



**NURSING INTERVENTIONS USED IN PROMOTING SPIRITUAL
HEALTH FOR PATIENTS WITH LIFE THREATENING ILLNESSES IN
HOSPITAL SETTINGS**

A Literature Review

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Author:

Siska Natalia

Advisor:

Marie Tyrrell

Examiner:

Pernilla Hillerås

ABSTRACT

Spiritual health is one of the essential components of health, where patients search for meaning and purpose in life. Patients with life threatening illnesses experience distress, both physically and spiritually. There are studies which found that nurses did not regularly integrate spiritual care into their daily routine, due to lack of time and lack of education. It is important to discover existing evidences of spiritual interventions which help the nurses promote spiritual health as regards to patients' need in hospital settings.

The aim of this study was to describe nursing interventions applied in promoting spiritual health for patients with life threatening illnesses in hospital settings. A literature review of sixteen articles was carried out. Articles were retrieved from CINAHL and MEDLINE databases to answer the study's objective. Eleven articles were retrieved from the databases and five articles were found using an ancestry search. A process of re-reading and finding the similar categories from articles was being used to develop themes in analyzing the data.

Results were categorized into three themes: person-centred communication, adapting a team approach, and modifying the physical environment. It was found that the nurses conducted a deeper level of communication which covered topics about patients' wishes and hopes, and being there for patients as major interventions. The nurses also assessed patients' spiritual needs prior to interventions, and were promoting patients and family belief and value in a respectful way. Family and referrals were also included in the intervention given by the palliative care team, moreover the nurses were providing privacy with regards to supporting a healing environment.

In conclusion acknowledgement of dying is essential in providing appropriate care. It is essential for the nurses to be prepared adequately through education, to conduct spiritual care interventions within a person-centred care approach. The information from this study may improve the quality of delivering spiritual care in hospital settings for patients with life threatening illnesses. Further recommendation for future research is to explore deeper about various spiritual nursing interventions from various cultures.

Keywords: nursing intervention, spiritual health, life threatening illnesses, hospital

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BACKGROUND

Palliative Care

The World Health Organization (WHO) defines palliative care as an approach that improves the quality of life both of patients and their families, in facing issues related to life-threatening illness, throughout the prevention and relief of suffering by early identification and impeccable assessment and treatment of pain and other issues related to physical, psychosocial and spiritual (WHO, 2002). The European Association of Palliative Care ([EAPC], 2010) defines palliative care as an active, total care from an interdisciplinary approach intended for patients whose disease are not responsive to curative treatment, control of pain, of other symptoms, and of social, psychological and spiritual; the palliative approach integrates patient, family and community, for providing the needs of the patient whether at home or hospital setting, affirms life and regards dying as a normal process, to preserve the best possible quality of life until death.

Gamondi, Larkinand, and Payne (2013) in EAPC white paper report describe ten core competencies in palliative care. The competencies are:

1. Applying the core constituents of palliative care in the setting where the patients and families are based,
2. Enhancing physical comfort throughout patients' disease trajectories,
3. Meeting patients' psychological needs,
4. Meeting patients' social needs,
5. Meeting patients' spiritual needs,
6. Responding to the needs of family care givers both in short and long-term patients care goals,
7. Responding to the challenges of clinical and ethical decision-making in palliative care,
8. Practicing comprehensive care co-ordination and interdisciplinary teamwork across all settings where palliative care is offered,
9. Developing interpersonal and communication skills,
10. Practicing self-awareness and undergoing continuing professional development.

Goals of Palliative Care

The main goal of palliative care are to promote and to improve the quality of life both for the patients and their families throughout the disease trajectory. Care is mainly based on the physical, psychological, social, and spiritual dimension of the individual (Radbruch, et al., 2009). The objectives of palliative care services include optimization in quality of life and dignity in dying, recognizing patients' choice and autonomy, and recognizing both patients' and families' needs in any care setting (Ahmedzai et al., 2004).

Palliative Care Settings

Palliative care can be applied in a number of settings. The services itself are coordinated through different settings of home, hospital, inpatient hospice, nursing home and other institutions (EAPC, 2010). Patients who have problematic symptoms such as recurrent pain and other symptoms from the diseases and medication side effects, also fear about condition and future which cannot be controlled. Patients have the rights to be referred to a palliative care team, preferably in patients' home, or other settings, such as day care, hospice care, and in-patient setting within a hospital (Ahmedzai et al., 2004).

Hospital Settings

Palliative care in hospital settings are frequently provided together with life-prolonging care, regardless of the patient's diagnosis or prognosis, and is an integral component of comprehensive care for critically ill patients (Aslakson, Curtis, & Nelson, 2014). Hospitals are part of healthcare institution facilities whose main goal is to deliver effective and efficient patient care. The hospital characteristics are in-patient beds, medical staff, nursing services, and other various specialties (Ferenc, 2013). Palliative care is expected to be routine delivered by the nurses or other health care providers in hospital settings (Weissman & Meier, 2008).

The majority of people in Europe are passing away in hospital settings, therefore, it is important to ensure that people receive good palliative care in an acute hospital setting (WHO, 2011). According to WHO (2011), in the past palliative care was mostly offered to persons with cancer in a hospice setting, but more recently is offered more widely and broadly not only for cancer but also other conditions. For instance, palliative care services in hospital settings can be provided in Palliative Care ward, Medical Surgical ward, and Acute Care ward such as emergency and critical care.

Approximately one in five deaths in the United States occurs during or shortly after admittance to Intensive Care Unit (ICU). There are more deaths that occur in the ICU than any other settings in the hospital (Aslakson et al., 2014). In addition, palliative care is an important component of comprehensive care for patients with life threatening illnesses, even from the period of ICU admission, it is neither an exclusive alternative, nor consequences to unsuccessful efforts at life prolonging care (Aslakson et al., 2014).

Life threatening illnesses

The need for palliative care is increasing not only for patients with cancer, but also for other patients with non-communicable diseases as well as life-threatening illness (Worldwide Palliative Care Alliance [WPCA], 2014). The term life threatening illnesses (LTI) refers to illness with significant threat to life (Sheilds et al., 2014). LTI means that there is no cure, and it might be highly distressing for patients and family, and have consequences not only to physical and financial states, but also social and spiritual conditions (Johnston, Miligan, Foster, & Kearney, 2012). According to Sheilds et al. (2014) the term critical illness also refers to a life threatening illness, a concept that also refers to illness with significant threat to life, with extensive variety of diseases, which require palliative care approaches.

Some examples of patients with LTI that require palliative care services for adults are; Alzheimer's disease and other Dementias, Cancer, Cardiovascular diseases (excluding sudden deaths), Cirrhosis of the liver, Chronic Obstructive Pulmonary Diseases, Diabetes, HIV/AIDS, Kidney failure, Multiple Sclerosis, Parkinson's disease, Rheumatoid Arthritis, Drug-resistant Tuberculosis (WPCA, 2014). According to WPCA (2014), in 2011 the expected number of adults need palliative care was more than 19 million, with majority died from cardiovascular diseases (38.5 percent) and cancer (34 percent).

According to EAPC report (2010), more people die as a result of serious chronic disease, and older people are more likely to suffer from multi-organ failure towards the end of life. The top five predicted causes of death for 2020 which are included in LTI are Heart disease, Cerebrovascular disease, Chronic respiratory disease, Respiratory infections and lung cancer (EAPC, 2010). Since LTI can provoke questions about deeper existential issues, such as the

meaning of life, spiritual care should be integrated to palliative care provision. It is important for nurses to be able to raise spiritual issues in a supportive and caring environment (Gamondi et al., 2013).

Spirituality

Based on EAPC (2010), spirituality is a part of dynamic dimension of life that relates to the way patients both as individuals and community members, express themselves and/or seek meaning, purpose of life and transcendence. Meeting patients' spiritual needs is one of the core competences in palliative care (Gamondi et al., 2013). According to EAPC (2010), it is the way to connect at a particular moment, to self, others, nature, the significant and/or the sacred. Spirituality is also a transcendent dimension of belief in a higher being and with more material and humanistic pursuits along a horizontal dimension (Ormsby & Harrington, 2003).

Some patients are longing for religious or spiritual care providers to help answer the question about why they experience the disease (Mueller, 2001). Moreover, describes by Mueller (2001), they might also seek answers to existential question when they consult with a physician to determine the cause and treatment of an illness. Puchalski (2002), notes that spiritual care needs for patients with LTI includes: having a warm relationship with their caregiver, being listened to, having someone to be trusted to share their fears and hopes, having someone with them when they are dying, being able to pray, and having others pray for them if required. Spiritual needs in general include the need to give and receive love; to have meaning, purpose, hope, values, and faith; and to experience transcendence, beauty, and so forth. When spiritual needs are not satisfied, spiritual suffering or distress occurs (Mueller, 2001).

Some studies found that nurses do not regularly incorporate spiritual care into their daily routine, and lack time to explore the patient's spiritual needs (Ellis & Narayanasamy, 2009). The nurses might feel they lack the essential skills to individually provide spiritual support to patients (Ellis & Narayanasamy, 2009). Spirituality in nursing is a part of holistic nursing care, yet many nurses are unprepared for spiritual care, which is a neglected area of practice (Pesut, 2008). There is a lack of education on spirituality within nurse training programs. Moreover, even though spirituality is discussed within nursing education, it is neglected in practice (Narayanasamy, 2006b).

Spiritual health

Spiritual health is part of human health, as well as physical, and mental health, this means that a person is able to deal with everyday life, in a way that lead to insight of potential, meaning and purpose of life, and satisfaction (Dhar, Chaturvedi, & Nandan, 2011). Therefore, every health care provider is obliged to provide spiritual support, as Driscoll (2001) mentions that spiritual care is beyond religious care; it includes respect for meaning and value of a human being. In addition, as mentioned by Scottish Executive (2002, as cited in Lugton & McIntyre, 2005), spiritual care is completely person-centred without any assumptions about personal belief or life orientation, and is usually given within the context of a personal relationship.

Person-Centred Care Framework

McCormack and McCance (2006) developed the Person-Centred Care (PCC) framework for use in the intervention that focused on measuring the effectiveness of the implementation of

PCC in hospital settings. Person-centred processes focus on providing care through various activities, which operationalize PCC nursing and including working with patient's beliefs and values, engagement, having sympathetic presence, sharing decision-making. McCormack & McCance (2006) describe the framework that includes four constructs (see Figure 1), such as prerequisites, which include attributes of nurses, caring environment, person-centred process, and expected outcomes.

The current focus of PCC is stepping away from a medically fragmented and disease oriented culture, toward relationship focused, collaborative, and holistic culture (McCance, McCormack, & Dewing, 2011a). As added by McCormack, Dewing, and McCance (2011b), moving from PCC moment to cultures is not an individual responsibility, it involves commitment from a whole team. Moreover, the importance of PCC in palliative care context in a hospital settings, leads advanced practitioner nurses' decision making from traditional nursing roles towards advanced communication, counseling, and care planning (McCormack et al., 2011b). Further in this study, the term patients' will be used refer to a person who is receiving care in a hospitals settings.



Figure 1. PCC Framework by McCormack and McCance (2006)

Nursing

Meleis (2012) describes the domain of nursing with seven central concepts. The concepts fundamental to nursing are: nurse-patient relationship, transitions, interaction, nursing process, environment, nursing therapeutics and health, elaborated as follows (Meleis, 2012):

1. Nurse-patient relationship, patients as individuals are the focus of nursing actions.
2. Transitions, nursing deals with patients experiencing, anticipating, or completing transitions. Transition category in health/illness transition, includes sudden role changes from health state to an acute illness or chronic illness and vice versa.
3. Interaction is a tool for assessment, diagnosis, or intervention, and for building relationships (Hawthorne & Yurkovich, 2002 as cited in Meleis, 2012).
4. The nursing process is built on communication and interaction tools, and processes for nursing practice.
5. Environment, as stated by Florence Nightingale (1946, as cited in Meleis, 2012) environment is identified as a nursing focus on optimizing an environment to promote healing and optimal health.
6. Nursing therapeutics is defined as all nursing actions intended to care for nursing clients. Examples of nursing therapeutics that are being used in the nursing literature are touch,

caring role, protection, comfort, use of self as a nursing therapeutic approach, symptom management, and transitional care.

7. Health is a goal shared by a number of health professions

In addition, by the International Council of Nurses ([ICN], 2012), stated that in providing care, the nurse promotes an environment in which human rights, values, customs and spiritual beliefs of the individual, family and community are respected. The nursing role refers to human nature, professional, interventions, development of therapeutic relationships, and decision making (Johnston in Lugton & McIntyre, 2005).

Nursing in Palliative Care

Palliative care nurses' major responsibilities are caring for dying patients and families, providing an empathetic relationship, being there and acting on the patient's behalf, fostering hope, supporting and helping them to live with the psychological, social, physical, and spiritual consequences of their illnesses (Johnston in Lugton & McIntyre, 2005). The nurses are expected to play a significant role in improving patients' and families' quality of life during a tough period (Murray, 2007). Some nurses hold very positive views about spiritual care and consider that they have a role to play in addressing patients' spiritual needs, however they need to have more education in order to provide spiritual care (Timmins et al., 2016).

Nurses are members of a team within palliative care and in hospital settings the team consists of doctors and nurses, including chaplain. The team provides support and advice of pain and symptoms control, management of pain, psychosocial and spiritual support, and bereavement support (Johnston in Lugton & McIntyre, 2005). Palliative care teams, especially nurses are expected to be able to provide opportunities for patients and families to express their spiritual and existential dimensions in a respectful manner, to integrate their spiritual, existential and religious needs in the care plan, respect their decisions, and be aware of the limitations and respect of cultural taboos, values and choices (Gamondi et al., 2013).

PROBLEM STATEMENT

Considering the magnitude of vast increments of life-threatening illnesses globally, in 2011 the estimated number of adults in need of palliative care at the end of life was over 19 million, with majority died from cardiovascular diseases (38.5%) and cancer (34%). Despite 'meeting spiritual needs of patients' with life threatening illnesses being as one of core competencies of palliative care, several studies have stated that nurses do not habitually integrate spiritual care to their routine care plan. These might be attributed to feeling of nurses lacking the essential skills to individually provide spiritual support to patients, lack of education on spirituality within nurse training programs and lack of time which makes spiritual care seem to be neglected. Therefore this literature review is emphasizing to determine the existing evidence of spiritual interventions that could help the nurses promote spiritual health according to patients need in clinical setting, specifically hospital.

AIM

The aim of this study was to describe nursing interventions applied in promoting spiritual health for patients with life threatening illnesses in hospital settings.

METHOD

Design

The research design in this study was systematic literature review. A systematic review is a design to identify comprehensively and discover all the available literature on a topic, with a comprehensive methodology, and well-focused searching strategy (Aveyard, 2010). In addition according to Aveyard (2010), inclusion and exclusion criteria are developed in order to assess which information to retrieve, and ensure included only studies that are relevant to the aim were addressed by the literature review. A literature review was used to carry out this study. A literature review is a critical summary of research on a topic of interest, frequently prepared with placed a research problem in the framework (Polit & Beck, 2012). In addition according to Garrard (2011), this method is done by reading, analyzing, accumulating knowledge about the topic studied, and writing scholarly materials about a specific subject or area of interest; the author must focus on the scientific methods, results, strengths, weakness, analysis and conclusions. The author was choose the literature review in order to find summary of topics to initiate research in spirituality and nursing interventions.

Data Collection

The electronic health-related databases used to gather articles were from Cumulative Index to Nursing and Allied Health Literature (CINAHL) and Medical Literature On-Line (MEDLINE). CINAHL is an important electronic database which covers references to all English-language nursing and allied health journals, books, dissertations, and selected conference proceedings in nursing and allied health fields (Polit & Beck, 2012). MEDLINE database accessed for free through PubMed website, it is cover mostly the biomedical literature, it used the controlled vocabulary called MeSH (Medical Subject Headings) to index articles (Polit & Beck, 2012).

The search words used by MeSH term in MEDLINE were palliative care, nursing, nurse, spirituality, terminal care, critical illness, acute, and emergency. The free text search words were hospital, life threatening illness, spiritual care, and spiritual health. The author used similar terms for search process in CINAHL, the difference was option for MeSH term was changed by MW word which included subject heading and subheadings. In both databases, the Boolean operators used “AND” and “OR” to connect words together to either narrow or broaden results.

Only peer-reviewed and primary research articles were included after being assessed to establish significance and trustworthiness (Richardson, 2011). According to Garrard (2011), a peer-reviewed paper is the one which has gone through one or more scientific experts. Primary research or primary source materials are original research papers written by the authors who essentially conducted the study. The primary source includes the purpose, methods, and results section of a research paper in a scientific journal (Garrard, 2011). The articles were classified on a three level scale which are high (I), moderate (II) and low (III) quality according to Sophiahemmet University grading criteria (see Appendix I).

The author chose matrix method according to Garrard (2011), as the articles presented in a matrix includes author, year, and country, title, aim, method, sample, results, type, and quality. In order to collect the documents, all titles from hits displayed were reviewed, then the author read the abstract to determine relevance to the aim. When the abstract’s objective and results seemed to be relevant to the study aim, then the entire article was read. Finally, the author decided which articles to be used in this review. Full text articles were gathered by

finding the free text, and which was obtained from Sophiahemmet University Library. Each article was read several times, and a few articles were eliminated if they did not include nursing interventions. The analysis process started when sixteen articles were found relevant to the aim, and data saturations have been reached.

Inclusion Criteria

The research focused on original studies or primary research which used either qualitative or quantitative, and mixed methods. The articles sources would be within ten years between 2006 and 2016, published in English, peer reviewed, related to palliative care, nursing interventions were included, and the population were adult patients.

Exclusion Criteria

Articles published prior to 2006, used language other than English, focused in home care setting, and articles which involved infant, children, and adolescent were not used. All reports, review articles, and grey literature with quality or grade (III) were also excluded.

Table 1. Searched Process in CINAHL

Date of search	Key Words	Identified articles (hits)	Abstract reviewed	Article examined	Article included
2016-03-13	Palliative Care AND Nursing AND Spiritual AND Acute setting AND Life Threatening Illness	22	6	6	2
2016-03-15	Palliative Care OR Terminal Care OR Critical Illness OR life threatening illness OR Spirituality OR Spiritual Care OR Spiritual health AND Acute OR Emergency	34	10	6	2
2016-03-22	Palliative Care OR Terminal Care OR Critical Illness OR life threatening illness OR Spirituality OR Spiritual Care OR Spiritual health AND Acute OR Emergency AND Nurse OR Nurses OR Nursing	68	20	8	1

Table 2. Searched Process in MEDLINE

Date of search	Key words	Identified articles (hits)	Abstract reviewed	Article examined	Article included
2016-03-13	Palliative Care OR Nursing OR spiritual OR hospital	208	-	-	0
2016-03-13	Palliative Care OR Nursing OR acute care OR spiritual	6	6	6	2

2016-03-15	Palliative Care [MeSH term] OR Terminal Care [MeSH term] OR Critical Illness [MeSH term] OR “life threatening illness” OR Spirituality [MeSH term] OR Spiritual Care OR Spiritual health AND Acute [MeSH term] OR Emergency	24	18	10	3
2016-03-22	Palliative Care [MeSH term] OR Terminal Care [MeSH term] OR Critical Illness [MeSH term] OR “life threatening illness” OR Spirituality [MeSH term] OR Spiritual Care OR Spiritual health AND Acute [MeSH term] OR Emergency AND Nurse OR Nurses OR Nursing	6	6	6	1

Ancestry Search

The author was carried out an ancestry search, which involved using citations from related studies to discover earlier research on the same topic (Polit & Beck, 2012). The author did the search by examined links suggested in the databases, and searched in references list from chosen articles. Five articles were included from the ancestry search in this literature review.

Data Analysis

Sixteen articles were included in this literature review. The assessment and analysis of the articles were done by using the matrix method, and steps used were organized in the documents in an Excel spreadsheet to set up the review matrix on computer and the documents were ordered in alphabetical order, prior to finding the themes (Garrard, 2011). According to Polit & Beck (2012), a convenient method to display information clearly and analyzing the data from a literature review is using matrix, as the information can be sorted chronologically, with author’s names, time of publication from oldest to recent, or common terms.

The result matrix contains information about findings of each research study that answered the aim of the literature review (Polit & Beck, 2012). Articles analysis used thematic analysis, which is the most common method for summarizing and synthesizing findings in a descriptive methods, and applicable for mixed literature, qualitative and quantitative studies (Coughlan, Cronin, & Ryan, 2013). Further, Coughlan et al. (2013) explained that the first step in thematic analysis is identifying codes, and labels to classify results from the findings of the research, PCC framework (McCormack & McCance, 2006) was used as guidelines for constructing themes in results.

ETHICAL CONSIDERATIONS

The term ‘ethics’ in the research context refers to the principles, rules and standards of conduct that apply to investigations (Wager & Wiffen, 2011). Ethical consideration is applied when one discusses data, articles, and research accurately, objectively, and honestly. It should be interpreted carefully to prevent misrepresentation, misinformation, and/or intentional misinterpretation (Polit & Beck, 2012).

In this literature review ethical consideration did not emphasize on the protection of human and animal subjects, but rather, focused on respecting the public trust. Thus, the author paid attention in research misconduct. Research misconduct refers to fabrication, falsification and plagiarism. Plagiarism is a form of misconduct and intentional representation of another person's own work (Wager & Wiffen, 2011). Falsification is manipulating data, or distorting results not as accurately represented as in reports. Fabrication involves making up data or study results (Polit & Beck, 2012). The author avoided plagiarism by fully admitting all data used and giving appropriate credit when using other researchers' work. Fabrication and falsification were avoided by writing whatever the results were in the articles without any distortion.

Articles selected for the review must take into consideration ethical principles in accordance with the World Medical Association's (WMA) Declaration of Helsinki, Ethical Principles for medical research, which stated that in research involving human subject, each participant must be adequately informed of the aims, methods, the anticipated benefits, and potential risk of the study (WMA, 2013). In this literature review, risk and benefit to participants have been assessed by the authors of the investigated studies. The author made sure that all participants included in the investigated study were given informed consent, and had the rights to refuse or withdraw consent to participate without reprisal. The author also made sure that the studies included privacy, confidentiality, and received approval from an ethical review board. In regards of professionals' code of ethics when undertaking a literature review, nurses have to consider their responsibility to care for people. In research context, the research should be used to improve nursing practice (ICN, 2012).

RESULTS

The results in this study are presented under three main themes; Person-centred communication, Adapting a team approach, and Modifying the physical environment. Sub-themes were included under the main themes.

Person-centred communication

Communicating on a deeper level

The nurses' facilitated communication in a deeper level found as one of the most frequently reported interventions. The nurses explored efforts on finding sense and meaning in life (Baldacchino, 2006; Kisvetrová et al., 2016). Baldacchino (2006) found that nurses did the communication about accepting the limitation and identifying the positive aspects of the current situation, assisting in finding sense and purpose in life. This was supported by Kisvetrová et al. (2016) that stated the nurses explored patients' hope and wishes for the future, moreover deeper into their wish for funeral arrangements. Coenen, Doorenbos, and Wilson (2007) also found that nurses in India were maintaining hope or faith, accepting clients' feelings helping and trying to fulfill patients' last wishes, while in Ethiopia the nurses and giving psychological reassurance.

Besides hope and wishes, the nurses' also explored patients' distresses by listening to patients' deep concerns (Giske & Cone, 2015; McBrien, 2010). Nursing intervention which explored patients' distress can also be a creative way, such as using pictures to help patients talk about spiritual aspects (van Leeuwen et al., 2006), and a storytelling method which allowed patients to share their personal experiences and achieved a sense of connectedness and intimacy (Tuck et al., 2012).

Active listening and being present

Nurses build nurse-patient trust relationship with active listening and being present with patients. Active listening can promote patient self-reflection (Burkhart & Hogan, 2008; Tanyi, et al., 2009; Tuck et al., 2012). Nurses attitudes in performing active listening demonstrated respects when talking to patients in order to support patients' coping with illness (Hanson et al., 2008), to communicate with empathy (Baldacchino, 2006; McBrien, 2010), to listen to patient expressing their feeling (Kisvetrová, Klugar, & Kabelka, 2013), to listen with interest, to be careful, and to listen deeply to patients story, to act with honesty, compassion (Coenen et al., 2007), and also to show gestures such as smiling and giving therapeutic touch by holding hand, and hand shaking (Coenen et al., 2007; Giske & Cone, 2015; McBrien, 2010).

Nurses also being present for patients and families in promoting spiritual health, by staying with patients at the bedside and also being with patient and family (Coenen et al., 2007; Gallison, Xu, Jurgens, & Boyle, 2013; McBrien, 2010; Smyth & Allen, 2011; Tuck et al., 2012). Nurses' intervention of being present is described by Tuck et al. (2012) as therapeutic presence, while Giske and Cone (2015) called it as attentive engaging.

Assessing spiritual needs

Assessments of patients' spiritual needs were carried out by the nurses prior to interventions. Assessments were done by listening to patients' complaints about their current condition, by assessing privacy, and nonverbal cues shown by patients (Baldacchino, 2006), by assessing spiritual needs (Burkhart & Hogan, 2008; Lundberg & Kerdonfag, 2010; Smyth & Allen, 2011), by assessing patient's comfort level with the spiritual topic (Tanyi, McKenzie, & Chapek, 2009), and by assessing whether patients belong to a religious community and patients spiritual view, and how patients handled previous situations (Hanson et al., 2008; van Leeuwen, Tiesinga, Post, & Jochemsen, 2006).

Promoting patients' belief and values

Nursing interventions in promoting patients' value and belief is manifested by treating patients with respect and dignity. This was found consistently in two studies (Kisvetrová et al., 2013; Kisvetrová et al., 2016). Nurses were facilitating patients religious coping (Baldacchino, 2006), allowing patients doing yoga or meditation (Coenen et al., 2007; Tanyi et al., 2013). Nurses allowed patients to conduct spiritual practices and religious rituals for instance praying in chapels (Lundberg & Kerdonfag, 2010).

Respecting patients' belief is demonstrated by respecting patient's belief about existential issues and connectedness with higher power (Burkhart & Hogan, 2008), and for Christian patients, nurses in USA and Ethiopia respected them to have assurance of belief from the Word of God (Coenen et al., 2007). Several articles stated that nurses prayed with patients, if only they were asked (Burkhart & Hogan, 2008; Gallison et al., 2013; Giske & Cone, 2015; Hanson et al., 2008; Kisvetrová et al., 2013; McBrien, 2010; van Leeuwen, et al., 2006).

In order to support culturally based spiritual practices, Coenen et al. (2007) found that nurses in India allowed patients to use Tulsi Patra leaves and water from Gangga river, or chanting prayers (Bhajams and shlokas) for preparing self to have a peaceful death. McBrien (2010) supported this by stating that nurses respected patients' and families' cultural belief and practices.

Adapting a team approach

Facilitating referrals to other team members

As part of health care providers and palliative care team, nurses collaborated in promoting patients' spiritual health. For more specific and detailed intervention in spiritual care, nurses collaborated by referring patients to hospital chaplains (Baldacchino, 2006; Gallison et al., 2013; Giske & Cone, 2015; McBrien, 2010), and calling religious ministers (Smyth & Allen, 2011).

Patients were also allowed to have their own spiritual advisors, as it had already been discussed with patient, family, and palliative care team (Kisvetrová et al., 2016). Another spiritual mentors such as priests, pastors, members of the clergy, or other spiritual leaders, were also facilitated by nurses for being with patients (Coenen et al., 2007).

Family and significant others

Nurses' support in promoting spiritual health was for patients as well as their families. Nurses showed respect and facilitated families' participation in the teamwork for spiritual care (Lundberg & Kerdonfag, 2010). Families' participation in caring patients can strengthen patient-family relationship (Baldacchino, 2006), as Kisvetrová et al. (2016) found that families were being involved by the nurses in giving spiritual support for patients, in order to promote connectedness between patients and families (Burkhart & Hogan, 2008).

Similarities in facilitating family members' presence were found in three studies (Baumhover & Hughes, 2009; Bloomer et al., 2013; Coenen et al., 2007). A study by Baumhover and Hughes (2009) addressed patients' and families' wishes to allow them together during critical and difficult situation, during invasive procedures and resuscitation in critical care unit and emergency department. In a palliative ward, nurses also cared for families by simply giving them cups of tea and offering chair to sit, and allowing visitors to stay as long as they like (Bloomer et al., 2013). Coenen et al. (2007) in their research found in four countries (Ethiopia, India, Kenya, and USA) that nurses were encouraged families to be with patients. In addition, Coenen et al. (2007) added that nurses supported, reassured, and involved families in the care to promote patients dying with dignity.

Furthermore, interventions for spiritual health for patients were not only given when patients were still alive, but also when patients had already passed away, as Smyth and Allen (2011) addressed that nursing care in providing spiritual care was demonstrated by nurses giving care after the patient died, including washing the body, placing flowers on the body, and letting family or partners to be involved in after death care. In Ethiopia, nurses helped family members in acceptance of death and the belief in life after death (Coenen et al., 2007).

Modifying the physical environment

Facilitating privacy

In two countries, United Kingdom and Czech Republic, nursing intervention includes environmental modifications which provide privacy and allow patients to have quiet time for spiritual activities (Giske & Cone, 2015; Kisvetrová et al., 2016). It is supported in a study in USA by Coenen et al. (2007), that nurses offered privacy, a homelike environment, a quiet room, and soft music and lighting. Coenen et al. (2007) added that nurses in India provided peaceful environment and allowed patients and family to sing their favorite songs. A support

in spiritual health can also come from domestic animals visit, this was covered in study in Australia (Smyth & Allen, 2011) and USA (Coenen et al., 2007).

A study has shown that modified ward design in a quiet and peaceful environment can support spiritual health (Baldacchino, 2006). On the other hand, Bloomer et al. (2013) argued from their findings, that end-of-life care in a single room could have negative consequences for the dying. It caused patients to feel scared and alone, and could be forgotten by the nurses, even though nurses modified the room by putting some tissue and a vase of flowers, and provided comfortable chairs for family and visitors.

DISCUSSION

Method Discussion

The method used to answer the aim in this study was a literature review. This method was considered suitable as the aim of the study was to describe narratively available published research (Aveyard, 2010). A qualitative study with semi structured interview or focus group discussion could have been an alternative method to carry out this research. The method, however, is time consuming for daily practice (Polit & Beck, 2012). Moreover, since the subjects are patients with LTI and spiritual health, this topic could have been as high risk for patients as vulnerable group in their critical situation.

The strength of a literature review method was the feasible and convenient method to answer the aim of the review (Polit & Beck, 2012; Garrard, 2011). Literature review is important because there was an increasing amount of studies that cannot be expected to be reviewed and assimilated in only one topic (Aveyard, 2010). Aveyards (2010) added in order to update the information, that it is one of suitable ways for practitioners to assimilate, decide, and implement all this information in their professional lives. Articles gathered within the past ten years, were taken from several countries, and used various methods such as qualitative, quantitative and mixed methods, recognized by the author as strength from this study.

According to Aveyard (2010), the weakness of literature review includes language issues and time limitation. At that point, the author was aware of time limitation and insufficient English language proficiency required to carry out an empirical study, thus the author decided to perform the study by using a literature review.

Researcher subjectivity is one of the biases that can occur in a research, where researcher may search findings within their expectations or their own experiences (Polit & Beck, 2012). This bias was avoided by the author by trying to explore various articles until data saturation was found. Data saturation in the literature review is similar to a qualitative study, which means pursuing information until saturation is achieved, and the analysis of data typically contains similar themes (Polit & Beck, 2012). Data saturation in this study were achieved when the findings contains similar topics and showed reappearance within the themes.

Validity and reliability in this study was obtained by evaluating and assessing the quality of the selected papers. Studies which do not meet the inclusion criteria, are excluded from the study. This is to ensure that only high-quality papers that are relevant to the aim are included (Aveyard, 2010). A comprehensive and systematic search was conducted in two databases (CINAHL and MEDLINE) in different times, and also an ancestry search was obtained. Exploration was within the aim in this study, which included nursing interventions, palliative care, and spiritual as the main contexts.

The author firstly focused on the general health and medical database (MEDLINE) to have a global picture of potential findings using search terms “palliative care”, “nursing”, and “hospital” which yield a great number of articles. Then the author continued the search in CINAHL, which covered subjects in nursing and allied health. There were duplicates of articles found both in MEDLINE and CINAHL. In order to gather specific articles according to the study aim, the author modified the search by using the MeSH terms in MEDLINE, and MW word in CINAHL, to be more specific in studies searched.

The search process was restricted by year between 2006 and 2016, the oldest article found was from 2006, and the most recent was 2016, most studies were published between 2008 to 2013. The articles covered several countries across the world, in which most articles are from United States of America (USA) seven articles, followed by two studies from Australia. There were also articles from Czech Republic, Norway, the Netherlands, Ireland, and Malta are taken as representatives from the European region. Other articles were from Ethiopia, Kenya, Thailand, and India.

The following results offer a large spectrum of findings from different countries and cultures. This picture offers information regarding palliative care in several countries and nurses as the subject of interest. It was surprising that the findings have shown similarities, even though they were conducted in different countries within ten years. However, a weakness of this literature review is that it is not truly representative of a global perspective with only two studies done in Asia: in India (Coenen et al., 2007) and Thailand (Lundberg & Kerdonfag, 2010). This could be due to the fact that palliative care is still developing in Asia, According to WPCA (2014) this group of countries are still in the development stage of palliative care due to funding issues, morphine limitation, and a small number of hospice-palliative care services compared to the size of the population.

Various settings in hospitals were found in the findings, such as medical surgical wards, palliative care wards, intensive care unit, and emergency department. Initially the author expected to find greater amount of research studies in acute settings as relevant settings to most patients with LTI. However, the search process showed that there were only a few articles that published specifically about spirituality in acute care settings. One main reason is in acute or emergency settings in which there were great responsibilities, as a result the nurses not having time to conduct spiritual assessments in order to facilitate patients’ spiritual needs (Ellis & Narayanasamy, 2009). On the other hand, this insufficiency of research in particular settings could be an opportunity to develop further research on how nurses may promote a spiritual care in acute care settings.

With the intention of articles evaluation and analysis, the author first read the titles, then abstracts, and then the entire text of each chosen article. Some articles that have no relevance to the aim were excluded. Likewise, the articles that more highlighted the nurses’ or patients’ perception and experience, and not included nursing interventions were excluded. There were articles by chaplains and physicians researchers that were excluded, as they were not really addressing nursing roles and interventions.

A critical evaluation of the articles selected was measured using the classification guide of academic articles for quantitative and qualitative studies based on guidelines from Sophiahemmet University. The assessment criteria was recommended by the university which means that the same research article evaluation tool was used in this review. The author found sometimes it was challenging to decide the grade of the article, from the strengths and

weaknesses of the studies. Uncertainties were discussed during the group advisory sessions and within supervision session with the advisor.

Findings of this review were based on the results of the included sixteen articles, which used different methods, eight articles used a qualitative method, five articles used a quantitative method, and three articles used mixed method both quantitative and qualitative approaches. Some articles displayed their results in tables, and other articles include the quotes from the participants' response. Having a variety of study methods is one of the strengths and might contribute to the validity of this literature review (Aveyard, 2010).

To avoid the risk of misinterpretation of the findings, the author read the articles several times, in addition, the author also discussed them with the advisor to double check the findings. The author sought to avoid falsification, misinterpretations or research misconduct (Polit & Beck, 2012). For ethical consideration, the author carefully searched and read for ethical approval in each article. Since the studies involved human as participants, ethical concerns in each study were examined to make sure participants get adequate information about the aim, method, benefit and risk of the study, and each study contributed to the improvement in nursing practice (WMA, 2013; ICN, 2012).

The author documented essential evaluation of methods used in each study which included sampling, setting, and data collection sections. The majority of studies used purposive sampling approach with convenience sample, where the researcher selected participants based on specific criteria such as which ones will be most informative (Polit & Beck, 2012). Only one study by Badalacchino (2006) used stratified random sampling for male and female nurses, it was where the participants were randomly selected from two or more strata of the population independently (Polit & Beck, 2012).

There were three studies which used enormous samples in data collection. Coenen et al. (2007) included 560 nurses within four countries (Ethiopia, Kenya, India, and USA). However the attrition rate was also plentiful 44 percent, as regards to emailed survey on the internet (USA) and at that time in Ethiopia there was political incident which caused many people including the participants, out of the country. Kisvetrova et al. (2013), conducted a research involving 750 nurses who had cared for patients with LTI, and several years later Kisvetrova et al. (2016) conducted a research with 450 ICU nurses, both in Czech Republic. Even though there were also a high attrition rate (38 percent), the internal consistency of the structured questionnaire was considered acceptable because Cronbach's α coefficient was 0.92 for the entire questionnaire (Kisvetrova et al., 2016).

In contrast, studies with small numbers of participants were represented by four studies. Smyth and Allen (2011) were doing research to 16 nurses from acute medical wards in a hospital in Australia. In spite of small numbers of participants and in one hospital, they did an unstructured focus group interview to explore more information from participants, and did triangulation in data analysis to strengthen the generalizability of the study. In the study by Tuck et al. (2016), there were 5 out of 18 participants dropped from the study, due to worsened condition and no longer being able to communicate. It was one of the condition that could occur in research within palliative care settings.

Another study with a small sample size was from Tanyi et al. (2009), which studied only ten participants with inclusion criteria of those who have lived the experiences in incorporating spiritual care in their practices as regards to phenomenological research methodology. Last study was from Thailand by Lundberg and Kerdofag (2010) that were obtained from a

relatively small number of registered nurses who are not representative of the whole population of nurses in Thailand, consequently results obtained should not be generalized to Thailand registered nurses in general.

The author was constructing the results findings according to theme. This review captured wide range of themes but most of the studies had similar findings. The author used different colors in order to highlight the recurrent sections relevant to each theme, while considering PCC as framework.

Results Discussion

The result of this literature review were displayed in themes according to nursing interventions in promoting spiritual health for patients with LTI in hospitals settings. The main theme focuses on patients, which is person-centred communication, the nurses also adapting a team approach by including family and chaplain in the team work, and in addition modifying physical environment to support patients and family privacy during their critical moments.

According to McCormack and McCance (2006), the primary stage in PCC approach is focus on the nurses' attributes, whereas professional competence focuses on the knowledge and skills to make decisions and prioritize care, and include competencies in taking assessments. This first step of caring was shown in several articles, due to the nurses taking assessments in patients' spiritual needs prior to interventions in order to recognize patients spiritual needs, spiritual history, and religious views (Baldacchino, 2006; Burkhart & Hogan, 2008; Hanson et al., 2008; Lundberg & Kerdonfag, 2010; Smyth & Allen, 2011; Tanyi et al., 2009; van Leeuwen et al., 2006).

Simply taking a spiritual history may honor the patient's need to be seen as more than a physical being, and health care providers can learn this skill (Hanson et al., 2008). In addition, Baldacchino (2006) stated that the nursing assessment might influence the patients to confide their inner self to nurses as a trustful nurse-patient relationship.

An early identification and holistic assessments related to physical, psychosocial needs, and spiritual needs are major parts in palliative care (WHO, 2002). Therefore, when the healthcare professionals address patients' spiritual needs to promote spiritual health; they provide spiritual care (Taylor, 2006). Spiritual care is closely tied up with dignity in care, holistic care, and respect patient's perspective (Cockel & McShery, 2012).

A person-centred communication conducted by nurses leads to a deeper level communications, such as explored patients sense, meaning, hope, and purpose in life (Badalacchino, 2006; Kisvetrova et al. 2016; Coenen et al., 2007). When discovering about patients' wishes, the nurses also gain more information about patients' distress and deep concerns (Giske & Cone, 2015; McBrien, 2010). Such approaches conducted by the nurses to allow patients to talk about their personal experiences include using pictures (van Leeuwen et al., 2006) and storytelling (Tuck et al., 2012).

There was finding that uncovered that the nurses did not only communicate about patients' hope and last wishes, but also talked further about funeral arrangements requests (Kisvetrová et al., 2016). Nursing interventions supported patient dignity in their last moments. Interventions identified by nurses to promote dignified dying reflected a holistic approach to caring for patients and their families (Coenen et al., 2007). As it is according to EAPC (2010), which stated that all people have the right to receive high quality care during serious illness

and to a dignified death free of overwhelming pain and in line with their spiritual and religious needs.

In order to perform communication on a deeper level, an active listening and being present for patients are important. More than half of the total articles results discussed these evidences. Active listening promoted patients' self-reflection (Burkhart & Hogan, 2008; Tanyi, et al., 2009; Tuck et al., 2012) and supported patients' coping with illness (Hanson et al., 2008). Listening to patients feeling required several approaches such as listening with interest, honesty, and compassion (Coenen et al., 2007), empathy (Baldacchino, 2006), and giving therapeutic touch like holding hands (Coenen et al., 2007; Giske & Cone, 2015; McBrien, 2010).

According to Tuck et al. (2012), when listening to a patient, the nurse pays attention not only to the patient's words, but also voice tone and body language. In addition, therapeutic touch was also described as positive affective and comforting touch. It is supported by Pesut (2008), that stated that nurses managed therapeutic use of self includes interventions such as presence, listening, touch, respect, in order to help patients to find meaning, purpose, hope, values, connection, and forgiveness.

Nurse presence for patients and families implies therapeutic presence, a special way of being with the other that recognizes other's values and priorities (Tuck et al., 2012) and attentive engaging (Giske & Cone, 2015). These results are in line with Pesut (2008), which described that nurses' caring presence as important to patients and has the potential to make a significant difference for patients to understand their circumstances.

Several studies addressed nursing interventions in promoting spiritual health by respecting patients' belief and values, by treating patients respect and dignity (Kisvetrová et al., 2013; Kisvetrová et al., 2016), facilitated religious coping (Baldacchino, 2006) such as praying in chapel (Lundberg & Kerdonfag, 2010), or through yoga and meditation (Coenen et al., 2007; Tanyi et al., 2013). Nurses also prayed with patients if they were asked (Burkhart & Hogan, 2008; Gallison et al., 2013; Giske & Cone, 2015; Hanson et al., 2008; Kisvetrová et al., 2013; McBrien, 2010; van Leeuwen, et al., 2006). These results have important implications for developing a PCC focus on providing care through various activities including working with patient's beliefs and values (McCormack & McCance, 2006).

There is only one study by Coenen et al. (2007) that showed specifically how nurses supported cultural based spiritual practices in India, nurses allowed patients and family used Tulsi Patra leaves and Gangga's river water, or doing specific chanting prayers (Bhajams and Shlokas) for preparing self to have a peaceful death. Even though it is only found in a particular study, this is an important issue for future research for nurses to conduct further research with regards to supporting spiritual practices in various cultures. According to the author's previous experience working in ICU ward in Indonesia, where there were plenty of traditional cultural diversities. The nurses there respected patients and families spiritual practices in the ICU ward, for example families asked the nurses to give the patients specific water with paper containing arabic prayer, with the purpose of cleaning from sin, and for drinking and bathing. One of the issues emerging from these findings is in accordance with the study by Gamondi et al. (2013), which stated nurses as a part of palliative care teams. Nurses provided opportunities for patients and families to express their spiritual and existential dimensions in a respectful manner.

Another important finding is including others in a teamwork, families and significant others, and also referrals to hospital chaplain. More than one studies shown that nurses included

families, relatives, visitors to participate in giving spiritual support to patients with LTI whether it was in a palliative care ward (Bloomer et al., 2013; Coenen et al., 2007) or during resuscitation and invasive procedure in ICU and emergency ward (Baumhover & Hughes, 2009). Furthermore, involving family in nursing care was also encouraged when patients had already passed away (Smyth & Allen, 2011; Coenen et al., 2007). According to EAPC, it is one of palliative care nursing competencies for practicing an interdisciplinary teamwork and providing comprehensive care co-ordination throughout all settings where palliative care is offered (Gamondi et al., 2013).

Collaboration with other team members was represented with nurses refer patients to hospital chaplains (Baldacchino, 2006; Gallison et al., 2013; Giske & Cone, 2015; McBrien, 2010), religious ministers (Smyth & Allen, 2011), spiritual advisors (Kisvetrová et al., 2016), and other spiritual mentors such as priests, pastors, members of the clergy, or other spiritual leaders (Coenen et al., 2007). These findings may help us to understand that nurses are members of a team within palliative care, who provide support not only for reducing pain and other symptoms, but also for promoting psychosocial, spiritual support, bereavement support (Johnston in Lugton & McIntyre, 2005). In addition, these results are in agreement with nurse's responsibilities to not only listen to the patient and assess any spiritual need, but also to make referrals to others who have the essential skills and experience to help (McCormack et al., 2011b).

Besides caring for patients and family, nurses should also caring for the physical environment (McCormack & McCance, 2006). The study also uncovered that by providing privacy and allowed patients to have quiet time for spiritual activity should be made possible (Giske & Cone, 2015; Kisvetrová et al., 2016). Although this may be true that a single room helps promote patients' privacy, surprisingly in contrast to the findings, Bloomer et al. (2013) found that care for patients with LTI in a single room could have negative consequences for patients who are dying, because they might feel alone and scared, and could be neglected by the nurses.

To emphasize PCC approach according to McCormack and McCance (2006), the care within environment should be a major impact on the implications of person-centred approach, it is involving the potential of innovation and risk taking. In line to the statement, the results found that creating a homelike environment in hospital settings (Coenen et al., 2007) supports patients' spiritual health, the same condition also relates to allowing domestic animals visit (Smyth & Allen, 2011; Coenen et al., 2007). From the author's experience working in Indonesia, there was a regulation that prohibits taking domestic animals into the hospitals, for hygiene and infection control reasons. In contrast, while the author conducted field studies in several hospitals in Stockholm, Sweden, the nurses allowed the patients in palliative wards to take their domestic animals in the room. It showed that the nurses carried out PCC approach in taking care of patients with LTI in their end of life condition.

There is a concept of environment that was expanded from Nightingale's primary focus about hygiene and sanitation, it also includes concerns about the social, psychological, and spiritual environments (Shaner, 2006, as cited in Small & Small, 2011). As a matter of facts, most hospitals and healthcare facilities have been constructed with clinical efficiency and not yet a person-centred approach. Infection control in many countries may be added to depersonalization, for instance no flower, plants of paintings are permitted in some clinical settings (McCormack et al., 2011b). Therefore, future study in evidence based care needs to consider PCC approach in environment modification in supporting patients' spiritual health.

CONCLUSION

Acknowledgement of dying is essential in providing appropriate care. The nurses need to be adequately prepared, educationally, socially and emotionally, to provide such care. The most common nursing interventions in promoting patients' spiritual health in hospitals settings within a PCC approach was a person-centred communication, which was built from a nurse-patient trust relationship and from a communication in deeper level. It is also important to realize that therapeutic communication was developed by active listening and being present for patients. Another points to address is that the nurses should respect patients' belief and values in the context of their cultural diversity. Nursing assessments on spiritual needs is conducted prior to interventions.

Nurses which worked in a team, should also involve families in promoting spiritual care, and making referrals to hospitals chaplains or other religious leaders. Facilitating patients' privacy and creating homelike environments should also be addressed in nursing interventions. As a result by addressing patients' spiritual needs sensitively and wisely, nurses certainly will promote not only spiritual health, but also holistic healing (EAPC, 2004).

CLINICAL SIGNIFICANCE

The information from this study may improve the delivery of spiritual care in hospital settings for patients with LTI. Application from this study is to enable nurses' use of available evidences available to improve quality of care and implement best practice in spiritual care in a PCC approach. Training and workshop about how to conduct interventions with regards to spiritual health might be needed in addition to regular nurses' education. Further recommendation for future research is to explore deeper about various spiritual nursing interventions from a culturally diverse perspective.

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APPENDIX I

Classification guide of academic articles and studies regarding quality in both quantitative and qualitative research, modified Berg, Dencker & Skärsäter (1999), Willman, Stoltz & Bahtsevani (2006).

CLASSIFICATION	GRADING OF ACADEMIC QUALITY		
	I = High quality	II = moderate	III = Low quality
Randomised controlled trial (RCT) is a prospective study that entails a comparison between a control group and one or more experiment groups.	Large, well planned and well executed multicenter study with an adequate description of protocol, material and methods including treatment techniques. The number of patients/participants is large enough to answer the research question. Adequate statistical methods.	*	Randomised study with few patients/participants and/or too many partial studies with insufficient statistical strength. Insufficient number of patients/participants, inadequately described method or large attrition rate (participant drop out rate).
Clinical controlled trial (CCT) is a prospective study that entails a comparison between a control group and one or more experiment groups. Not randomised.	Large, well planned and well executed study with an adequate description of protocol, material and methods including treatment techniques. The number of patients/participants is large enough to answer the research question. Adequate statistical methods	*	Limited number of patients/participants, method inadequately described, faults or lacking in protocol and insufficient statistical strength.
Non- controlled study (P) is a prospective study but without a control group.	Well defined research questions, sufficient number of patients/participants and adequate statistical methods.	*	Limited number of patients/participants, method inadequately described, faults or lacking in protocol and insufficient statistical strength.
Retrospective study (R) is an analysis of a historical material that is related to something that already happened, for example patient charts.	Number of patients/participants sufficient to answer the research question. Well planned and well executed study with an adequate description of protocol, material and methods.	*	Limited number of patients/participants, method inadequately described, faults or lacking in protocol and insufficient statistical strength.
Qualitative study (Q) often is an investigation where the aim is to study phenomena or interpret meaning, perceptions and experiences from the perspectives of the participants. The aim can also be to develop concepts, theories and models.	Context clearly described. Selection of participants motivated. Clearly described selection criteria, data collection, transcription process and method of analysis. Credibility and reliability described. Relation between data and interpretation evident. Critique of method.	*	Poorly formulated research questions. Patient/participant group inadequately described. Method and analysis not sufficiently described. Presentation of results incomplete.

* Some of the criteria for level I are not met, but the academic quality is deemed higher than level III – Low quality.

APPENDIX II

Articles Matrix

No	Author(s)	Title	Aim	Method	Participants (Attrition rate)	Results	Type/ Quality
	Year						
	Country						
1	Baldacchino , D. R. 2006. Malta	Nursing competencies for spiritual care	To identify and explore the nursing main competencies for spiritual care, which emerged from the data	Stage 1: Mixed method, questionnaire and two closed ended questions on types of spiritual distress, and five open- ended questions explored specific nursing care. Stage 2: semi structured interview	Stage 1: Male nurses n= 160 (115), Female nurses n = 215 (183). Stage 2: 14 (0)	Nurses do assessments by listening to patients' present condition and aware of nonverbal cues, and identifying patients' needs. Nurses communicating with empathy by addressing patients' anxiety and trustful communication, extending physical care to holistic care, providing a quiet peaceful environment, helping to accept the limitations of the current situation, identifying the positive aspects of the situation, facilitating religious coping, instilling hope for the future, assisting in finding meaning and purpose in life, strengthening patient–family relationship, and referring patients to the hospital/community chaplain.	P and Q/I

2	Baumhover, N., & Hughes, L. 2009. United States of America (USA)	Spirituality and support for family presence during invasive procedures and resuscitations in adults	To determine the relationship between spirituality of health care professionals and their support for family presence during invasive procedures and resuscitative efforts in adults.	Questionnaire	n = 115, 73 nurses n = 73 (0), physicians n = 31 (0), and physician assistants n = 13 (7)	A significant positive relationship was found between spirituality and support for family presence during resuscitative efforts in adults. Nurses being asked both by patients and family members to allow family presence during invasive and resuscitation procedures. Nurses allowed family to remain present with their loved one during a resuscitative and invasive effort. Nurses unhesitant to bring family to the bedside regardless of written policy.	P/I
3	Bloomer, M. J., Endacott, R., O'Connor, M., & Cross, W. 2013. Australia	The 'disease' of dying: Challenges in nursing care of the dying in the acute hospital setting. A qualitative observational study	To explore nurses' 'recognition of' and 'responsiveness to' dying patients and to understand the nurses' influence on end-of-life care.	Observation, focus group interview	n= 25 nurses (0)	Nurses providing active care, providing comfort care such as gave a full wash, washed hair, did mouth care, turned the patient, changed the linen and applied moisturizer, keep the curtains pulled, put some tissues and a vase of flowers in the room. Nurses also look after families in this situation by give them cups of tea and make sure they have chairs to sit on, also visitors can stay as long as they like. Ward design, nurse allocate dying patient in a single room, however end-of-life care in a single room can have negative consequences for the dying, patients feel scared and alone, and can be forgotten by the nurses.	Q/I

4	Burkhart L., & Hogan N. 2008. USA	An experiential theory of spiritual care in nursing practice	To explore nurses' experiences of providing spiritual care within a health system	Focus group discussion	n = 25 nurses (0)	Nurses assess patients spiritual and religious needs prior to interventions. The spiritual intervention category has three subcategories describing the types of spiritual interventions: promoting patient self-reflection by discussing patients understanding of the meaning of their illness, promoting connectedness between patient and family by allowing them together during critical moments, and promoting patient connectedness with a Higher Power/God by facilitating adherence to religious rituals and through prayer.	Q/I
5	Coenen A., Doorenbos A.Z., & Wilson S.A. 2007. Ethiopia, Kenya, India, and USA	Nursing interventions to promote dignified dying in four countries	To describe nursing interventions to promote dignified dying as identified by nurses in four countries	Survey questionnaire, open ended questions	n = total last samples of 560 nurses; Ethiopia n = 14 (0), India n = 362 (133), Kenya n = 50 (14), and the United States n = 906 (685).	Interventions identified by nurses to promote dignified dying reflected a holistic approach to caring for patients and their families. There are several findings such as: 1. Psychological and spiritual support: giving psychological reassurance (Ethiopia), psychological and spiritual comfort (Kenya), maintaining hope or faith and accepting clients' feelings (India), and grief work facilitation and memories (USA). 2. Encouraging autonomy and control: keeping patients involved in treatment decisions and allowing patient control (USA), trying to fulfill patient wishes (Ethiopia), and helping patients to fulfill their last wishes (India). 3. Facilitating spiritual concerns related to praying: praying with the patient and family (USA), praying for the patient (Kenya, india), and chanting prayers (both Christian and Hindu, India). 4. Facilitating the presence of spiritual mentors: priests, pastors, chaplains, members of the clergy, or other spiritual leaders. 5. Supporting culturally based spiritual practices: allowing patients using Tulsi Patra leaves and water from Gangga river, offer chanting of prayers (Bhajams and shlokas), for having a peaceful death. (India), and	P/I

						<p>for Christians, assurance from the word of God (Ethiopia and USA).</p> <p>6. Family-focused interventions : encouraging family members’ presence and involving them in care, reassuring and supporting family members (Ethiopia, India, Kenya, USA), educating and explaining to the family about the patient’s condition (India, USA), and helping family members’ acceptance of death and the belief in life after death (Ethiopia).</p> <p>7. Environmental interventions: Offered privacy, a homelike environment, a quiet room, domestic animal visits, and soft music and lighting (US). Provided peaceful environment and allowed patients and family singing favorite songs (India).</p> <p>8. Nurses attitudes in providing care: maintaining an active presence, listening with interest, careful, and deep to patients story, act with honesty, compassion, and respect of cultural, religious, or personal traditions (US), try to fulfill/comply with patient wishes” (Ethiopia, India); maintain confidentiality and “give love” (Kenya); avoid giving other stress to the patient, offer human respect, and offer tender loving care, stay with patient (india.) Positive physical contact were shown in holding hands (India, Kenya, USA), gentle touch (India, USA).</p>	
6	Hanson, L. C., & Dobbs, D., & Usher, B. M., & Williams, S., & Rawlings, J., & Daaleman,	Providers and types of spiritual care during serious illness.	To describe spiritual care received by patients and families during serious illness, and test whether the provider	Interview with open ended questions and questionnaire	n = 125 (22)	Patients identified 21 different types of spiritual care activities. The most common activity was help coping with illness and the least common intercessory prayer. Half of recipients were very or somewhat satisfied with spiritual care, and half found it very helpful for facilitating inner peace and meaning making.	Q and P/I

	T. P. 2008. USA		and the type of care is associated with satisfaction with care.				
7	Kisvetrová, H., Klugar, M., & Kabelka, L. 2013. Czech Republic	Spiritual support interventions in nursing care for patients suffering death anxiety in the final phase of life	To investigate which activities from the 'Spiritual Support' intervention of the Nursing Interventions Classification (NIC) are used in patients with the nursing diagnosis 'Death Anxiety' in the Czech Republic, and which activities could feasibly be implemented into practice	Questionnaire	n = 750 (282)	Nurses use of the activities by society type and religion, the most frequently used activity was treat individual with dignity and respect, be available to listen to individual's feelings, the least frequently used was pray with the individual.	P/I

8	Kisvetrová, H., Školoudík, D., Joanovič, E., Konečná, J., & Mikšová, Z. 2016. Czech Republic	Dying Care Interventions in the Intensive Care Unit	to assess the practice of registered nurses (RNs) with respect to dying care and spiritual support interventions in intensive care units (ICUs) in the Czech Republic (CR) and find correlations between particular factors or conditions and the frequency of NIC interventions usage.	Questionnaire	n = 450 nurses (173)	The most and least frequently reported RN activities were treat individuals with dignity and respect and facilitate discussion of funeral arrangements, respectively. Other activities in the spiritual dimensions were provide privacy and quiet times for spiritual activities, arrange visit by individual's spiritual advisors, facilitate obtaining spiritual support for patient and family, and communicate willingness to discuss death.	P/I
9	Gallison, B. S., Xu, Y., Jurgens, C. Y., & Boyle, S. M. 2013. USA	Acute Care Nurses' Spiritual Care Practices	To identify barriers in providing spiritual care to hospitalized patients	Questionnaire and open ended question	n = 271 nurses (7)	The common barriers were time, system, patient resistance, and lack of appropriate education. The common themes for meaningful spiritual interventions described by nurses included making referrals, praying with patients and families, and being present with patient and families.	P/I

10	Giske, T., & Cone, P. H., 2015. Norway	Discerning the healing path – how nurses assist patient spirituality in diverse health care settings	To examine nurses' experiences in spiritual care in diverse clinical settings, preferably not palliative care.	Focus Group Discussion	n = 22 nurses (0)	The participants resolved this by 'discerning the healing path', which comprises three stages: Tuning in on spirituality, uncovering deep concerns and Facilitating the healing process. Nurses interventions begins with two shepherding/leading process, which are praying only if patients ask, and building a trusting relationship by meet with patients and families with smile and handshake. Other interventions such as respecting patients privacy, active listening, following the patient's pace of wishes, attentive engaging (be present with patients, furthermore facilitate patient's and family rituals), referring to other spiritual specialist such as hospital's chaplain.	Q/I
11	Lundberg P.C., & Kerdonfag, P. 2010. Thailand	Spiritual care provided by Thai nurses in intensive care units	to explore how Thai nurses in intensive care units of a university hospital in Bangkok provided spiritual care to their patients	explorative study, in depth interview	n = 30 ICU nurses (0)	Five themes related to the provision of spiritual care emerged: giving mental support, facilitating religious rituals and cultural beliefs, communicating with patients and patients' families, assessing the spiritual needs of patients and showing respect, and facilitating relatives and parents to participate in the team work as a part of their spiritual care.	Q/II
12	McBrien, B. 2010. Ireland	Nurses' provision of spiritual care in the emergency setting -- an Irish perspective.	to describe nurses provide spiritual care, in an emergency setting	Semi structured interview	n = 10 (0) emergency nurses	Participants regarded spiritual care to be an integral component of their role, and participants reported that they derived positive personal outcomes from providing this aspect of nursing care. The interventions provided by nurses were providing interpersonal communication, giving therapeutic touch such as hold patient's hand, building trust relationship, being there with patients, providing referral by chaplaincy and prayers, respecting cultural belief and practices, providing comfort by being honest and listen to patients' concerns, and providing empathetic reassurance.	Q/II

13	van Leeuwen, R., Tiesinga L, Post, D., Jochemsen H. 2006. Netherlands	Spiritual care: implications for nurses' professional responsibility	To gain insight into the spiritual aspects of nursing care within the context of health care in the Netherlands and to provide recommendations for the development of care in this area and the promotion of the professional expertise of nurses.	Focus group interview	n = 67, nurses n = 30 (0), patients n = 25 (0), hospital chaplains 12 (0)	Nurses do assessment by asking patients' whether belongs to a religious community, patients' spiritual belief, and how patients' handled situations. In a limited number of situations, nurses sometimes prayed with a patient if they were asked. A few nurses used tools to talk about spiritual aspects, such as pictures to help the patient tell his or her personal history, and models to deal with the illness.	Q/I
14	Smyth, T. & Allen, S. 2011. Australia	Nurses' experiences assessing the spirituality of terminally ill patients in acute clinical practice	To explore and describe how nurses define spirituality and incorporate spiritual care into their clinical practice.	Mixed method: stage 1 demographic questionnaire, stage 2 unstructured focus group interview	n = 16 nurses (0)	Four themes were identified: understanding spirituality, assessment of spirituality, difficulties in meeting spiritual needs, and education. The exploration of the nurses' experiences showed that they did not clearly define or recognize the concept of spirituality, but they did recognize a specific way to caring terminal patients such as assisted patients in accepting their situation by just being with them, telling them it's okay, having their domestic animals come in to visit, calling the minister, and holding their hand. Furthermore, the nurses giving care after the patient died included wash the body, place flowers on the body, still respect the patient, and let family or partners be involved, and sit with them.	P and Q/II

15	Tanyi R.A., McKenzie M. & Chapek C. 2009. USA	How family practice physicians, nurse practitioners, and physician assistants incorporate spiritual care in practice.	To investigate how primary care family practice providers incorporate spirituality into their practices in spite of documented barriers	Semi Structured interview	n = 10, physicians n = 3 (0), nurses n = 5 (0), physician's assistant n = 2 (0)	Five major theme clusters emerged: discerning instances for overt spiritual assessment (perceiving the patient's comfort level with the topic and treating patients who frequently visited their practice); displaying a genuine and caring attitude by active listening; encouraging the use of existing spiritual practices, or exercise and yoga; documenting spiritual care for continuity of care; managing perceived barriers to spiritual care by provided spiritual care by actively listening to their patients' needs and being present with them.	Q/II
16	Tuck, I. & Johnson, S. C., Kuznetsova, M., McCrocklin, C., Baxter, M., & Bennington, L. K. 2012. USA	Sacred Healing Stories Told at the End of Life	To implement a storytelling approach to explore the experience of living with terminal cancer, and documented the presence of spirituality and healing in the narratives.	Narrative interview	n = 18 (5) patients with cancer	Nurses explored patients' story through implementing the PATS (Presence, Active Listening, Touch, Sacred Story). Essential elements of the intervention include the facilitation of therapeutic presence, active listening, and physical and emotional touch. Storytelling allowed the participants to share personal experiences and achieve a sense of connectedness and intimacy.	Q/II