description of ordinary conscious experience of everyday life and a description of “things” as people perceive or view them. These “things” include hearing, seeing, believing, feeling, remembering, deciding, evaluating and acting (Polit & Beck 2017:471). The aim of the describing operation was to communicate and bring to written and verbal descriptions distinct, critical elements of the phenomenon (Streubert & Carpenter 2011:82). The description was based on the classification or grouping of the phenomenon. However, Streubert and Carpenter (2011:82) alert researchers to avoid describing the phenomenon prematurely, as

premature description is a common methodological error associated with descriptive research.

Interpretive phenomenology

Interpretive phenomenology or hermeneutics implies interpreting and understanding how humans view or perceive phenomena. In this study, key principles of interpretive phenomenological analysis were applied by the researcher to investigate the phenomenon of perspectives of a person in the context of nursing students. It required intense interpretation and engagement with the data obtained from the participants and the data was examined in detail. In-depth individual unstructured interviews were conducted with participants during which phenomenology or hermeneutics as proposed by Heidegger brought out the art and philosophy of interpreting the meaning of the participants' perspectives (Polit & Beck 2012:496-497).

Interpretation of the text was also done through the process termed by Heidegger as fusion of horizons (Holloway & Wheeler 2010:228). Therefore, the data collection and analysis was also guided by Heidegger on how participants expressed themselves and attached meaning to their views and understanding of the phenomenon. Participants elicited meaning, experiences or perception from their point of view, rather than the researcher's perspective.

Inductive reasoning underpinned the philosophical stance by applying inferences from the specifics to the general premises.

2.4.1.5 Inductive reasoning

Inductive reasoning is defined as a logical process in which multiple premises, all believed to be true or found true most of the time, are combined to obtain a specific conclusion (Polit & Beck 2012:12). Polit & Beck (2012: 10) indicate that inductive reasoning is the process of developing generalisations from specific observations to the general premise. Inductive reasoning in this study stemmed from a specific scientific premise to the general in which particular events were narrated and combined into a larger whole or general statement in relation to perspectives of nursing students about

how nurses provide spiritual care to patients. Through inductive reasoning the researcher reduced themes until only three major themes, six categories and eleven subcategories were established (Creswell 2014:198).

Research methods that were followed in this study included population, population sample and sampling technique, data collection and analysis, ensuring trustworthiness and ethical considerations.

2.4.2 Research method

Research method refers to the logical process followed during the application of scientific methods and techniques when a particular phenomenon is empirically investigated (Polit & Beck 2012:765). According to Burns et al (2013:195), research method refers to the process or development of plans for actually carrying out the exact steps of the study. Research method in this study referred to techniques and processes that the researcher used to structure the study and how to gather and analyse information relevant to the research question in a systematic manner (Polit & Beck 2012:735). Research methods that were used were population, sample and sampling technique, data collection and analysis, ensuring trustworthiness and ethical considerations.

2.4.2.1 Population

A research population is defined as the entire aggregation of cases having some common characteristics in which a researcher has interest. Burns et al (2013:703) elaborate the explanation of population as all elements (individuals, objects, events or substances) that meet the sample criteria for inclusion in a study. The different types of populations are universal, target and accessible.

These population types and sample are exhibited on figure 2.2

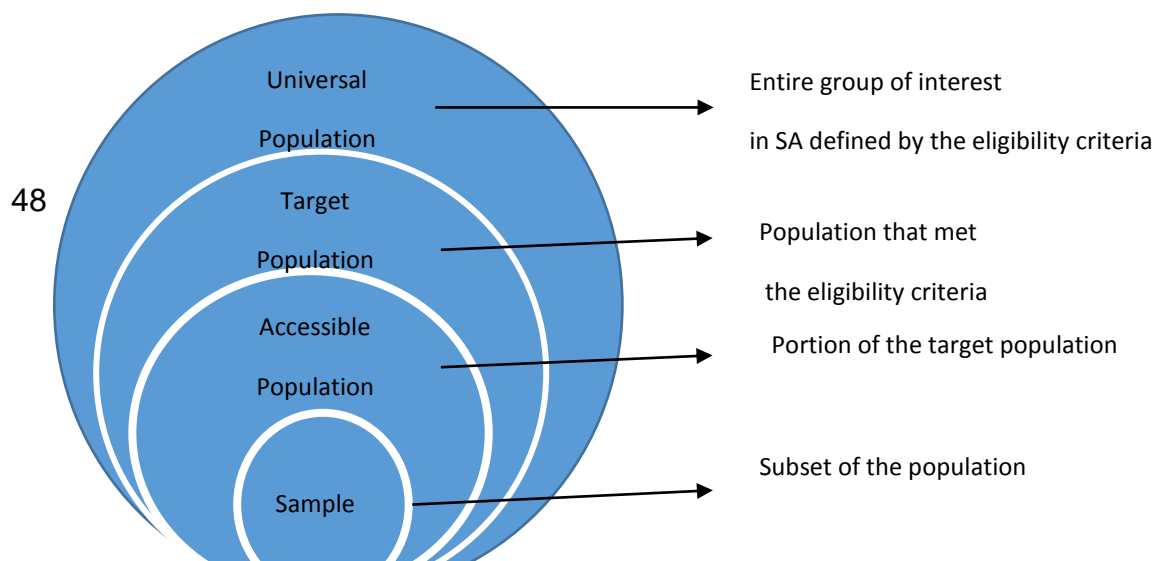


Figure 2.2 Population and Sample (Adapted from Burns et al 2013:352).

In this study universal population referred to all nursing students registered for the Bridging course in SA (Polit & Beck 2012:238). The target population referred to the entire population of nursing students who met the inclusion criteria (Polit & Beck 2017:747). The accessible population comprised of nursing students that were available and willing to participate in the day of data collection through individual interviews (Polit & Beck 2012:744).

Inclusion and exclusion criteria

The *inclusion criteria* refer to the characteristics determined to be essential for membership or participation in a study as it reflects distinguishing descriptors (Brink et al 2012: 131). The inclusion criteria in this study was two or more years of clinical experience, age between 25 and 50, both males and females who were registered in the Bridging course programme. The inclusion criteria were applied to select eligible participants.

The *exclusion criteria* as explained in Polit and Beck (2012:275) refer to the characteristics that people must not possess to be part of a study. In this study all those who do not have two years' clinical experience and are younger than 25 years old even though they were undergoing training of the same programme were excluded.

2.4.2.2. Sample and sampling technique

A sample is defined as a portion of the population to represent the entire population as demonstrated in figure 2.2 (Polit & Beck 2012: 742). In this study, eligible participants who were willing to participate in the study and were available during data collection formed the sample.

Non – probability sampling

The selection process in non – probability sampling involves a choice, preference or use of discretion by the researcher (Tappen 2016: 122). This is a convenience sample which may not accurately represent the population. It places a greater judgement on the researcher who must judge and select those who know more about the phenomenon (Brink et al 2012: 139).

Sampling method

The *purposive sampling* method was used to recruit participants in this study. Purposive sampling is a non-probability form of sampling done in a strategic way so that those sampled are rich with information relevant to answer the grand tour question (Bryman et al 2014:186). Purposive sampling was found to be ideal for this study as the inquiry was specific to the Bridging course nursing students who were the rich source to answer the research question compared to any other student in the Sub-campus as they were regularly in the clinical area.

Sample size

In qualitative studies the *sample size* is not predetermined as data was collected until saturation occurred at the ninth interview when no new information was obtained and data collection was discontinued (Polit & Beck 2012: 521).

2.4.2.3 Data collection

Data collection is defined by Polit and Beck (2012:7250) as the gathering of information needed to address a research problem. In this study, an interview guide was used to

collect data from individuals through in-depth individual face to face interviews. These interviews entailed, according to Burns et al (2013: 698) conducting an unstructured verbal communication between the researcher and the participants. A grand tour question is a broad general question that gives an overview insight of a phenomenon from which subsequent questions are based (Polit & Beck 2012: 729). In this study, a grand tour question that was asked was “Tell me, what do you understand by spiritual care and how do you implement it during patient care in clinical practice?”

Subsequent probing questions were guided by responses of participants for further exploration and clarification. Probing in this study took three forms:

- **Detail – oriented probes** which aimed at ensuring that the answer given by the participant is understood by the researcher.
- **Elaboration probes** involved asking more details of a certain answer so as to get a full picture of the response and
- **Clarification probes** were for confirming with the participant whether what the researcher understood in the message was what the participant meant (Maree 2015: 5). Data was captured on a digital tape recorder, transcribed verbatim and typed by the researcher. Processes such as reflexivity; the responsibility of the researcher to reflect on self, examining and exploring personal values and beliefs that could affect data collection and interpretation was done through bracketing (Polit & Beck 2012: 179). All collected data were kept under lock and key in the office of the researcher and only authorised people had access to it. Data analysis occurred simultaneously with data collection.

Pre-test

In this study, a pre – test focused on the data collection instrument to test the ability of the researcher as a novice researcher to use the instrument and also ascertain whether the participants understood the grand tour question. Two eligible participants were recruited who did not participate in the main study. The pre – test helped to determine the time required for collecting data from one participant and how the question was

presented and follow up questions asked. The question that was posed to the participants was well understood but the response was not easy because of the abstract nature of the study phenomenon.

Arrangements were made with those who volunteered to participate in terms of venue, dates and times of interviews.

Data collection approach

Data collection approach in this study included information on data collection instruments, data collection process and the in-depth unstructured individual interviews.

Data collection instruments

In this study, a questionnaire as part A, and an interview guide which comprised part B for in-depth individual unstructured interview was utilised. According to Monareng (2009:130), an interview is build-up of four kinds of questions, which are demographic, open ended, probing and follow-up questions. In this study, the interview guide (Annexure E) had two sections. Section A was demographic collection tool used to collect biographic data. Demographic questions were used as an ice breaker. They were presented as written responses in a questionnaire format. Section B had a grand tour question, commonly known as a broad question which was asked to explore the participants' perspectives. The question was asked consistently to all the 9 participants. This was followed by probing questions for more clarity on the responses.

Questionnaire

A questionnaire (Annexure E) was used to collect data from participants who provided their profile in terms of gender, age, clinical experience; any courses done that are related to spiritual care and religious affiliation.

The researcher as the key instrument

The researcher was the main instrument in this study and was subjectively involved in the research process. The researcher collected data by requesting participants to fill in the demographic form and conducted an unstructured in-depth face to face interview using an interview guide (Annexure E) (Creswell 2014:10).

Data collection process

The data collection process entailed preparations of resources to be used and the venue. The following resources were given to the gate keepers and participants in the process to facilitate data collection.

- Ethical clearance from UNISA, the approval from the Department of Health, permission letter from the Principal of KZNCN, information about the study with consent and confidentiality forms for participants to sign, and a two-part interview guide, section A for filling in and Section B had the grant tour question.
- After permission was granted by all relevant stakeholders, a suitable venue for conducting interviews was secured. Accessible participants who volunteered to participate were invited telephonically to the venue. The researcher brought some stationery, the digital tape for recording during the session. Date, time, length of interviews, were captured in the researcher's journal.
- Soft drinks, fried chicken and bread rolls were provided for lunch.

Preparation of the venue for interview

The interview dates and time were arranged with the Sub – Campus management and the participant before the actual date of the interview. Interviews were conducted on different dates due to the diversity of work commitments but in the same venue. The arrangement was convenient for the researcher to find key participants in one area. The interviews were conducted over five days. The interviews were conducted in a boardroom after permission was obtained. A notice for no disturbance was pasted at the door to ensure privacy and avoid interruptions.

In-depth unstructured individual interviews

The unstructured interview also referred as in-depth, open-ended and narrative or long face to face interview is the favoured method used by qualitative researchers (Brink et al 2012:158). In this study, the unstructured interviews were conducted more like a normal conversation, but with a purpose of obtaining information to answer the grand tour question (Brink et al 2012:158).

Advantages of using unstructured interviews

According to several researchers (Brink et al 2012:158; Polit & Beck 2012:536), there are advantages to an in-depth, unstructured interview outlined as follows:

- The process of collecting data was cost effective, the data collected was of quality and collected in a relatively short time frame.
- An adequate sample was obtained through data saturation.
- The process was flexible, permitted the researcher to pursue emergent themes, follow the lead of the interviewee and gained new insights.
- It was easy to observe non-verbal communication and mannerisms that could be interpreted
- The researcher and participants were able to clarify questions through probing

However, there were some disadvantages encountered during the unstructured interview (Polit & Beck 2012:296):

- There was inconsistency in data collection with regard to how the question was perceived, answered and responded to by participants.
- More time was required from the interviewer as compared to self-administered questionnaires
- There was a huge volume of data obtained through the transcripts which made the transcribing, typing, analysis to be time consuming and laborious.

Interviewing

All 9 participants consented to be audio recorded. The tape recorder was put on the table at the convenient place for the researcher to operate. The arrangement of sitting allowed for eye contact. The participants were given an opportunity to fill in the demographic form prior the interviewing process. The researcher asked the individual participants the grand tour question followed by probing questions.

The interview sessions ranged between 30 to 45 minutes each. A digital tape recorder was used to capture the interviews verbatim for more comprehensive record keeping after permission to do so was obtained from the participants. The transcripts were typed by the researcher and subjected for manual qualitative analysis, **whereby the researcher used coloured paper clips to mark similar expressions from which themes were deduced (Polit & Beck 2012: 560)**

Challenges encountered during conducting interviews

As a novice researcher, handling responses of participants who answered the research question incoherently was a challenge, especially to pick up key concepts related to the study phenomenon. The concept of spiritual care sounded new to them and abstract. The challenge was the use of participant's lunch break which deprived them of the resting time for the day. Some recordings were very soft and hard to listen to for recording them verbatim.

2.5 DATA MANAGEMENT AND ANALYSIS

Data management refers to the way the data is managed as well as how it is kept safe after being collected. The documents of the participants were given codes to ensure anonymity and confidentiality and kept under lock and key in the researchers' office. It is noted that in qualitative studies data management is "reductionist" in nature which

involves reducing masses or large amounts of data into smaller portions. In this study, data reduction was a form of analysis that helped the research to sharpen, sort, focus, discard and organises data in such a way that the final conclusions were drawn and verified (Polit & Beck 2012: 562). In this study, data management and analysis occurred simultaneously. The audio-recorded interviews were transcribed verbatim immediately after data collection. They were labelled and captured on a memory stick for analysis purposes and later for audit trail (Burns et al 2015:531).

2.5.1 Data analysis

The process of data analysis began during transcription of the audio-records during data collection. Data analysis was done using thematic analysis approach including inductive, descriptive open coding technique (Creswell 2014:198; Burns et al 2013:89). Data analysis in qualitative studies is also “constructivist” in nature whose goal is to understand how individuals construct reality within their context (Polit & Beck 2012: 562).

The audio-recorded interviews were transcribed verbatim by the researcher. The transcripts were then written in a dialogue form for easy coding (Annexure F). The collected data was synthesised and organised systematically to account for the processes (Polit & Beck 2012:125). The process of listening and transcribing data recorded gave the researcher an opportunity to be immersed in the data, as this was important for data analysis. Dwelling with data means that one is fully invested in data and spend extensive amount of time listening, reading, re-reading and interpreting (Gray, Grove & Sutherland 2017:270). The participants’ responses and patterns were identified as well as their conceptual relationships. Data was reduced into codes and clusters until 4 themes, categories and sub-categories were developed (Table 2.1). Both Thematic analysis and the key principles of interpretive phenomenological or Hermeneutics’ analysis (section 2.4.1.4) as proposed by Heidegger were applied.

Thematic data analysis

A thematic analysis method was used to describe, analyse and interpret the findings. Thematic analysis is a flexible method that is not tied to a specific philosophical orientation whose goal is to identify, analyse and describe patterns or themes across the data set (Bryman et al 2014:351). A theme refers to a recurring regularity emerging from an analysis of data and the meaning from data that relates to the research question at hand (Polit & Beck 2012:562). In this study, thematic analysis focused on the human perspectives of the study construct and emphasised pinpointing, examining and recording patterns or themes within data. The following phases in Thematic data analysis according to Polit and Beck (2012: 562 – 566) were followed:

Phase 1 becoming familiar with the data

This phase involved reading the material over and over again until the researcher was familiar with data; notes were taken to assist in developing potential codes, concepts and patterns through coding. The coding process involved going back and forth between the phases of data analysis until the researcher was satisfied with the final themes, categories and sub- categories.

Phase 2 generating initial codes

Coding refers to a system of organising and gaining meaning of data in relation to the research question. At this phase, a list of items from the data set that had recurring patterns was generated.

Phase 3 searching for themes

The list compiled in phase two was scrutinised to identify what works and what does not work within themes and categories, but not discarding any item. The researcher engaged with data examining how codes combined to form themes and categories and how relationships were formed between codes and themes and between existing codes.

Phase 4 reviewing themes

At this point the initial themes were re-examined to see if there was no need to condense them or re-arrange them into each other as family clusters and categories. Themes were examined to determine if they relate back to the data set and the process was repeated until the researcher was satisfied with the thematic map.

Phase 5 defining and naming themes

Analysis at this level involved identification of aspects of data that were being captured, what was of interest about the themes and the related categories and why were they interesting. The researcher defined what themes and categories consisted of and explained each of them.

Phase 6 producing the report

The final report was written based on themes, categories and sub-categories that made meaningful contributions to answering the research question.

Heidegger's interpretive analysis method

For triangulation purposes, Heidegger's interpretive analysis method of data analysis based on the construct of Being and Time (Polit & Beck 2017: 496) was incorporated to elicit the meaning that students attached to the construct under study.

The transcripts (annexure F) were read intensely and recurrent themes, categories and sub-categories were identified. These themes were presented in a discourse for coding purposes. Heidegger's interpretive analysis based on the research and probing

questions that were posed to the nursing students' to elicit interpretations of their perspective of "being in" nurse/patient interactions with the intent to provide spiritual care. This process was done following the seven steps suggested by Diekelmann and colleagues (1989), as cited in Polit and Beck (2012: 568), which broadened the notion of Heideggerian hermeneutics analysis as follows:

- All the transcripts were read for an overall understanding
- Interpretive summaries of each interview were written
- Selected transcribed interviews were analysed.
- there were no disagreements on interpretation, there was therefore no need for the transcripts to be read all over again
- Common meanings were identified by comparing and contrasting the interview summaries
- Emerging relationships amongst themes, categories and sub - categories were noted.
- A draft of the themes with examples was presented to the mentor and the responses and suggestions were incorporated into the final draft.

Through this process commonalities and variations amongst participants' responses were discovered.

2.6 MEASURES TO ENSURE TRUSTWORTHINESS

Trustworthiness according to Lincoln and Guba (1985:290) refers to the quality value of the final results and conclusions reached in a qualitative research. In qualitative research rigor is measured by its trustworthiness or the extent to which the findings are true to the data collected and analysed (Polit & Beck 2012:583). Lincoln and Guba (1985:290) identified criteria of credibility, transferability, confirmability and dependability to encompass trustworthiness.

Credibility refers to confidence in the truth of the data and interpretations of them. In this study, Credibility was ensured when the researcher employed elements of researcher credibility, prolonged engagement, bracketing, peer debriefing, member checking and triangulation (Bryman 2012:390; Lincoln & Guba 1985:301; Polit & Beck 2012:585).

Researcher credibility had to do with the faith that can be put in the researchers' experience with the study phenomenon, qualifications and position to establish confidence in the data. *Prolonged engagement* was ensured as the researcher spent an extended period of time with the participants while conducting qualitative interviews. *Bracketing* was used to hold at abeyance the researchers' experiences, knowledge and view about the study phenomenon. *Triangulation* was reinforced by the use of multiple data analysis approaches. *Member checking* was made possible as the participants were given an opportunity to make an input about the findings and interpretation in relation to the development of the nursing care plan. *Peer debriefing* was ensured by holding sessions with objective peers to review and explore some aspects of the study (Polit & Beck 2012: 584-585).

Transferability refers to the extent to which the findings can be applied or have applicability in other similar settings or groups. Transferability was ensured by providing thick descriptions of the research steps undertaken that can be audited and be transferred to other settings (Bryman 2012:390; Lincoln & Guba 1985:301; Polit & Beck 2012:585). Various techniques were applied to enhance the transferability of the findings of this study such as the way of how information rich participants were selected. In this study, the researcher conducted purposive sampling through which participants who shared a wealth of insight about their perspectives on spiritual care with the researcher. Providing a thick description of the research context, participant's perceptions and views on the study construct, and the research methodology can make it possible for application of this study in other settings (Polit & Beck 2012:585).

Confirmability refers to objectivity or neutrality of data which allows for agreement between two or more independent persons about accuracy, relevance or meaning of

the data (Polit & Beck 2012: 723). Confirmability was enhanced by establishing an audit trail to enable other researcher to conduct a dependability audit trail (Lincoln & Guba 1985:328; Polit & Beck 2012:585). For the purpose of an audit trail the researcher did the following:

- All the feedback from the study supervisor was kept
- The research method, including the instrument development was recorded. The probing questions that were posed to the participants were captured
- Intentions to write research articles on certain aspects of the findings were indicated
- The data reduction and reconstruction products such as drafts and the final reports were kept
- A detailed research report was presented for examination by nurse scholars

Dependability refers to the stability of data over time and over relatively similar conditions. In this current study, dependability was taken care of by being diligent in reporting every step of the research process and submitting for an audit by examiners (Polit & Beck 2012:585). The transcribed interviews and data analysis process were scrutinised by an independent reviewer. Relevant supporting documents such as audio tapes and verbatim transcribed notes were made available. The researcher established an audit trail also by presenting the coded interviews to the study supervisor and the findings and differences in the themes, categories and subcategories were noted (Polit & Beck 2012:585).

In qualitative research trustworthiness of data need to be demonstrated. The central feature of the effort is to confirm that the findings accurately reflect the viewpoints of participants (Polit & Beck 2012:585).

2.7 ETHICAL CONSIDERATION

Ethics is defined as a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal and social obligations to a study (Polit & Beck 2012:727). Ethical considerations in this study were ensured by

demonstrating respect of the rights of the study institution, participants and ensuring scientific integrity.

2.7.1 Protection of the rights of the study institution

The rights of the institutions were protected by obtaining ethical clearance from the Ethical Research Higher Degrees Committee of the Department of Health Studies at the University of South Africa (UNISA) (Annexure A). Permission to conduct the study was secured from the KZN Department of Health and Research Ethics Committee (Annexure B). Permission was requested and granted by the KZNC management (Annexure C). The name of the study institution where the research was conducted was not mentioned to adhere to the principle of anonymity and confidentiality.

2.7.2 Protection of the rights of the participants

Informed and written consent was obtained from the participants after the study was well explained to them in terms of the benefits and risks ratio, right to withdraw from the study at any time they feel uncomfortable and a counsellor was arranged for them if needed. Permission was [sought from participants](#) for tape-recording the interview (Annexure D). Other elements of consideration were respect for confidentiality, anonymity, human dignity, fair treatment and right to full disclosure.

2.7.3 Scientific integrity

Scientific integrity has been maintained by correctly citing sources, avoiding falsification of data and plagiarism. All the chapters with resources used were submitted to the study supervisor for expert supervision and corrections.

2.8 DISSEMINATION OF FINDINGS

The findings of this study will be published in accredited journals for worldwide accessibility by other likeminded scholars for further research. A copy of the written report will be made available to the institution where the study was conducted if needed. The findings will also be disseminated by presenting in in- service education for nurse educators, nurse managers and other nurses in the clinical environment.

2.9 CONCLUSION

This chapter described the research design and the method which was used to conduct the study. A qualitative, non-experimental, explorative and descriptive study design was used based on the phenomenological tradition. The research method such as the population, sampling, sampling techniques, data collection, data analysis, measures of ensuring trustworthiness, ethical considerations and scientific integrity were also described.

In chapter 3 data analysis, interpretation thereof was presented.

CHAPTER 3

DATA ANALYSIS AND INTEPRETATION OF THE RESEARCH FINDINGS

“Your perception is your reality”

3.1 INTRODUCTION

The purpose of this study was to describe the perspectives of nursing students on spiritual care in clinical practice hence the participants of this study were student nurses of the Bridging Course only. This chapter presents data analysis and findings of the study phenomenon. The demographic information of participants was analysed in context prior to the presentation of the main themes, categories and sub-categories that emerged during analysis. This occurred when the conceptual patterns and codes emerged during the repeated analytical reflection of the data (Polit & Beck 2012:744). Thematic data analysis method as well as the interpretative phenomenological analysis were used to analyse participants' perspectives on the study phenomenon (Maltby et al 2010: 146) and findings were presented in the form of three themes, six categories and 11 sub-categories for empirical evidence. The direct quotes from the participants were used as meaning units and supported by literature where needed.

The processes of this chapter occurred during the *third stage* and the researcher was engaged in data collection, analysis and interpretation of the research findings. Use of the phenomenological tradition involved application of the descriptive and interpretive phenomenological research with the elements of bracketing, intuiting, analysing and describing which guided the researcher to apply scholarly thinking during the analysis process (explained in details in chapter 2 section 2.4.1.4). Interpretation of the text was also done through the process termed by Heidegger as fusion of horizons (Holloway & Wheeler 2010:228). Therefore, the data collection and analysis was also guided by Heidegger on how participants expressed themselves and attached meaning to their Being present and in Time. Inductive reasoning underpinned the philosophical stance by applying inferences from the specifics to the general premises that influenced the interpretation.

3.2 DATA ANALYSIS

Data analysis is defined by Polit and Beck (2012:725) as a process of speculation, fitting data together, making the invisible obvious and verification of data. In this study, the process of constructivism was used by the researcher systemically to organise and synthesise the research data making descriptions and inferences on the study phenomenon. Data analysis was ongoing during collection and throughout the study. The analysis commenced with that of the demographics of the participants.

3.2.1 Analysis of participant's demographic data

The participants' ages ranged from 31 -35 years and one participant was in the bracket of 46 – 50. This participant was the most liberal with information owing to her age, level of maturity and professional experience in clinical practice which contributed a wealth of insight into the study phenomenon. What was of note also was that this participant had attended spiritual counselling courses which enabled her to comprehend the concept well. Only one participant was between 25 — 30 years. Four of the participants were males (44%) and five were females (55%) which still denote the nursing profession to be female dominated. Both males and females alluded to the fact that spiritual care is as important as all other aspects of comprehensive care. Comprehensive care according to O' Brien (2014:9), refers to the concept of holism which undergirds the understanding of human beings as being connected in body, mind and spirit. In applying it to the western health care context, it supports a health care approach that incorporates all aspects of bodily, psychosocial and spiritual human functions. The general view was that provision of spiritual care is not adequate as shown by the rating on a scale of 1 to 5; none of the participants gave 100% scoring; only one rated care at 80% and the rest ranged between 40% and 60%.

Amongst the participants, seven (77%) shared above 5 years' clinical experience as an enrolled nurse. The variations in years of clinical experience depicted a group of people who have better insight of clinical practices and as they were

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from different clinical institutions who seconded them for the Bridging course programme. Five of the participants attended the spiritual counselling course and the other two learnt about spiritual care for patients at their churches. Their religious affiliation was that of nominal and protestant churches. Although most people's belief system is learnt at their churches, however only two participants reported to have learnt something about spiritual care for patients at church. The participants had adequate experience of a clinical practice environment and as such eligible to contribute valuable rich data on their individual experiences and perceptions on spiritual care. However, none mentioned being empowered about spiritual care from the clinical environment itself or from educational institutions.

Presentation of the themes, categories and sub-categories

Findings were tabled as three themes, six categories, 11 sub-categories and meaning units (Table 3.1).

Table 3.1: Themes, categories, sub-categories and meaning units

Main themes	Categories	Sub-categories	Quotes /meaning units
<p>Theme 1</p> <p>How do participants provide spiritual care?</p>	<p>1.1 patient's spiritual needs</p>	<p>1.1.1. Need for prayer</p>	<p><i>"...some patients do not ask questions, they do not say anything – they just pray because we are doing prayer – it is allocated as a daily living not as individual the wards are divided into units we go nearer that section and avail ourselves to patients we ask them to pray with them" (P09)</i></p> <p><i>"praying with the patient, also asking a patient his religion so that you will go according to what he believe in [how do you know what is expected of a particular religion], we live in a society that has so many churches and religions we end up interacting with until you find your own church, you find your stand, so as someone in a society I have seen so many churches if I know what to do or say to a patient concerning I religion yakhe like the Nazareth – as for me I grew up in that church so I am able to go accordingly and meet his needs" (P06)</i></p> <p><i>Caring for a patient in full. Not only physically but also emotional support. You as a nurse will put yourself or a loved one in the patient's shoes and you will care for them the same way you will care for the people you love. The patient should be able to trust you, as the</i></p>

	<p>1.2 Nurse's spiritual needs</p>	<p>1.1.2 Need for transcendence through singing spiritual songs</p> <p>1.1.3 Need for reading Bible scriptures</p> <p>1.2.1 need for spiritual support</p>	<p><i>nurse because they are in your hands and you will possibly see them at the most vulnerable times.” (P09)</i></p> <p><i>“I think it is the inner aspect of self which we need to take care of. The client may be a Christian, a Nazareth or whichever religion – in the morning when we start day duty – we start with prayers, we also involve patients to start songs or even read the bible verses” (P05)</i></p> <p><i>“it is part of work, every morning we use to pray so that patients can have time with God, I think there must be someone who is sort of a spiritual counsellor so that if ever a patient needs more time to have this comfort – he may be referred to the person [As nurses] we are not sure whether patients are satisfied – and at the same time we have to continue with the routine” (P09)</i></p> <p><i>“from my point of view, we as nurses also need spiritual support, I do not know from whom but I feel we do need spiritual support due to the cases that we come across in our working environments; sometimes we come across traumatic situations” (P07)</i></p> <p><i>“if you are free in your spirit it is easy to face what you come across even the challenges you face because the more kunomsindo emoyeni the more your spirit is occluded and you perceive things differently, you see</i></p>
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	1.3. Religious activities	1.3.1 Religious care	<p><i>challenges that are not there” (P06)</i></p> <p><i>“a patient is asked – what is his religion and nurses consider that information and if the nurse is not familiar with the patient’s religion, she has to ask from the patient which food is he allowed to eat – we admit people of different religions some do not eat hot meals on Saturday – those are given special food” (P07)</i></p> <p><i>“I believe they do when I am talking about nursing everything is a pack and I do not know if there is anything on top of that..... nursing is rooted on Christianity..... So it is our package to with.... We have the nurses pledge it is binding irrespective of religion” (P09).</i></p>
	1.4 Referral	1.3.2 Intuitive care	<p><i>“Allow a patient to be visited by the priest – sometimes they come as a group and they may not be allowed in as a group since visitors are limited to specific numbers in certain instances” (P01)</i></p>
		1.4.1 Need for referral to pastors or spiritual supporter/ counsellor	<p><i>“We ask the religion where the patient belongs, if he does not have one – that is where we see a need, there are Pastors who come and preach in the ward and we refer patients to them. (P011)</i></p> <p><i>“on Sundays worshippers normally visit the hospital sharing the word of God and praying for patients” (P03)</i></p>
Theme 2	2.1 Human being	2.1.1 Nurse as a	<p><i>“... Approaching a person as a person and not as a patient, and again allowing the</i></p>

<p>Meaning of spiritual care</p>		<p>spiritual being</p> <p>2.1.2 Patient as a spiritual being</p>	<p><i>communication or the relationship just to be normal. I am not a nurse or she is not a patient. We are all on the same level where we are able to communicate as human beings” (P06).</i></p> <p><i>“ I think to respect culture considering dietary restrictions e.g. if a patient does not take pork – he must be given pork free diet and that is part of spiritual care – observing and respecting beliefs” (P05)</i></p> <p><i>“the focus is on physical aspect and spiritual care is overlooked, this score (2 out of 5) is for morning prayers, respecting culture and allowing pastors to visit but a lot still need to be done” (P05)</i></p> <p><i>“I can say it’s a prayer to those who believe in prayer, others believe in performing rituals for ancestors – it is about doing what you believe is your way of being relieved from a certain pressure” (P07).</i></p> <p><i>“I can say we must let the patient practice those rituals; if a person believes in praying or believes in slaughtering we must allow him – sometimes we become judgemental and criticize certain practices” (P07)</i></p>
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<p>Theme 3 Challenges in the provision of spiritual care</p>	<p>3.1 Feeling spiritually inadequate to provide spiritual care</p>	<p>3.1.1 Lack of education and training on provision of spiritual care</p> <p>3.1.2 Lack of time</p>	<p><i>“Mmm Asifundisekile on how to tap on spiritual being – we just ask how are you feeling, we do not go deeper and I do not know why is it not stressed, training is not adequate. (P06)</i></p> <p><i>“yyes, there is teaching but may be if nursing students can be given assignments to preach to patients ...they will be able (P011)</i></p> <p><i>“sometimes when you give spiritual support other nurses say – you are too forward... so I lack confidence” (P05)</i></p> <p><i>“it is because when they get there they come across those senior colleagues who when they try to do what they were taught will discourage them, and a newly qualified can easily adopt the style and forget about what he was taught – they feel outnumbered and doubt the skill and knowledge”(P03)</i></p> <p><i>“ no I have not seen any guide – it is only the understanding of nurses hence I say there must be a good nurse- patient relationship because there is nothing guiding us what to do - we depend on our understanding”(P01)</i></p> <p><i>“I think nurses do not give enough time to patients and some patients are not free to express their feelings, in some instances nurse’s behaviour towards patients scare them (P010)</i></p> <p><i>“we always think of time – that the routine is too tight and have to do tasks that we are assigned to do at that particular time and we cater for the physical needs more, we do not</i></p>
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		3.1.3 Different religious beliefs	<i>go deeper” (P06)</i> <i>“eishhhh it is not easy, with diverse religions it is not easy because sometimes you offend the patient, I can only talk about Christ and do not know how to relate to other religions” (P06)</i>
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Table 3.1 presents an overview of all the themes, categories and sub-categories generated from data as the findings of the study. The findings of the analysed data were discussed and literature control applied where necessary.

The researcher identified and examined the themes in view of literature with intent to describe the conceptualisation of participants in relation to the provision of spiritual care in the clinical practice environment. The research question addressed was:

Tell me, what do you understand by spiritual care and how do you provide it during patient care? Responses from participants on the phenomenon under study enabled the researcher to be able to identify the meaning attached from the context of their emic perspective.

3.2.2 Presentation of data analysis and interpretation

Table 3.1 shows the themes, categories and sub-categories which the researcher generated from the most frequently given answers to the questions answered by the participants, and the interpretation thereof. There are various definitions of the word theme by different sources, but generally it means it is a phrase that identifies what a section of data means. Saldana (2013:175-176) gives the word theme the following definition: “A theme is an abstract entity that brings meaning and identity to a recurrent experience and its variant manifestations. As such, a theme captures and unifies the

nature or basis of the experience into a meaningful whole". Holloway & Wheeler (2010:228) defines a category as a cluster of concepts or codes with similar characteristics.

3.2.2.1 THEME 1: HOW DO PARTICIPANTS PROVIDE SPIRITUAL CARE

Spiritual care is a process that nurtures the essence of a person's being, the identification of one's inner resources and an awareness of who and what one is, the purpose of being and what shapes one's journey during illness (Wallace et al 2008:1). The participants in this study responded in various ways of their understanding the concept as demonstrated in this excerpt:

"it is part of work, every morning we use to pray so that patients can have time with God, I think there must be someone who is sort of a spiritual counsellor so that if ever a patient needs more time to have this comfort – he may be referred to the person [As nurses] we are not sure whether patients are satisfied – and at the same time we have to continue with the routine" (P09).

The understanding demonstrated a perception that spiritual care brings comfort to **patients**. However, this comfort was not evident whether it is spiritual, emotional, physical or psychological comfort. This finding showed a low level of differentiating human dimensions. It was however commendable of the insight that spiritual care provides comfort. In a study conducted by Alpert (2010: 141), spiritual care is viewed as any act that provides comfort to the soul and nurses are the right people to provide this kind of care as people who spend most of the time at bedside with patients than other members of the multidisciplinary team.

The four categories of this theme were spiritual needs of patients and of nurses; religious activities and referral denoted as interventions of how nurses provide spiritual care.

Category 1.1: Patient's spiritual needs

Nurses often have a difficulty to conduct spiritual assessments and to meet the spiritual needs of patients, possibly due to lack of knowledge about spiritual human needs, spiritual well-being and spiritual distress. Although nurses increasingly realise that spiritual considerations cannot be ignored when adopting a holistic view of the person as the foundation of nursing practice; nurses in practice still are confused about the nature of spiritual care they need to give (Sawatzky & Pesut 2005:19).

Human spirituality is expressed as spiritual needs and requires spiritual nursing care to promote spiritual health and well-being. However, the nurses' ability to meet their patients' spiritual needs is hampered by confusion about the meaning of the concepts spiritual care, and the practical implications of the latter. While viewing spiritual care in terms of religion may be simplistic, the importance of religion as a useful means for expressing such care cannot be ignored or undervalued. It is therefore necessary to explore the meaning of these concepts, with specific reference to spiritual care as nurses see it as part of their work but with no understanding as to what to do. One participant lamented and said:

"it is part of work, every morning we use to pray so that patients can have time with God, I think there must be someone who is sort of a spiritual counsellor so that if ever a patient needs more time to have this comfort – he may be referred to the person [As nurses] we are not sure whether patients are satisfied – and at the same time we have to continue with the routine" (P09)

The finding from the data, that participants talk about nurses not being sure if the patients are satisfied, is supported by Monareng (2013:7), who comments that if nurses feel that they are not able to provide spiritual care fully, they can still meet their patients' spiritual needs by being present, giving compassionate care and listening to their anxieties regarding their illness, pain and suffering (Monareng 2013:5-7). One participant (P09) mentioned meeting patients' needs fully based on the following response:

"Caring for a patient in full. Not only physically but also emotional support. You as a nurse will put yourself or a loved one in the patient's shoes and you will care for them

the same way you will care for the people you love. The patient should be able to trust you, as the nurses because they are in your hands and you will possibly see them at the most vulnerable times.” (P09)

A lack of understanding of human spirituality and the meaning of people’s expressions of their spiritual human needs, hamper nurse’s efforts to provide spiritual care meaningfully. Linda, NS, Klopper, HC, Phethu, DR. (2015:4) indicate that nurses may fail to address patients’ spiritual needs if the patients do not express any religious affiliation. One participant had this to say in support of this assertion; *“We ask the religion where the patient belongs, if he does not have one – that is where we see a need, there are Pastors who come and preach in the ward and we refer patients to them. (P011)*

Whilst participation in matters of religion satisfy the existential needs of meaning and purpose of some people, the existential concerns of others who do not identify with a particular religious creed may remain unresolved yet spiritual nursing care is a mechanism of facilitating spiritual health and promoting a sense of wholeness and well – being (McEwen 2005: 163).

Subcategory 1.1.1: Need for Prayer

Prayer is described by DiJoseph and Cavendish (2005:147) as personal communication with God or higher power of one’s belief system. Almost all the participants indicated prayer as a relevant spiritual care activity. Participants preferred to connect patients with God through the gesture of prayer as it is quickly available, time saving and connects the patient with the higher power at the faith level of the nurse or both. Prayer was cited as the most common spiritual intervention employed by nurses to care for their patients. One participant articulated that practice by stating that:

“praying with the patient, also asking a patient his religion so that you will go according to what he believe in [how do you know what is expected of a particular religion], we live in a society that has so many churches and religions we end up interacting with until

you find your own church, you find your stand, so as someone in a society I have seen so many churches if I know what to do or say to a patient concerning I religion yakhe like the Nazareth – as for me I grew up in that church so I am able to go accordingly and meet his needs” (P06)

Another participant contributed by stating that:

“...some patients do not ask questions, they do not say anything – they just pray because we are doing prayer – it is allocated as a daily living not as individual the wards are divided into units we go nearer that section and avail ourselves to patients we ask them to pray with them” (P09)

Another participant concurred with this response by stating that:

Yah..... prayer is like the first thing that I would go for because, when you're preparing a patient for surgery in a busy setting; you haven't got like the whole of other staff. Prayer is the easiest thing you can have right there to reassure a patient, and to ah... to make them feel that even though they don't go to church or anything; God is looking out for them. So that's ... that's the first thing that ah! I would do and some of my colleagues as well” (P08)

Almost all the participants cited prayer as an immediate, time saving and effective way of meeting the spiritual needs of patients. Prayer was cited with the highest frequency than all the actions taken or demonstrated by the participants as provision of spiritual care. **This assertion is affirmed in the list of spiritual nursing interventions according to McEwen (2005: 164) which is citing prayer as one of the nursing interventions.**

Subcategory 1.1.2: need for transcendence through singing spiritual songs

The Concise Oxford Dictionary (1995: 1295) defines singing as “to utter words in tuneful succession or to provide a vocal melody”. The words and lyrics can be intentionally chosen in a song to bring hope and comfort to the singers or listeners. In this instance

the participant s reported singing as a way of providing comfort through the words in the song and the melody thereof. As demonstrated in this statement:

“On specific days we have some evangelists mothers who come to give prayers, songs and read scriptures” (P015).

Another participant shared light on the impact of the morning devotions held with patients as follows:

“I think it is the inner aspect of self which we need to take care of. The client may be a Christian, a Nazareth or whichever religion – in the morning when we start day duty – we start with prayers; we also involve patients to start songs or even read the bible verses” (P05)

Furthermore, participants mentioned the reason they rate the spiritual care provision so low is that the only time nurses provide and make time for spiritual care of the patients is only in the morning, normally where almost all staff members assembly together, pray and share the word of the God. According to the participant this is not enough in terms of providing spiritual care because it is not a one-on-one session, nobody is holding their hands (patient) and praying for them individually or even giving them reassurance that they will get better.

Participants mentioned that this deprived other patients an opportunity to open up about their spiritual needs, *this is attributed to lack of time and knowledge (Giske 2012: 1054).*

Subcategory 1.1.3: Need for reading Bible scriptures

Participants engaged in spiritual practices such as reading the Bible scriptures to the patients in order to connect them with God as evidenced in this comment:

“I think it is the inner aspect of self which we need to take care of. The client may be a Christian, a Nazareth or whichever religion – in the morning when we start day duty – we start with prayers; we also involve patients to start songs or even read the bible verses” (P05)

Another response on this code was as follows:

“I read and interpret relevant verses in the bible, if he is able to read – I stay at the bedside and talk about the verse relevant to his situation” (P011)

Reading Bible verses is reported as one of the important intervention to meet spiritual needs by nurses:

“Sometimes you realise that some of the conditions the patient’s experiences are not amenable to medical treatment. I comfort my patients that things are not out of control or help because God is there for them or even share the scriptures with the patient” (P05).

Medical treatment is needed and has its part (major part) to play in the healing of the body. However, in response to the interview questions, participants argued that taking care of the spiritual needs is equally important. It was evident that some of the participants were Bible readers and easily played this role. Nurses in the units are often very busy and short staffed. The challenge of provision of such care was that not all nurses in the units read the bible or can share the scriptures with patients although Bibles were available in some of the wards, [Giske \(2012: 1055\) points out that some students lack comfort from their own spirituality hence difficulty in providing spiritual care to patients.](#)

Category 1.2: Nurses’ spiritual needs

Although nurses are expected to provide spiritual care to patients, it was however an interesting observation to note that nurses also need spiritual care. Most of the public and private institutions do not have formal programmes that provide spiritual support to

staff; spirituality is treated as a private matter. Although provision of holistic care particularly for patients, which is inclusive of the spiritual dimension, seem only to be on policies, or papers or curricula with no evidence of practice; the situation is exacerbated when most nurses themselves suffer spiritual distress as demonstrated in this excerpt:

“from my point of view, we as nurses also need spiritual support, I do not know from whom but I feel we do need spiritual support due to the cases that we come across in our working environments; sometimes we come across traumatic situations” (P07).

Another participant explained that:

“If you are free in your spirit it is easy to face what you come across even the challenges you face because the more kunomsindo emoyeni the more your spirit is occluded and you perceive things differently, you see challenges that are not there” (P06)

This finding is supported by Tiew et al (2013: 577) who contends that supporting and nurturing of nurses’ spiritual being is important as carers of those in need of such care.

Category 1.3 Religious activities

Sub –category 1.3.1. Religious Care

Religious care is interpreted by the participants as similar to spiritual care hence visitation by church members or belonging to a particular religion is regarded as spiritual care. One participant lamented and said

“We ask the religion where the patient belongs, if he does not have one – that is where we see a need, there are Pastors who come and preach in the ward and we refer patients to them. (P011)

It was observed that nurses in this study think of spiritual care as synonymous with religious care. This notion limits care to this sub-category, whereas spiritual care is broader in its sense as it integrates intuitive, interpersonal, altruistic and caring presence of the nurse that is contingent on the nurse’s awareness of the transcendent

dimension of life and reflects the patient's reality (Sawatzky & Pesut 2005:23). This practice is observed in this statement:

“praying with the patient, also asking a patient his religion so that you will go according to what he believe in [how do you know what is expected of a particular religion], we live in a society that has so many churches and religions we end up interacting with until you find your own church, you find your stand, so as someone in a society I have seen so many churches if I know what to do or say to a patient concerning I religion yakhe like the Nazareth – as for me I grew up in that church so I am able to go accordingly and meet his needs” (P06)

Nurses, based on this finding may be criticised or seen as praying for patients during on duty time which is a duty perceived to be done by religious agents such as chaplains, pastors or other. When participants shared their faith with patients; being available as patients asked questions in a situation of sickness and suffering was interpreted as spiritual care. Some aspects of care such specific diets were considered as religious care as demonstrated in this statement:

“a patient is asked – what is his religion and nurses consider that information and if the nurse is not familiar with the patient's religion, she has to ask from the patient which food is he allowed to eat – we admit people of different religions some do not eat hot meals on Saturday – those are given special food” (P07)

However, this finding from the individual interviews gave evidence that there was confusion of differentiating religious and spiritual care needs of patients. One participant responded that religious care and related rituals may be initiated by the patients themselves according to perceived needs in times of sickness or fear of death as exemplified in this excerpt:

“I can say we must let the patient practice those rituals; if a person believes in praying or believes in slaughtering we must allow him – sometimes we become judgemental and criticize certain practices” (P07)

Nurses may not be in a position to accommodate rituals practiced by patients in a health care environment, but may have to refer patients to the appropriate spiritual resource. Nurses are therefore under challenge to differentiate between religious and spiritual care needs which confounds the clear understanding of what spiritual care is. Additionally, the participants were asked what route they take or questions they asked the patient to arrive at the patient religious beliefs, participants answered that:

"during admission of the patient, nurses ask the patient straight to which religious denomination they belong and they ask the patient about their history and keep that information on records so that should it happens that the patient is admitted the medical care institution will already have patient religious information "(P05)

This is done to ensure that the spiritual rights of the patient are not violated. Even though there's an assessment format available to find such information, all participants agreed that this assessment format is not enough to teach the clinical care providers about the religious belief and practises of the patients, their culture, customs and practices. As exemplified by the following excerpt:

"...the focus is on physical aspect and spiritual care is overlooked, this score (2 out of 5) is for morning prayers, respecting culture and allowing pastors to visit but a lot still need to be done" (P05)

This always makes it hard for the clinical care provider to be able to provide any care to the patient without offending the patient's beliefs or culture. This finding is comparative to the argument presented by Zamanzadeh et al (2015:218) that there is tension in the literature between the two variables of spiritual and religious care. Nurses who provide spiritual care have a religious commitment to a particular community of faith that has particular spiritual practices, beliefs, attitudes and sentiments. In practice, it is hard to draw the line as nurses provide spiritual care based on their religious involvement and understanding of such care.

Sub-category 1.3.2: Intuitive care

Intuition is defined as the quality or state of having insight or immediate comprehension or of having untaught knowledge (Freshwater & Maslin-Prothero 2005:309). Provision of spiritual care according to the findings in this study, did not seem to be part of the expectation from nurses as professional care providers, but depended on the individual nurse who had the knowledge or passion to do so. It was confirmed by one of the participants that to provide such care is a decision of a nurse who probably must know something about it:

“I think also that it lies within the individual on how to carry out spiritual care. We were not guided or given the spiritual principles during training; I do not think that this is in our training curriculum” (P06).

“With the spiritual care of a patient, it comes from within a nurse” (P05).

According to this finding, spiritual care was not understood as part of the professional responsibility of the nurse. It was perceived as extra care one could give, depending on the individual nurse’s decision. It confirms the conclusion by Biro (2012:1003) that the approach to spiritual care is apparently largely unsystematic and delivered haphazardly by the nurses who have the interest to do so.

Category 1.4: Referral

Referral to pastoral or Christian counselling was reported to be done for patients who expressed spiritual concern. Some of the participants related their experiences of having to refer their patients, but this was after nurses attempted to provide spiritual care by talking to the patient and validating with them acceptability of such care. Some institutions have resident spiritual agents as a formal structure available for provision of spiritual care to patients as reported in this response:

“In other hospitals you will find that there are hospital chaplains or a pastor available where you can refer a patient or let the patients be seen by a particular religious’ person” (P09)

The same participant added that:

“it is part of work, every morning we use to pray so that patients can have time with God, I think there must be someone who is sort of a spiritual counsellor so that if ever a patient needs more time to have this comfort – he may be referred to the person [As nurses] we are not sure whether patients are satisfied – and at the same time we have to continue with the routine” (P09)

Most patients belong to a community of believers in some form of belief system; members would visit their member at the hospital. Therefore, it is imperative that nurses show respect to visiting hours and honour policies in that regard as demonstrated in the following excerpt:

“On Sundays worshippers normally visit the hospital sharing the word of God and praying for patients” (P03)

However, one participant viewed visiting of patients’ church members as a nuisance and brings disturbance to the unit routine. This is very sad as patient visitors fill in a gap for meeting some of the spiritual needs of patients and needs to be encouraged and respected. The participant mentioned that:

“On Sundays we usually see people from churches bringing prayers- although we are not involved much but we give space, our routine also must continue because we have shortage and so our routine must not be disturbed” (P05)

Nurse referrals to or involving their spiritual leaders as expressed by the participants either occurred at a patient’s request or were initiated by the nurse. Arrangements were made by the nurses according to this finding to have the clergy of the patients’ own choice come and offer spiritual care:

“So that’s why we will make some arrangements with that particular pastor that is associated with the individual patient or the individual hospital to come and do the necessary rituals” (P09).

In such instances one is concerned about patients experiencing spiritual distress in the interim when there is no religious agent to refer to. There is possibility that the pastor might not be available or delayed to come as confirmed in this response:

“My concern is when there is no relevant person to can send the patient to like a pastor in the vicinity, and that we have to postpone the time or date of appointment. Counselling may not be done immediately and the patient’s distress worsens” (P09).

If such services are not available in the hospital, participants reported that on their own they referred patients to outside spiritual agencies for further counselling. Linda et al (2015: 3) comments in relation to this finding that nurses need to recognise their own spiritual limitations and know when to make a referral or may utilise other team members who are spiritually competent to provide such care.

Some institutions have resident spiritual care givers while others don’t. One would assume that even this kind of initiative is often not followed up because of the lack of culture to formally support provision of spiritual nursing care or knowledge about availability of spiritual sources where patients with spiritual distress may be referred to. This finding is supported by the findings in a study conducted by Reid, Field, Payne and Relf (2006:436) that in general there are few alternative formal spiritual resources to access to refer patients to for spiritual care, as a result this part of care is ignored or not understood.

Subcategory 1.4.1 Need for referral to pastors or spiritual

The emergent findings demonstrated the notion that patients have their own perspective or understanding about who should attend to their spiritual needs. Culture in this finding dominated the scenario as spiritual agents such as priest were identified to be appropriate to render spiritual care as per this response:

“Allow a patient to be visited by the priest – sometimes they come as a group and they may not be allowed in as a group since visitors are limited to specific numbers in certain instances” (P01)

Some participants are aware of spiritual people that come to hospitals to offer spiritual care to the sick and one mentioned that:

“We ask the religion where the patient belongs, if he does not have one – that is where we see a need, there are Pastors who come and preach in the ward and we refer patients to them. (P09)

Participants however showed respect to this belief or spiritual related attitude of referring patients to outsider to care for their spiritual needs. The challenge is how to facilitate prayer for patients with a different way of praying or praying to another deity other than God. However, no mention is made as to how this matter is further handled to meet the spiritual needs of these patients except that they do not force people to pray with them, some nurses shy away avoiding to offend the patient particularly if the patient’s beliefs are contrary to those of the nurse (Alpert 2010: 140).

Concluding remarks on theme 1

It seemed a bit complex for the participants to render spiritual nursing care to the patients more than when giving professional care or attending to the needs of other dimensions. Spiritual care, according to this study, was provided based on the spiritual background of the nurse, and not necessarily as part of professional preparation of the nurse. It was religious care that was provided as an in-between practice depending on the ability of the nurse to identify spiritual needs and do something about it. Prayer was cited as the most frequently used activity of spiritual care by both nurses and those patients who are referred to religious agents. It is a notable finding to realise that spiritual care is not only about prayer, reading scriptures or use of sacred music only, but other modes of care such as intuition were cited. Approach to care focuses on recognising a patient as a spiritual being worthy of respect and dignity.

3.2.2.2 THEME 2: MEANING OF SPIRITUAL CARE

This theme explored and described the meaning of spiritual care as expressed by the participants accordingly. Participants understood themselves and the patient as human beings in the realm of health care. This was described especially in relation to the application of the concept 'spiritual being' as it applied to the nurse and to the patient. From this theme, the understanding of the interrelationship of body, mind and spirit was explored from the responses presented. According to Monareng (2013:2), spiritual care refers to the support and engagement with patients in a compassionate relationship; assisting them to find meaning and purpose in life in relation to the presenting health condition of trauma, sickness, injury or pain which may be a need for faith support in a form of prayer, sacrament or sacred scriptures. The challenges experienced in understanding what spiritual care is were also captured. Participants had a challenge in understanding the meaning of 'spiritual care'. They expressed their belief that physical care cannot be complete without spiritual care as stated in the following response:

"...the focus is on physical aspect and spiritual care is overlooked, this score (2 out of 5) is for morning prayers, respecting culture and allowing pastors to visit but a lot still need to be done" (P05)

Although the responses identify commonly the physical and spiritual dimensions that constitute a human being, it is noted with regard that the need for spiritual care is not recognised or overlooked. However, it was obvious that the participants struggled to understand what spiritual care was. This was evidenced by various responses and answers in relation to religious care and intuitive care alluded to earlier on. The understanding of patients and nurses as human beings was closely related to the participants' understanding of what spiritual care is. Spiritual care is described by **Van Leeuwen, Tiesinga, Post & Jochemsen** (2006:881) as simply actions of assisting a patient as a human being to recognise a personal unique meaning of life in times of sickness, to strengthen that person's relationship with God and to bring an appreciation of nurse's spiritual actions/interventions in the immediate environment of care.

Category 2.1: Human being

A human being is defined by the *Concise Oxford Dictionary* (1995:661) as a being that is distinguished from animals, machines or objects by superior mental development, power of articulate speech and upright posture. Being refers to existence or nature of a person as a Supreme Being (*The Concise Oxford Dictionary* 1995: 117). It seemed appropriate to briefly share light about the concept, 'human being' as some of the participants referred to their patients as human beings.

Both the nurse and patient were seen as human beings as exemplified in this excerpt:

" ... So this is what challenges me on daily basis that I may treat people well as human beings and as people who are created in the image of God, not as an object which will help me get some money come month end" (P08).

Another participant iterated this finding in the following response:

"in my E/N training I did not knowI am only realizing now that the person lying there is a human being ...some patients need guidance more than others..... holding a hand and reassurance.....some really need spiritual care" (P05)

Firstly, from these responses the understanding of the concept 'human being' emerged as a category. Secondly, participants in this study viewed man as a human being with spirit, mind and physical dimension. One participant suggested that relating with a patient should go beyond the status of being a patient but as a person who is worthy of all respect, attention and consideration of the status of being a human being. They also expressed what a human being is from the perspective of approaching a patient as a normal person and who is at the same level with the nurse:

"... Approaching a person as a person and not as a patient, and again allowing the communication or the relationship just to be normal. I am not a nurse or she is not a patient. We are all on the same level where we are able to communicate as human beings" (P06).

This expression shows the need to respect patients by how they are addressed as they enter the health care arena and treated as an equal partner in the provision of care. This finding is supported by Maphosa (2017:33) classic conclusion that behaviour of human beings can be understood in the context of who they are as spirit beings. Based on the metaphysics of being and Christian doctrine, being and spirit tend to collide and actually do so in complete identity in God.

Further discussions about human being provided a background to introduce the expressions of how the nurse and the patient were seen and interpreted by the participants as not only humans but as spiritual beings.

Sub-category 2.1.1: Nurse as a spiritual being

Nurses are professionally trained and equipped to deal with disease, sickness injury and health promotion. The experience of spirituality both for themselves and their patients becomes normally irrelevant in a medical science environment. In this study it was however realised that nurses are also human beings that have spiritual needs. Heaviness of heart and feelings of being low and dispirited was noted to affect nurses too. One of the participants explained that:

“from my point of view, we as nurses also need spiritual support, I do not know from whom but I feel we do need spiritual support due to the cases that we come across in our working environments; sometimes we come across traumatic situations” (P07)

Nurses also as human beings struggle with issues of transcendence especially when faced with spiritual concerns of their own and that of patients they have to care for. They have spiritual needs and one can imagine if the provider of care is spiritually burdened what should happen to the patients. From this finding one realises that even if nurses are expected to provide spiritual care to patients, they also have spiritual needs and experience spiritual distress in the work place as human and spiritual beings.

Zamanzadeh et al (2015:220) supports this finding that it is difficult to respond to spiritual needs of others if nurses themselves are experiencing unresolved spiritual concerns or distresses of their own. There is however, an expression reported that

explains nurses as human beings the authors remark that nurses and patients are spiritual beings with spiritual needs. It is therefore this commonality that should form the basis of the understanding about the need to be aware of patients as spiritual beings with spiritual needs that need to be cared for by nurses Zamanzadeh et al (2015:220).

Subcategory 2.1.2: Patient as a spiritual being

Although patients are indirect participants in the study, they played a vital role in this finding because of the role they played in guiding nurses to make sense of their world as spiritual care providers. Participants demonstrated awareness of patients as human beings and having needs that are beyond the help of medications. Three participants responded in line with this notion as summarised in the following statement:

“Sometimes you realise that some of the conditions the patient’s experiences are not amenable to medical treatment. I comfort my patients that things are not out of control or help because God is there for them or even share the scriptures with the patient” (P05).

Patients come to the health care institutions primarily for medical attention. However, their whole being which includes the spiritual dimension is affected. The nursing profession claims in literature that nurses treat patients, not only as physical beings with disease, but as spiritual beings (Van Leeuwen et al 2006:881). This claim seems according to this finding not to be implemented in clinical practice.

Concluding remark for theme 2

Nurses in clinical practice seem to be experiencing difficulty to conceptualise what spiritual care is. It is interesting to note that both the nurses and patients are understood as spiritual beings and therefore share common humanity and understanding of need for transcendence. Patients are therefore understood as having spiritual needs,

although this seems not to be put in perspective. Rather spiritual needs were confused with religious needs. It is evidenced that nurses do need exposure to education and training on spiritual nursing care to delineate what it is and how the needs of body, mind and spirit can be met in balance to achieve the goals of holistic patient care.

3.2.2.3 THEME 3: CHALLENGES IN PROVISION OF SPIRITUAL CARE

Although not overtly mentioned, participants had a challenge in understanding the meaning of what 'spiritual care' is and how to implement it. There was some understanding on the phenomenon as they believed that physical care cannot be complete without spiritual care. Although the responses identify commonly the physical and spiritual dimensions that constitute a human being, it was noted with regard that the need for spiritual care is recognised. However, it was obvious that the participants struggled to understand what spiritual care was. This was evidenced by various responses and answers in relation to religious care and intuitive care. Out of this theme emerged one category which is feeling spiritually inadequate and three subcategories which were lack of education and training on spiritual care, lack of time and differences in belief systems.

Category 3.1: Feeling spiritually inadequate

Most of the participants reported to be feeling inadequately prepared to render spiritual care to patients. Most of them cited that spiritual care was done as part of their spirituality and service to God, and not necessarily as part of their professional responsibility. According to McEwan (2005: 165) the findings of the study conducted to assess understanding of spiritual care revealed that students do consider spiritual care an important and essential component of holistic care however, they are not adequately prepared to fulfil the responsibility. This assertion is confirmed by Linda et al (2015: 1) who acknowledges that health care professionals are not adequately and formerly groomed to provide spiritual care. This feeling of inadequacy was experienced as lack

of education and training, lack of time and the challenge of having to deal with different religions right in clinical practice.

Subcategory 3.1.1: Lack of education and training

Participants when asked about whether they knew how to provide spiritual care, indicated lack of guidelines during their basic training years on how to provide such care as demonstrated in the following excerpt:

“P01” – no I have not seen any guide – it is only the understanding of the nurses hence I say there must be a good nurse – patient relationship because there is nothing guiding us what to do - we depend on our understanding

“I think also that it lies within the individual on how to carry out spiritual care. We were not guided or given the spiritual principles during training, I do not think that this is in our training curriculum” (P06).

Participants in the study had only basic training as E/Ns but with no exposure to content related to spiritual care except for one. Tiew et al (2013: 575) argued that teaching, understanding and application of spirituality by nursing students in practice has not been given much attention despite the notion of acknowledging the importance of holistic care. Even though nurses are trained on basic aspects of patient care and communication skills, it does seem that little is said on spiritual aspects of care. One would thus assume that according to the above stated finding that spiritual needs of patients are not adequately met in clinical practice as the majority of competent nurses are not necessarily spiritually competent.

There has been a debate over the topic; whether nurses get adequate training regarding providing both medical and spiritual care for patients.

Participant four, voiced out that based on her experience:

"Nurses do not get enough training because I only discovered in a workplace that I have to provide care for a patient both, physically and spiritually and I was not

trained for that" (P04).

Another participant added that:

"...they need to have guidelines to give direction on various expectations of patient as determined by various religions, allocate time to do the activities that will cater for spiritual needs of patients" (P05)

In addition to assist the nurses to acquire enough training regarding caring for patients both medically and spiritually, participant recommended that the health care institution or clinical care practise must host workshop that will teach health care professionals that a patient is more than just a physical being but also a spiritual being and going back to be taught that caring for the patient involves holistic care that ranges from emotional, social, physical and spiritual. This was evidenced in the following statement:

"...is to organise the experts orientate nurses and assist them to understand its importance, they will implement spiritual care" (P08)

Another participant added by saying that:

"...I think going back to basics, conducting workshops – making nurses realize that a patient is a spiritual being and a physical being worth respect and dignity – one day it will be your mother or relative....." (P05)

Although inclusion of spiritual care into the education of different health professionals is already evident, there is still a need for conceptual consensus that is coherent across all the different health professions, particularly amongst nurses. Nurses still struggle to teach and integrate spiritual care to nursing practice, even though some of the literature has such content (Linda et al (2015: 2).

Subcategory 3.1.2: Lack of time

One participant in the individual interviews expressed that limitation of time is one of the barriers or aspect that makes it difficult for them to deal with the patients' spiritual needs:

"... Lack of time, lack of training, concern about activity outside of physician's area of expertise ... lack of interest or awareness" (P03).

It does seem that to provide spiritual care is qualitatively different compared to other treatments given in a health care unit. Providing spiritual care is seen as something extra that needs special time to be done and not as part of the nurse's professional expertise in clinical practice. Findings from Linda et al (2015:3)'s study states that attending to someone's spiritual need is time consuming and presents a challenge to the nurse who is over stretched by under-staffing and the routine demands of busy public hospitals. Van Leeuwen et al. (2006:883) as cited by Linda et al (2015:2) also confirm that nurses encounter varied demands and pressures in their practice.

Subcategory 3.1.3: Different religious beliefs

People express their belief or faith in the way in which they live. According to the participants, some of the patients expressed their spiritual choices or preferences in terms of prayer or should be referred to others when the nurses feels incompetent to deal with issues that have spiritual connotation as noted in the following excerpt:

"You will find that the patient needs to be prayed for, or needs to be eh! [Scratches her head.....pause] need to be spiritually taken care of by the pastor of the religion where she belongs. She will then ask you to call the pastor of her church" (P05)

Another participant responded as follows:

"eishhhh it is not easy, with diverse religions it is not easy because sometimes you offend the patient, I can only talk about Christ and do not know how to relate to other religions" (P06)

Participants in the study seemed to fear that the patients might perceive providing spiritual care as an act of imposing their faith on them. There seem to be a limitation of

this understanding as the nurse should see seeking outside spiritual help for meeting patient's spiritual needs as provision of spiritual care and as respect of the patients' religious views and preferences.

Although the participants reported that they hold devotions in the morning in some of the wards, it is evident that some of the nurses do not want to partake in such practices. It is their right to be respected in that regard. Participants in the study were aware that both nurses, patients' and their families' belief system should be respected and their faith not to be imposed on others as demonstrated in this excerpt:

“Not all people believe in God or prayer. Some nurses are uncomfortable to talk about spiritual matters in health care settings for fear of stigmatisation about their faith or accusation that they are imposing their beliefs on vulnerable patients. We should not force people to come for prayers or read the word of God” (P05).

The participants were however asked if it happens that the medical care provider is from the different side of the world and had no idea or any information about the culture of the area, will this person be able to provide the expected care. Two (P01 and P07) participants answered as follows:

“....no guide - it is only the understanding of a nurse unless he is being mentored..... on his own I do not think he will manage.....nurses have to attend in-service about this regularly I think the government must do something about it and guides are needed...” (P01)

“I am talking from experience if you do not know you ask from others.....” (P07)

The South African constitution (see South Africa 1996) allows people to have freedom of religious affiliation as evidenced by the following statement:

“.....and South African constitution states that all denominations are allowed, they are recognised and respected so.....no one is forced to participate in prayer

even nurses and patients as well.....just tell them it's prayer time and those who are willing will join no one is forced" (P05)

Participants seem to have understood this right and integrated spiritual care from their point of view and belief with a non-judgmental attitude towards the beliefs of their patients. **This observation is in agreement with the findings of the study by Linda et al (2015: 6) that patient's beliefs and needs are a priority in practice hence nurses put aside their own feelings and attend to patients' needs.**

Concluding remarks on theme 3

One would remark that providing spiritual care to patients does not need any special education other than what nurses can be taught from the classroom and at clinical accompaniment sessions. There seem to be a need for mentors to role model provision of spiritual care at both theory and practice. It was remarkable to note that participants seemed to view spiritual care as an extra care that needs special time and not as part of their day to day patient care responsibility. It was however a challenge as patients subscribes to different belief systems or not to any which was perceived as a barrier to provision of spiritual care. The nurse's own belief system may be in contrary to that of the patient. In spite of the constraints identified, the importance of providing spiritual care cannot be underestimated (Savel & Munro 2014: 3).

In general, the findings suggest that the participants concur with the understanding of the importance of providing spiritual care, but lack of guidance both in theory and practice makes it difficult for them to develop spiritual competency in a way that robs patients from receiving quality holistic care.

3.3 CONCLUSION

This chapter included an analysis and interpretation of the findings of the study. A non-mathematical process of analysis and interpretation was employed. Major themes, categories and subcategories that emerged from the data were tabled and discussed accordingly. Meaning units for each theme that were represented by appropriate quotations from the participants' words were indicated in table 3.1. Creation of meaning

was identified as an important component of the findings as the participants were challenged in understanding what spiritual nursing care is or how to provide it. Different ways of how nurses in the study provided spiritual care was reported as expressed by the participants. Challenges that were indicated by the participants as to what made it difficult for them to provide spiritual care were also reported.

CHAPTER 4

SUMMARY, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

“Spirituality is not adopting more beliefs and assumptions but uncovering the best in you”

Amit Ray

4.1 INTRODUCTION

This chapter focused on discussions, making conclusions and appropriate feasible recommendations based on the findings. The primary purpose of this study was to explore and describe how nursing students provide spiritual care in clinical practice and to identify gaps or grey areas that need attention both in theory and practice

4.2 PURPOSE OF THE STUDY

The purpose of the study was to describe the perspectives of the Bridging course nursing students on spiritual care in clinical practice.

The research objectives of this study were to:

- Explore and describe the perspective of the Bridging course nursing students on spiritual care in clinical practice.
- Identify factors underlying the perspective of the Bridging course nursing students on spiritual care in clinical practice.

A qualitative, explorative and descriptive research study involving nursing students registered in the Bridging course was conducted to gain a view on what is their perspective on spiritual care and how they incorporate it in clinical practice.

The ontological, teleological, epistemological and methodological assumptions of this social researcher were described in chapter 1 (section 1.4.2) of the study.

4.3 CONCLUSIONS OF THE STUDY

The conclusions of the study in this chapter were based on the demographic information, qualitative data findings, themes that emerged from the data, scope and limitations, recommendations and implications of the study for future research.

4.3.1 Demographic information

The demographic information was not directly sought as part of data collection or analysis of the study. However, the quantitative data obtained gave the researcher a good view as to the profile of the participants and to realise that most of them were not exposed to any courses on spirituality. Their application of spiritual knowledge was purely from their religious background, local churches as some of them were Christians and had to adapt this knowledge to their nursing situation.

4.3.2 Qualitative data findings

The research was conducted in three stages as evidenced on Figure 1.1 in chapter 1.

The central theoretical statement for this study was: What are the perspectives of the Bridging course nursing students on spiritual care in clinical practice?

Probing questions were posed guided by the participants' responses for more clarity and explanations. The interview allowed them to engage in storytelling as they were asked open-ended questions through probing questions (an average of 9 probing questions per interviewee were asked) such as:

In your opinion, what are spiritual needs of patients?

How do you get to know these needs for a patient?

Are you confident to provide spiritual care?

Can you share one experience when you provided spiritual care?

What do you suggest nursing leadership should do to improve implementation of

spiritual care?

How would you motivate your colleagues to provide spiritual care as earnestly as they do with physical care?

The aim of this approach was to allow the **participants** to describe their perspectives about spiritual care from their point of view freely without any influence or imposition by the researcher's bias.

A pre-testing of the interview guide was done with two individuals who did not then participate in the main study. The purpose of the pre-testing of the interview guide was to evaluate the comprehension of questions, the duration of the interview and to test the interviewing skills of the researcher as well as the use of the digital tape device. There were not many errors experienced during the pre-testing except for the poor sound of the tape. It was corrected by fixing the device and better positioning on the table which enabled the researcher to be able to correct the main data collection process in the actual interviews with better quality of data collection. The researcher collected the data personally from individuals using an unstructured interview guide. A digital-tape was also used after obtaining permission for its use to capture all information during interviews. The transcripts from the digital-tape were then transcribed verbatim before data could be analysed. Data analysis triangulation manual methods such as thematic analysis and the Heidegger's hermeneutics phenomenological analysis methods were used Creswell (2014:192-193).

The category system was used to sort and organise the findings. Subcategories which were subsections of the categories were identified. Three themes finally emerged from the data because of recurring regularity. These were validated through literature control. The direct quotes of the participants were presented as meaning units on a table (3.1) to validate use of some of the concepts to label the categories. Some of the quotes through constant re-aligning of the presentation were collapsed.

Table 3.1 in chapter 3 of the study contain a summary of the themes, categories and subcategories that emerged from the data. The conclusions of the study were based on the achievement of the study objective as per the findings.

4.3.2.1 How do participants provide spiritual care?

The first and the second objectives were achieved as per the empirical evidence presented in chapter 3 and summarised in this chapter. Provision of spiritual care was summarised in four categories which were described in chapter 3 as patients' spiritual needs (3.1.1), nurses' spiritual needs (3.1.2), religious activities (3.1.3) and referral (3.1.4). Subcategories and meaning units that emerged were displayed in table 3.1.

There seemed to be an inadequate understanding in nursing practice on how to integrate spiritual nursing care especially as a formal responsibility of the nurse. Participants provided spiritual related care as a duty and service to God not necessarily as part of their professional holistic care using the Christian approach of prayer, bible reading and singing spiritual songs as the mode of spiritual care. Some of the colleagues were supportive of involving prayer in the mornings, the word of God or other spiritual strategies to the care practice but some were not. O'Brien 2014 (125) adds that this makes provision of patient care which includes spiritual aspects as an individual nurses' choice or out of own interest.

The issue of prayer, reading the word of God to patients and singing sacred music was cited frequently as practices of spiritual care that nurses would engage in and understood as spiritual care. This however confused differentiation between religious care which outside agents can provide and spiritual care that should be part of nurses' responsibility. The finding that prayer was the most commonly reported way of connecting with God is similar to other reports in literature. However, Alpert (2010:143) argues that the value of prayer in nursing needs empirical data to support it as a valuable strategy to meet patients' spiritual needs. Nurses in the study were comfortable in provide spiritual care especially where it involved prayer.

Referral was commonly used to address social and emotional needs that were confused for spiritual needs. Patients were referred to priest, pastors and church members for comfort or prayer. However, although spiritual care was provided as an intuitive act, positive outcomes were noted and reported in the data. This is an

indication that if proper attention was given to the preparation of nurses both at basic and advanced level to provide spiritual care, it would have positive outcomes for patients in terms of quality patient care. However, the challenge still remains in practical terms that the nurse should develop spiritual competency and have own spiritual awareness and sensitivity to that of others (Wu et al 2012:5).

4.3.2.2 Meaning of spiritual care

This second theme that emerged was a response to the first interview question. One category namely human being and two subcategories which were nurse as a spiritual being and patient as a spiritual being (table 3.1) emerged. Meaning of what spiritual care is from the perspective of the participants was captured from their significant statements or direct quote. The created meaning revealed how the participants understood what spiritual care was from their own worldview and knowledge background. **Understanding that nurses and patients are human beings with basic needs inclusive of spiritual care; a need for well-being would pave way for holistic approach to care.** Giske (2012:1053) concurs with the notion that spiritual needs are often confused with the other dimensions such as social, psychological and emotional needs. This is problematic because referrals are most of the time inappropriate as patients with spiritual needs are referred to psychologists and sociologists.

The other matter observed from the findings is that, although the nurses in the study had interest to provide spiritual care, they were however unable to differentiate the patients' spiritual needs from their religious needs. Patients' spiritual needs were equated to a desire to engage in religious rituals such as prayer or reading the sacred text or singing spiritual songs. However, these religious activities brought comfort to the patient as a significant finding. Some of the participants had different perspective and regarded spiritual care as cultural and traditional activities. However, one can conclude based on the data that the understanding of nurses and patients as human and spiritual beings seemed complex and abstract. The implementation of spiritual care according to

Savel and Munro (2014: 2) is often dismissed or ignored by the health care system, unless if it is seen as care that can be quantified and seen to bring profit to health care institutions.

4.3.2.3 Challenges in the provision of spiritual nursing care

In this theme, the second objective was achieved relation to factors that influences perspective of students with regard to spiritual care. One category and three subcategories emerged from the meaning units are presented on table 3.1. The participants perceived barriers or difficulties to provide spiritual care in a number of aspects. Lack of education and training of nurses on how to incorporate spiritual care to clinical practice remains the greatest challenge for nurse clinicians, managers and educators. Some text books begin to incorporate content of spiritual care by nurses, but if the educators do not see it as important curriculum content for training nursing students, it remains of no use or value a supported by Linda et al (2015:2). It is a sad state of affairs for such a crucial part of patient care to be perceived as a waste of time. It requires the involvement of senior members of the profession to establish programs in clinical practice to assist nurses in this regard.

Lack of time could be an issue because of staff shortages and busy routines in hospitals. Some of the suggested strategies need time to be implemented effectively to effect spiritual care. Participants in the study, in practical terms felt under pressure to provide spiritual care, but busy routines and shortage of staff could not afford them that opportunity. They thus viewed visiting by church members as a nuisance or disturbance of their routine. Although most of them understood providing spiritual care as important, nurses however experienced time constraint in providing spiritual care. One could conclude that lack of support and guidance remains a challenge in practice for nurses to provide holistic patient care inclusive of spiritual care. Prayer was cited as the most common and quick way of meeting patients' spiritual need in times of stress.

Zamanzadeh et al (2015:224) cautions that some aspects of spiritual care needed to be carried out with spiritual sensitivity and caution lest more damage is done than good as people belong to different religious backgrounds and belief systems.

Nurses may not be able to make the time to really understand the importance of the spiritual aspect of care especially in the context of busy days in the units (Skall 2006:747) which does not take away its value to promote healing.

4.4 SCOPE AND LIMITATION OF THE STUDY

Although this contextual research study will yield in-depth insight into various aspects of spiritual care, some people may criticise it for a lack of generalisability of its findings because of the sample size. Although the number of participants was small, but the responses generated by the open-ended questions with probing questions generated a huge amount of data enough to afford the researcher to make conclusions on provision of spiritual care.

However, qualitative research in general is not aimed at yielding generalizable findings, but research processes that can be replicated in similar settings can be utilised. The findings of this study may not necessarily be generalised to other hospitals and nursing colleges, but the understanding of the phenomenon of spiritual care can be disseminated to diverse health care groups and nursing environments. The researcher provided rich descriptions to enable other researchers to judge the applicability of the research methods or findings to other similar contexts.

A noted limitation that may have affected the credibility of the findings was the use of the purposive sampling methods. Some of the participants were known to the researcher based on their participation in the Bridging course programme. The latter was overcome by use of bracketing and application of the research values and processes without bias.

4.5 RECOMMENDATIONS

The recommendations for clinical practice were as follows:

- Recommendations based on the findings of this study are that dissemination of relevant information and research findings in nursing literature on spiritual care studies be increased and made available to nurses in practice. Skills, attitudes and knowledge on the understanding of what spiritual care is and how can it be integrated in clinical practice is crucial for better health outcomes.
- In cases where nurses themselves, or their loved ones become patients, the nature of their personal experience of spiritual care would have a profound effect on how they would desire that such care be provided. They may be asked to write narratives of how that care was experienced to give feedback to nurses in practice, nurse managers and in classes.
- Providing nurse's clinicians with a forum for open and honest discussions with their managers about issues of integrating spiritual care to practice can be useful.
- In-service education, workshops and conferences can be held for various groups about provision of spiritual care for nurse managers, educators, students and nurses in the units. Addressing relevant topics such as:
 - Provision of holistic nursing care
 - The importance of prayer, scriptures and spiritual songs
 - Developing spiritual competency to apply the nursing process
 - Developing spiritual nursing care plans
 - Religious care – How does it differ from spiritual care?
 - Seeing the nurse and patient as human/spiritual beings
 - Developing meaningful referral system for spiritual care
 - Integrating spiritual care in curricula

- It would help to remind busy nurses that patients are spiritual beings and have spiritual needs and spiritual preferences which should be considered during history taking, planning and implementation of care plans
- Attention can be focused on the formative years during the training of student nurses when they come to the clinical practice arena. The senior nurses to model spiritual nursing care behaviours to them. Mentoring is particularly important to provide guidance to the younger nurses as to what spiritual care is and what activities would evidence provision of such care.
- Management to support such aspects of care by making spiritual care to be evidenced in policies, appraisal systems, documentation, training and evaluation processes. Those in senior positions can model provision of spiritual care through related gestures towards the staff members
 - None of the suggestions recommended will make much impact if nurses, managers and educators remain unaware of the importance of incorporating spiritual care in clinical practice to improve the quality of patient care.

4.6 IMPLICATIONS OF THE STUDY

According to the Oxford Advanced Learners Dictionary (2015:188), implications are the conclusions or inferences or insinuations that can be drawn from something, although it is not explicitly stated. In this study implications were inferred on nursing practice, nursing education and research.

4.6.1 Implications for nursing practice

The nursing profession is conflicted about its obligation to provide holistic care which suggests meeting the spiritual care needs of patients. This phenomena is complicated by issues such as lack of spiritually competent nurses, different religious worldviews, confusion about what spiritual nursing care is all about (Pesut 2006:126). Spiritual nursing care as part of holistic patient care is viewed by many as complex, abstract and problematic. The spiritual aspect of provision of patient care represents a fundamental

element of humane care, as well as an unrecognised valuable component of holistic patient care ([Maphosa 2017: 32](#)).

- Though not scientifically proven, nurses in practice need to be aware that the spiritual dimension of humans integrates and transcends the biological and psychological nature manifested through observable behaviours. It must therefore be dealt with particularly by nurses who spend more time with patients than any other member of the health care team. Nurses understand patients very well and are in a good position to can relate with the patient and family on religious matters
- Nurses in clinical practice must realise that suffering through sickness, disease or injury or illness in one way or other is associated with spiritual suffering. Patients experiencing sicknesses and disease whose spirit is therefore affected will benefit from having their spiritual needs catered for. Kliwer (620:2004:620) concludes that the process of learning how to integrate spiritual nursing care to clinical practice is a given and not a choice if quality patient care is to be improved.
- Nurses should be empowered to be able to identify spiritual distress experienced by patients where appropriate and provide sensible, humane spiritual intervention as suggested in the findings.
- Referral to pastoral care givers should be seen as secondary intervention based on the choices that patients make in this regard. In addition, nurse managers need this understanding of provision of holistic care and provide the needed support and training for nurses. Participants in the study had much to share from their perspectives in clinical practice which were mostly intuitive responses to caring for the spiritual needs of patients rather than as a learnt art of patient care.
- Nursing care is most effective if it acknowledges the integration of spiritual nursing care in the overall care of patients. Of central importance in this study is the need for nurses to be guided on the integration of spiritual care in clinical practice.

- Nurse clinicians must ensure that patients must never believe that their nursing care will be affected because of their belief system that may be different from that of the nurse.

Nurse Managers currently provide adequate supervision of nursing care activities in practice, but mentoring nurses for performing spiritual skills remain lacking in the clinical experience of most nurses. Nurse leaders in clinical practice have the responsibility for providing guidance to nurses on how to adequately meet the spiritual needs of patients in all realms which are physical, psychosocial, emotional and spiritual.

4.6.2 Implications for nursing education

Implications for nursing education are as follows:

- Skills, attitudes and knowledge on how to provide spiritual care in terms of overall quality of care should be incorporated in both basic and advanced training of nurses. Student nurses in the classroom can be given an opportunity to imagine themselves as patients and role play themselves as patients to experience how their spiritual needs are being met, or how they would provide such care.
- There is a need for education and training for nurses on spiritual conversation methods, personal spiritual awareness and sensitivity, provision of information on spiritual care activities in the curriculum and the spiritual language that goes with it.
- Training of nurses on the provision of spiritual nursing care to be approached through the use of the nursing process methodology in terms of nursing diagnosis of spiritual problems, conducting spiritual assessments, planning, implementation, evaluation and documentation of such care.

4.6.3 Implications for nursing research

Implications for nursing research are as follows:

- Findings in this study indicate that nurses need to promote nursing research for more clarity and understanding on how to provide spiritual nursing care in a way that differentiates the shared values in the findings of this study from traditional professional values which are not necessarily spiritual in nature.
- Future research may need to focus on a multidisciplinary approach involving doctors and allied professionals and not only the nursing staff.
- The research presented here should be seen as a step toward contributing towards an understanding of what spiritual care is and how to provide it to patients in simplified ways within the discipline of nursing.
- In addition to learning about how to provide spiritual care to patients, there would be value in researching the spiritual needs of nurses and how they can be provided for.
- Further research should be conducted on participants who do not belong to the Christian faith for diversity of responses and report of perspectives.

A great deal more of research in this phenomenon still needs to take place before health professionals fully understand the ways in which spiritual care has a bearing on the quality of care for patients.

4.7 CONCLUSION

This chapter focused on making conclusions on the themes that emerged from data and recommendations based on the qualitative data analysis findings. The researcher summarised the findings on the provision of spiritual care based on the identified themes, categories and subcategories. The scope and limitation of the study were indicated. Recommendations in general were stated and implications related to clinical practice, nursing education and nursing research were outlined.

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UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE

REC-012714-039

HSHDC/514/2016

Date: 2 March 2016

Student No: 3016-886-4

Project Title: Nursing students perspectives on spiritual care in clinical practice.

Researcher: CG Nkala

Degree: MA in Nursing Science

Code: MPCHS94

Supervisor: Prof LV Monareng

Qualification: D Litt et Phil Joint

Supervisor: -

DECISION OF COMMITTEE

Approved

Conditionally Approved



Prof L Roets

CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE



Prof MM Moteki

ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

ANNEXURE 2: LETTER REQUESTING PERMISSION

P.O.Box 1192

Mtubatuba

3935

2015.09.24

The CEO & Nursing Manager

Hlabisa Hopital

P/Bag x 5001

Hlabisa

3937

REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY

Gugulethu Cynthia Nkala hereby request permission to conduct a study in your institution in 2016. I am a registered student at UNISA (30168864) for Master's Degree.

The topic of my research is: Nursing student's perspectives on spiritual care in clinical practice. The purpose of the study is to explore and describe the perspectives of nursing students regarding spiritual care as experienced in clinical practice. My target group are the Bridging course students. Participants will be interviewed and engaged in individual and focus groups, participant's privacy and confidentiality of information will be ensured. Participants who wish to withdraw from the study will do so without any qualms. The research clearance certificate will be submitted after receiving approval from the University. Herewith find enclosed the informed consent that will be signed by participants.

Yours faithfully

Mrs G.C.Nkala

Tel (w) 035 8388767 cell: 0835544533 e-mail: nkalagugu@gmail.com

ANNEXURE C INFORMED CONSENT

Research Title:

Institution: University of South African (UNISA)

Department of Health Studies

Researcher: Mrs Gugu Nkala

Supervisor: Professor. L.V. Monareng

Dear participant

My name is Mrs Gugulethu Cynthia Nkala; I am a registered nurse working at KwaZulu Natal College of Nursing – Sub-campus as a lecturer. I am conducting a research project as a UNISA Masters student (30168864) to explore and describe nursing student's perspectives on spiritual care in clinical practice. I would appreciate it very much if you could participate in my research project. I can assure you that interviews will be conducted with integrity, your privacy will be ensured and the information you share will be kept confidentially. If you consent your name will not appear on the questionnaire neither will your responses bear or link to your identity.

This study is neither invasive nor harmful. As a participant, you are entitled to information; you must know the purpose and the significance of the study. You have a right to refuse to participate if you feel uncomfortable. If you consent to participate, you will give honest answers freely without being intimidated. You are free to withdraw from participating if you feel uneasy, even though you have signed this consent form. Your decision will not in any way interfere with your rights as a student nor deprive you of any privileges you enjoyed before participating in this study.

I ----- (Names in full) have read this consent form and voluntarily consent for my participation in the study.

Participant's signature: ----- Date -----.

I have explained the study to the students and sought an informed consent.

Researcher's signature: ----- Date: -----.

Witness: ----- Date -----.

ANNEXURE E

INTERVIEW GUIDE

All information herewith provided will be treated confidentially. It is not necessary to indicate your name or personal information on this interview guide

INSTRUCTIONS

1. Answer all questions on section A by providing an "X" in the box corresponding to the chosen alternative
2. Answer all questions as honestly, objectively as possible
3. Answer according to your own personal opinion, knowledge and experience
4. Hand in the interview guide to the researcher immediately after completion

Answer the question in section A by placing an "X" in the box corresponding to the alternative which is applicable to you

SECTION A DEMOGRAPHIC DATE

REF No:	<table border="1" style="margin: auto; border-collapse: collapse;"> <tr> <td style="width: 30px; height: 20px;"></td> <td style="width: 30px; height: 20px;"></td> <td style="width: 30px; height: 20px;"></td> </tr> </table>													
<p>What is your gender category?</p> <table border="1" style="margin: 20px auto; border-collapse: collapse;"> <tr> <td style="width: 30px; text-align: center;">1</td> <td style="width: 150px;">Male</td> <td style="width: 30px;"></td> </tr> <tr> <td style="text-align: center;">2</td> <td>Female</td> <td></td> </tr> <tr> <td></td> <td>Other</td> <td></td> </tr> </table>	1	Male		2	Female			Other		<table border="1" style="margin: auto; border-collapse: collapse;"> <tr> <td style="width: 100px; height: 20px;"></td> </tr> <tr> <td style="width: 100px; height: 20px;"></td> </tr> </table>				
1	Male													
2	Female													
	Other													
<p>How many years have you worked in clinical practice as an enrolled nurse?</p> <table border="1" style="margin: 20px auto; border-collapse: collapse;"> <tr> <td style="width: 30px; text-align: center;">1</td> <td style="width: 150px;">2-3 years</td> <td style="width: 30px;"></td> </tr> <tr> <td style="text-align: center;">2</td> <td>3-4 years</td> <td></td> </tr> <tr> <td style="text-align: center;">3</td> <td>4-5 years</td> <td></td> </tr> <tr> <td style="text-align: center;">4</td> <td>above 5 years</td> <td></td> </tr> </table>	1	2-3 years		2	3-4 years		3	4-5 years		4	above 5 years		<table border="1" style="margin: auto; border-collapse: collapse;"> <tr> <td style="width: 100px; height: 40px;"></td> </tr> </table>	
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2	3-4 years													
3	4-5 years													
4	above 5 years													

<p>What age category do you belong to?</p> <table border="1" style="margin-left: auto; margin-right: auto; border-collapse: collapse;"> <tr><td style="width: 5%; text-align: center;">1</td><td style="width: 70%;">25-30</td><td style="width: 25%; text-align: center;">1</td></tr> <tr><td style="text-align: center;">2</td><td>31-35</td><td style="text-align: center;">2</td></tr> <tr><td style="text-align: center;">3</td><td>36-40</td><td style="text-align: center;">3</td></tr> <tr><td style="text-align: center;">4</td><td>41-45</td><td style="text-align: center;">4</td></tr> <tr><td style="text-align: center;">5</td><td>46-50</td><td style="text-align: center;">5</td></tr> </table>	1	25-30	1	2	31-35	2	3	36-40	3	4	41-45	4	5	46-50	5	<table border="1" style="width: 100%; height: 100%; border-collapse: collapse;"> <tr><td style="width: 50%; height: 80px;"></td><td style="width: 50%;"></td></tr> </table>					
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2	31-35	2																			
3	36-40	3																			
4	41-45	4																			
5	46-50	5																			
<p>What courses related to spiritual care have you attended before?</p> <table border="1" style="margin-left: auto; margin-right: auto; border-collapse: collapse;"> <tr><td style="width: 5%;"></td><td style="width: 70%;">counselling</td><td style="width: 25%; text-align: center;">1</td></tr> <tr><td></td><td>witnessing</td><td style="text-align: center;">2</td></tr> <tr><td></td><td>HCF training on spiritual care</td><td style="text-align: center;">3</td></tr> <tr><td></td><td>Other</td><td style="text-align: center;">4</td></tr> </table>		counselling	1		witnessing	2		HCF training on spiritual care	3		Other	4	<table border="1" style="width: 100%; height: 100%; border-collapse: collapse;"> <tr><td style="width: 100%; height: 100px;"></td></tr> </table>								
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	Other	4																			
<p>What is your religious affiliation?</p> <table border="1" style="margin-left: auto; margin-right: auto; border-collapse: collapse;"> <tr><td style="width: 5%;"></td><td style="width: 70%;">Roman Catholic</td><td style="width: 25%; text-align: center;">1</td></tr> <tr><td></td><td>Jehova's witness</td><td style="text-align: center;">2</td></tr> <tr><td></td><td>Baptist</td><td style="text-align: center;">3</td></tr> <tr><td></td><td>Protestant</td><td style="text-align: center;">4</td></tr> <tr><td></td><td>Evangelical</td><td style="text-align: center;">5</td></tr> <tr><td></td><td>Other</td><td style="text-align: center;">6</td></tr> </table>		Roman Catholic	1		Jehova's witness	2		Baptist	3		Protestant	4		Evangelical	5		Other	6	<table border="1" style="width: 100%; height: 100%; border-collapse: collapse;"> <tr><td style="width: 50%; height: 100px;"></td><td style="width: 50%;"></td></tr> </table>		
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SECTION B

The Grand tour unstructured individual interview question will be posed as follows:

“Please tell me “What do you understand by spiritual care and how do you implement it during patient care”?

Probes will be guided by the participants' response

THANK YOU FOR YOUR PARTICIPATION IN THIS STUDY