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ORIGINAL ARTICLE

Discerning the healing path – how nurses assist patient spirituality in diverse health care settings

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Aims and objectives. To examine nurses' experiences in spiritual care in diverse clinical settings, preferably not palliative care.

Background. Spirituality is part of holistic nursing care. The concept of spiritual literacy is introduced as the nurse's ability to read the spiritual signs of the human experience.

Design. Classical grounded theory methodology with open and selective coding was used to identify the participants' main concern and the strategies they used to resolve it, and to develop a substantive grounded theory.

Method. Data were collected in 2008 and 2014 during eight focus group interviews with a total of 22 nurses recruited from a master's programme, postgraduate programmes and a local hospital. Data were analysed through constant comparison until the grounded theory emerged.

Results. The participants' main concern was *how to assist the patient to alleviation*. 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*. These three stages are accompanied all the way by the participants' *Willingness to overcome own comfort zone* and *Building a trusting relationship*.

Conclusion. Spirituality is of relevance for all areas of nursing care, not just dying patients or those in palliative care. Spirituality relates to the deep and important things in life and affects how patients face health issues. Nurses attend to spirituality in patients because the pain of the soul touches them and the calmness of spiritual peace amazes them.

Relevance to clinical practice. The professional culture in the health care team socialises nurses into the workplace, and leaders need to pay close attention to how they can foster openness to spiritual matters. The personal and professional maturity of the nurse is fundamental to his or her willingness and ability to overcome own comfort zone.

What does this paper contribute to the wider global clinical community?

- Spirituality has relevance in all areas and patient age groups, not just dying patients.
- Spiritual concerns are pivotal in patients' well-being.
- It is critically important that nurses are willing and able to uncover spiritual concerns and facilitate the healing process in whatever way patients need.
- Spirituality is deeply related to health and healing and affects both the patient and the nurse.

Key words: clinical practice, existential care, nurse–patient relationship, nursing intervention, qualitative method, spiritual care

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Introduction

Spirituality is part of holistic nursing and a professional responsibility. The International Council of Nursing Code of Ethics (2012) states: 'In providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family, and community are respected' (p. 2). Spirituality is embedded in nursing theories and is integrated into the nursing documentation system (Harding & Bishop 2010).

There is no agreed upon definition of spiritual care in nursing. The description given by the National Health Service Education of Scotland (NES 2009) acknowledges diversity in spiritual expression, underlines the need for a trusting relationship and posits that the nurse should allow him/herself to be taken on a journey decided by the other:

> Spiritual care is care, which recognizes and responds to the needs of the human spirit when faced with trauma, ill health or sadness and can include the need for meaning, for self-worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener. Spiritual care begins with encouraging the human contact in compassionate relationship, and moves in whatever direction need requires (NES 2009, p. 6).

Spirituality in nursing is mostly studied in palliative care, where guidelines for spiritual care are most developed (Gijsberts *et al.* 2011, Kalish 2012). However, spiritual concerns may surface for any patient at any time, so there is a need to develop nursing knowledge related to spiritual care for all groups of patients. Nurse researchers van Leeuwen and Cusveller (2004) identified six core competencies for spiritual care: handling personal beliefs, addressing the subject, collecting information, discussing and planning, providing and evaluating, and integrating spiritual care into policy. These competencies are used by some nursing education programmes, although there is limited research on how these competencies help nurses facilitate spiritual care. The Royal College of Nursing later developed a pocket guide for spirituality in nursing (2011b) based on a survey of its members (2011a). This guide provides nursing with general guidelines such as the importance of adopting a caring attitude, recognising and responding to individual needs, appropriately referring to other resources, and reflecting on the individual's own values and life experiences. This guide is useful in hospice and palliative care where patients often face their deepest fears and concerns and where much research has been done related to spirituality and spiritual care.

The authors' interest is in how nurses in fields other than palliative care recognise and attend to spiritual concerns of patients. This study takes place in Norway, where spirituality is seen as private and taboo to discuss (Cone & Giske 2013) and where about 80% of the inhabitants belong to a Christian denomination (Statistics Norway 2014). The nurse-population ratio is high (15/1000 inhabitants), and there is a well-developed public health care system, both in hospitals and in home nursing care and nursing homes. The stay in somatic acute care hospitals averages four days.

Background

The concept of health literacy is regarded as the sixth vital sign; it plays a key role in improving health outcomes (Heinrich 2012, Mullen 2013). Ratzan and Parker (2000) define health literacy as 'the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions' (p. 32). The concept of spiritual literacy is new to nursing literature and provides a concept that is helpful in moving the discussion forward. The authors use the term *spiritual literacy* to promote common language about spiritual care knowledge because nurses repeatedly report that they feel ill prepared for spiritual care. There is also confusion around what spirituality is and what the nurse's role is in relation to spirituality (Ross 2006, Molzahn & Sheilds 2008, Raffay 2013).

In nursing, religion and spirituality are seen as two different phenomena (Pike 2011, Sessanna *et al.* 2011, Taylor *et al.* 2014). It is important for nurses to be literate in different religions and faith traditions. Taylor (2012) has contributed greatly to the profession with her religious guide for nurses. However, not all patients see themselves as religious. Spirituality, which is a broader concept than religion, is a universal trait for all people, according to the Scottish description (NES 2009), though for many, spirituality incorporates their religious faith. The authors therefore see the concept of spiritual literacy as important for nursing. Brussat and Brussat (1996) introduced the term spiritual literacy as 'the ability to read the signs written in the text of our experiences' (p. 15). Although Brussat and Brussat wrote for the general public, many of the concepts that they made into an alphabet of spiritual literacy resonate well with nursing, for example, being present (Delgado 2007, Carson 2011), compassion (Biro 2012, Keall *et al.* 2014, Pfeiffer *et al.* 2014), connectedness (Cone 1997, Rykkje *et al.* 2011, 2012), hope (Delgado 2007, Biro 2012), kindness (Biro 2012), listening (Delgado 2007, Biro 2012, Keall *et al.* 2014), meaning (Biro 2012), openness (Giske & Cone 2012) and silence (Keall *et al.* 2014).

Method

Aim

The aim of this grounded theory study was to gain insight into how nurses, beyond palliative care, recognise, understand and practice spiritual care and what it takes to do this well.

Design

A classical grounded theory design (Glaser 1978) was chosen to discover how nurses understand and handle spiritual concerns of patients in diverse clinical areas. Data collection, coding and analysis were conducted concurrently. In the constant comparing process, the researchers sought to discover the nurses' main concern and how the participants try to resolve it.

Participants

Inclusion criteria were working nurses from diverse clinical settings along the west coast of Norway. Twenty-two nurses attended one of the eight focus group interviews. Five nurses were recruited from a master's programme at a university, eight from postgraduate courses at a private university college and nine nurses came from a small local hospital. Three participants were male. The average age was 40 years (24–59), and nursing experience ranged from one month to 31 years, averaging 11 years. Participants had experience in a variety of clinical settings including home care, nursing homes, ambulance care, hospital emergency admission, medical units, surgical units, paediatric units, palliative units, ICU, addiction centres, mental health settings, a patient hotel and an education department. Cultural backgrounds included one participant from each of these countries: Sweden, UK, USA, India and Latin-America. The remaining 17 participants were Norwegians. Participants' view of life indicated that the majority had a Christian life view (13); one was Sikh, four were humanist, one self-identified as 'liberal', two said 'none' and one did not identify.

Data collection

Focus group interviews provide a forum to share personal experiences, discuss ideas with others and thus, bring forth a diversity of views and experiences (Polit & Beck 2012). Six focus group interviews were conducted in 2014, each lasting 45–66 minutes. Two were master's student focus group interviews from 2008 from a spiritual care educational study (Giske & Cone 2012). Data from the master's students were quite different from the undergraduate students, so these data were not used in the previous study (Giske & Cone 2012). However, their relevance to the current study became clear as analysis of the first focus group began.

Each focus group had a minimum of two and maximum of four participants, which provided everyone with opportunity to speak. Due to difficulties of participants to take time away from work, the researchers carried out the focus group interview even when only two attended. As the co-investigator was English-speaking, six focus group interviews were conducted in English and the group facilitated Norwegian translation into English when needed. This allowed both researchers to have direct access to primary data. Due to limited English fluency of some potential participants, two interviews were conducted in Norwegian with codes translated into English.

After completing the anonymous demographic sheet, participants were invited to share their experiences around questions like 'Please share your experiences related to spiritual care' and 'How do you recognise spirituality?' In later interviews, driven by the emerging theory, the researchers sampled theoretically by asking questions like 'Why is spirituality important in nursing?' and 'How is spirituality related to health?' All interviews were audiotaped, and six were transcribed verbatim.

Data analysis

After the first 2014 focus group interview, the researchers started the open coding process manually. To stay open in the analysis, the researchers coded for as many incidents as possible while using the reflexive approach and asking the question: 'What is this a study of?' This process involved searching for the participants' main concern and coding for the different strategies that participants used to resolve it as well as the conditions influencing the process. Memos were written by each researcher and then discussed at regular meetings, leading to more memos reflecting the researchers' thought processes. Constant comparison of data led to the discovery of the participants' main concern and an understanding of the core concept of the emerging theory (Glaser 1978). At that point, the researchers moved on to selective coding and continued writing memos. During the analysis, it became clear that the two focus group interviews with master's students, from the 2008 study about spirituality in nursing education, dealt with the same main concern as the current study, and therefore, these interviews were incorpo-

rated into the analysing process. The last two interviews from 2014 were in Norwegian, and the open codes were translated into English. Constant comparison of the data and codes led to theoretical coding where all the concepts of the grounded theory were related to each other, forming a basic social process.

Ethics

The project was evaluated by Norwegian Data Protection Office (NSD # 36839 http://pvo.nsd.no/prosjekt/36839). Permission to invite postgraduate students and nurses was obtained from the university programmes and hospital. Participants were informed orally and in writing, and informed consent was implied through attendance at focus group interviews.

Results

The concepts developed in this grounded theory, such as the main concern, the core concepts, the strategies and the conditions are written in italics in this text to assist the reader to think conceptually about what spirituality in nursing care entails. The main concern of the participants was *how to assist the patient to alleviation*. Nurses are deeply concerned about what the patient is experiencing and how the patient is feeling; alleviation takes many forms. Nurses simply want to alleviate whatever is causing pain, suffering or other difficulties in the patient. This alleviation is accomplished through *Discerning the healing path*, which explains how the participants solve their main concern, is the core category of this substantive grounded theory. Before presenting the theory, the authors will address how participants understood spirituality and conditions that have an impact on the theory.

Spirituality in nursing

The participants found it difficult to define spirituality and to separate it out in a situation or spiritual care episode. However, the participants all gave examples of what it could be. They said that spirituality is about deep, important and big things in life. Spirituality is seen as a part of the whole person, but it is fluid and dynamic, and is more than religion and faith. In health care, nurses encounter people in vulnerable life situations and life crises, where what really matters becomes clarified. Nurses recognise patients' deep thoughts and pain; they encounter questions related to life and death, heaven and hell, meaning, hope and guilt.

Why are nurses concerned with spirituality when it is so hard to describe? They see spirituality as a part of life and humanity, and therefore, a part of nursing. They are touched by the pain of the soul, the agony in the questions they receive, and the bitterness they sometimes witness. And they are amazed by the calmness they see when some patients face death, the courage some have to accept difficult life situations and the peace some patients have to endure whatever life brings.

Conditions

Four main conditions influence how nurses recognise and work with patients' spirituality.

The nurse

The personality and background of the nurse influence her/his nursing, as do age and education. Maturity, gained from personal or professional experiences, can aid the nurse to know him/herself more deeply and thus allow the nurse to dare to open up for what is important for patients. Comfort level with own spirituality is tied to the nurse's view of the patient in illness and the nurse's sense of professional responsibility for spiritual care. This personal comfort level with spirituality is called the nurse's 'comfort zone'. Life view, more than personal faith tradition, influences the nurse's ease with spiritual concerns.

The patient

Patient age influences nursing care. When working with a child, the nurse must work with and through the parents as children and adolescents may lack language for spiritual pain. Older patients may be lonely and lack social networks. A dying patient opens up to spiritual awareness more readily than others. Acute or chronic health issues or diagnoses that affect the ability to communicate also influence the nurse–patient relationship. The interaction with the nurse is also influenced by how long the relationship lasts as demonstrated by the longer relationship with patients living in a nursing home or living at home. The patient environment provides the nurse with information about the patient's lived life, interests and values. However, it is important that nurses confirm the meaning of signs/symbols to the individual patient. One nurse commented, 'The house looks like a cathedral, but it has no meaning for the patient'. Meeting patients in an ambulance, emergency room or postsurgery care offers short meetings that might be filled with spiritual pain. The level of crisis and the patient's readiness and willingness to open up to the nurse determine their relationship. Ethnic Norwegians are

more reserved about spiritual matters than many other cultures; however, nurses see the same spiritual core in all patients, just with a different cultural packing.

The family

Nurses work a great deal with patients' families and relatives. Family values, knowledge about and preparedness for the situation affect the collaboration with them, such as when a parent does not allow the nurse to talk about dying with the ill child. When a patient is critically or terminally ill, nurses know that family members are very sensitive to what is said and done in that situation and that whatever happens can impact their grieving process for better or worse. When there is sudden death or suicide, the nurse focuses on the family to facilitate the grieving process.

The workplace

The number of staff, time available per patient, busyness of the workplace and pace of the different shifts frame the relationship with patients. All these factors influence how the nurse can prepare him or herself, seek knowledge and discuss spirituality with colleagues. These conditions also affect patients. Many mention how night shifts are different as the pace might be more relaxed and with less activity. Patients seem to feel more alone, and find it is easier to go deeper into conversations when they cannot sleep at night.

Spatial conditions impact the content of communication between the nurse and the patient. For example, when patients have to share a room, it is more difficult to engage in more profound talks. The professional culture in the team, such as a strong focus on physical and medical care or a high degree of openness among nurses to discuss spirituality, socialises nurses into a specific workplace.

Discerning the healing path

The substantive grounded theory of *Discerning the healing path* comprises three stages: *Tuning in on spirituality*, *Uncovering deep concerns* and *Facilitating the healing process* (see Fig. 1). The process is accompanied or shepherded from beginning to end by two fundamental strategies. Because they are essential to the process and carry with them the sense of nurturing the process along, the researchers call these two strategies shepherding processes. The first is a *Willingness to overcome own comfort zone*. Nurses focus on the patient and stretch themselves to be of help to the other. It might be to put aside own tiredness, to pray with a patient who asks even though it feels unfamiliar to do so or to overcome one's own shyness in assessing the patient. The other shepherding strategy is *Building a trusting relationship*. This is a continuous process with smaller actions such as meeting the patient with a smile, greeting patients or family with a handshake, offering tea or coffee to visiting family, to more fundamental conditions such as providing a sense of time and availability and opening the inner door of self towards the patient. Without these two shepherding processes, *Discerning the healing path* cannot happen. The three stages build on each other, and the process can happen over a shorter or longer time span.

Tuning in on spirituality

Tuning in on spirituality means to keep the holistic understanding of patients in mind and to be attentive to subtle cues from the patient; nurses do so by *Opening up self*. The nurse sees the patient as a person and is ready and willing to be sensitive to whatever crosses her/his mind as related to spirituality. One nurse said she was guided by 'getting a feeling'; another stated, 'It is just a sense that you have'.

In this openness, nurses *Look for signs of spirituality*, which have multiple manifestations. These signs can be how a patient is lying in bed or facial expressions; there can be restlessness or anxiety, or a patient is sleepless or crying. Nurses also listen to what patients say and ask for, such as 'what will happen to me?' and questions related to death. 'It is how they say it', one nurse commented, 'that makes me aware that there is something underneath'. Another said 'I have learned to read the small signs of man'. *Recognising signs of a spiritual nature* might include symbols patients are wearing such as a jewelry cross. It can also be pictures or literature around the patient. In acute situations when patients are very sick or if somebody is alone or dying, they might ask direct questions, even if they see no signs of a spiritual nature, to introduce spiritual support. The nurse responds to a sense of urgency by preparing the patient and family for what will happen. When spiritual signs are recognised, the nurse moves to the 'uncovering' stage.

Uncovering deep concerns

Uncovering deep concerns is the process of respectfully identifying and understanding what is important for patient and family. It can be questions related to shame, guilt, forgiveness, meaning, heaven, hell, church or struggle with hope or faith. In uncovering deep patient concerns, timing is of essence in busy health care settings. *Discerning time* helps nurses to allocate time to those who need their attention most and to use the time they have well. They are sensitive to when the patient is ready to open up her/his own inner door. In *Respecting patient's privacy*, nurses want to

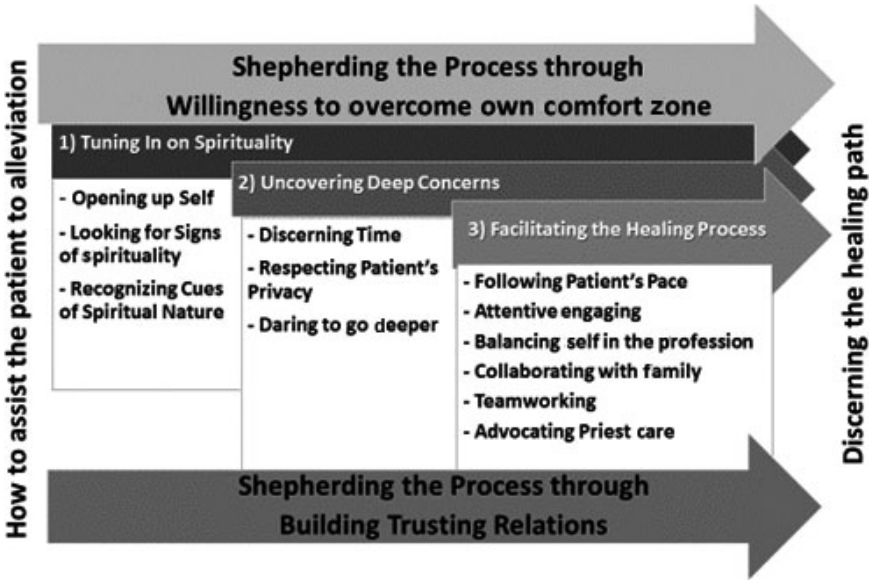

Figure 1 Discerning the healing path.

take the patient seriously, so they consider where and how to talk with patients, acknowledging that spiritual concerns are deeply personal. As religious and existential themes are seen as private and taboo in Norway, it challenges the nurse and the patient to communicate in a way so that the true nature of the patient's concern becomes clear; it is a process building on both of the shepherding processes. As the professional, the nurse carries the main responsibility for the uncovering process, but uncovering cannot happen without active patient participation.

Daring to go deeper is about the inner process in the nurse that makes him/her stay open in the revealing process. 'To put myself in the patient's situation', tells how nurses work within themselves. Active listening or being quiet so the patient can speak might take courage as the nurse listens into thoughts and feelings of patients. To master the art of asking questions, 'to ask the right questions the right way', is a key in professional judgement. In the uncovering process, nurses also look for spiritual recourses of patients as they have seen how important spiritual resources can be in handling deep concerns. As deep concerns become clearer to the nurse, she/he can start to facilitate the healing process. In this way, stages 2 and 3 of *Discerning the healing path* often overlap.

Facilitating the healing process

Facilitation of the healing process for the patient and/or family might take a great deal of collaborative work. However, it must be guided by *Following the patient's pace*. If that pace is violated, the trusting relationship can break down. Nurses are sensitive to patients' wishes and try to wait until they are ready. If it is not an emergency situation, nurses allow the time needed and try to create space for appropriate conversations. *Attentive engaging* refers to the tailored ways the nurse uses him/herself to aid the healing process, motivated by a desire to do what is best for the patient. *Attentive engaging* can be to simply sit by the patient and be present. It can be to listen, ask questions, talk, sing or pray for or with patients, or just listen to the patient praying. It can also be to make end-of-life situations as dignified as possible, to use rituals as markers in patients' and families' lives, or to assist patients to participate in Sunday services in the hospital chapel.

Nurses are also *Collaborating with family*. Nurses give information, demonstrate behaviours around the ill person, and guide and teach family members. They acknowledge the sensitivity of relatives related to what is said and what happens in critical situations and how that affects their coping or grieving process. The importance of inviting in and providing space for close relatives to be present when family members are dying was especially highlighted. Nurses sometimes witness helplessness among family members of terminally ill patients, mainly people with no religious background, lacking rituals to lean on that can guide how to behave in the dying process of a family member.

To be able to help the patient and collaborate with the family, *Balancing self in the profession* is needed. Personal strengths and challenges mark the nurse, so knowing oneself is of high importance. When there are differences in life view between nurse and patient, the nurse considers what it means to help the patient in a respectful way and how she/he can be genuine and true to both the patient and him/her-

self. *Teamworking* is vital for facilitation of the healing process. Nurses use the expertise available on the team, and they collaborate for optimal care of their patients. They use each other when time and challenges call for it; for example when a nurse recognises spiritual concerns with a patient with whom she/he is not comfortable, consultation with other nurses makes it possible to make a decision together about who should follow up the patient. To facilitate other nurses to follow up on patients, nurses document respectfully the patient's situation. Nurses refer to other spiritual specialists; in home care or nursing homes, it would be the local parish priest, and in hospital, the hospital chaplain. They are active in *Advocating priest care* for their patients. Nurses trust the priest/chaplain to be respectful and helpful for patients with spiritual concerns regardless of the patient's beliefs, so they present the priest as an expert in listening, a partner for conversation, and someone who has time to spend at the bedside. They emphasise that the patient does not need to be religious or a Christian to make use of this service, and they calm any fears related to a visit with a priest.

The outcome of spiritual care

The researchers asked participants how they saw spirituality related to health, and one nurse said, 'Spirituality influences the whole situation'. Spiritual care can change patients' situations. One nurse described how a patient was less depressed and experienced less emotional pain after talking with a deacon. Death anxiety left another patient after talking with a priest, and he became peaceful. One patient felt unburdened after a nurse had listened to her, and she could sleep without the use of medication. Nurses also give more general examples, such as, when patients experience peace from God, they can endure and accept whatever life has in store for them. To trust in God is a resource for patients; as one nurse put it, 'There can be calmness despite trouble when people rest and find peace in their faith'. The participants expressed that spiritual meaning and peace affect how patients live with chronic illness; it influences motivation and promotes faster recovery. They also saw that spirituality enables patients to reach their goals. However, nurses have also seen that bitterness and guilt from previous life experiences can darken patients' life situations.

Interestingly, the participants also commented on how spiritual involvement with their patients influences the nurse. The nurses feel good when they can attend to spiritual concerns of patients and have time to listen to them. This leads to feelings of do a good job and having meaningful work. However, nurses must constantly handle the tension between ideal practice and reality. It is painful not to be able to meet patients' needs due to a lack of time. This could lead to burnout, because not to be able to attend to a fellow human being's spiritual concerns wears a person down.

Discussion

Findings demonstrate spiritual literacy (Brussat & Brussat 1996) in the nurse participants in diverse patient situations when *Tuning in on spirituality* and *Uncovering deep concerns*. Participants see spirituality as a part of the whole and recognise patients' quest for meaning. The lack of an agreed upon definition of spirituality (Molzahn & Sheilds 2008, Pike 2011, Kalish 2012) and the confusion about religion and spirituality (Pike 2011, Sessanna *et al.* 2011, Taylor *et al.* 2014) are seen as challenges to nursing practice. Participants in this study recognised spiritual concerns of patients as something deep and important in their patients' lives. The challenges they saw are more consistent with the three barriers to spiritual care reported in the literature: barriers related to the nurse (Cone & Giske 2013, Keall *et al.* 2014, Pfeiffer *et al.* 2014), barriers regarding the relationship to patients (Keall *et al.* 2014, Pfeiffer *et al.* 2014, Taylor *et al.* 2014) and barriers related to work environment (Biro 2012, Giske 2012, Keall *et al.* 2014).

Overcoming barriers to spiritual care, which is related to the nurse, is fundamental to the whole process of *Discerning the path to alleviation* both in the shepherding process of *Willingness to overcome own comfort zone* and in the sub-strategies of *Opening up self*, *Daring to go deeper* and *Balancing self in the profession*. They overcame this barrier by maturity gained from life – and professional experiences. Education can also lead to more knowledge and deeper understanding. All this contributes to knowing oneself and cultivates self-awareness. To handle one's own beliefs is one of the core competencies of spiritual care described by van Leeuwen and Cusveller (2004). Spiritual care guidelines delineated by the RCN (2011b) are similar, requiring nurses to reflect about personal values and life experiences. The importance of consciously working on personal self-awareness is recommended throughout the spiritual care literature so that she/he can be open to meet the patient where the patient is within his/her life (Cone 1997, Taylor 2007).

Every nurse should have a minimum of spiritual literacy, which the authors call *general* expertise or competencies in spiritual care. The general competencies include a caring attitude, being able to recognise and clarify spiritual concerns, discussing how and who should follow up, and appro-

priately referring to others (van Leeuwen & Cusveller 2004, RCN 2011b). To make sure that every nurse has a minimum of general competence in spiritual care, time must be allocated to encourage and assist undergraduate nursing educators to teach and to choose methods that encourage integration of necessary knowledge and skills, including ability to self-reflect in both theory and practice (Giske & Cone 2012, Giske 2012). Education together with reflection over life experiences makes the nurse able and willing to open up towards the patient (Cockell & McSherry 2012). This openness to journey with patients is important (Cone & Giske 2013) and is part of spiritual care, according to NES (2009).

The second barrier is about the nurse–patient relationship. In the grounded theory of *Discerning the path to healing,* this is presented as the need for continuously *Building a trusting relationships with patients* and is also articulated in the theory as *Respecting patient's privacy* and *Following patient's pace*. The importance of being open towards the patient, being attentive and listening (Delgado 2007, Biro 2012, Keall *et al.* 2014) seems to be the key to connect with patients (Cone 1997, Rykkje *et al.* 2011, 2012) and for spiritual care to be recognised and encouraged (van Leeuwen & Cusveller 2004, RCN 2011b, Taylor *et al.* 2014).

The last barrier relates to the working environment of the nurse. Participants shared how staffing, pace of work and the working culture socialise nurses and affect spiritual care practices. To overcome this barrier in nursing practice, we need mature leaders who actively build a conducive working environment that integrates spirituality in patient care. Such leadership is reported to reap positive benefits for both patient and nurse (Carpenter *et al.* 2008). A supportive work environment is also important for development of more advanced competences in spiritual care and to increase the level of spiritual literacy among nursing staff (Molzahn & Sheilds 2008, Cockell & McSherry 2012).

As the nurse matures, she/he develops *special* competence in spiritual care that helps the individual nurse to go deeper with different patients (Taylor *et al.* 2014). Nurses working in teams know that individual nurses have different special competencies and they use each other's competence as appropriate. van Leeuwen and Cusveller (2004) consider development and integration of spiritual care into policy as one of their core competences, which is a special responsibility for nursing leaders.

Limitations

This study was carried out in Norway among nurses who were mainly influenced by the Norwegian culture. Most of the focus groups were in English, which is the second language of the participants. Two interviews were originally with master's students from another study conducted in a different time period. While the sample came from nurses working in different settings, representing various life views of Norway, and from two different studies six years apart, the authors see the sample as unbiased and the emergent theory is transferable to nurses around the world.

Conclusion

Spirituality is related to the deep and important things in life and affects how patients face health issues and life crises in all areas of nursing care, not just dying patients or those in palliative care. Nurses attend to spirituality of patients because the pain of the soul touches them and the calmness of spiritual peace amazes them. Personal maturity, education and professional experiences help nurses move from basic spiritual literacy or a level of general competence in spirituality, towards a higher level of specialised competencies. Nurses concern about how to assist patients who are faced with challenges and going through difficulties to alleviation, leads them to *Discern the path to healing*, which is a process that assists nurses to resolve their main concern.

Relevance to clinical practice

The professional culture of the health care team socialises nurses into the workplace and requires leaders to foster openness to spiritual matters in nurses as this will facilitate nurses to deliver care that might improve patient outcomes. The personal and professional maturity of nurses is fundamental for the willingness and ability to overcome his or her comfort zone and to build a trusting relationship with patients. To foster such maturity is both a personal and leadership responsibility. The positive outcomes of attending to spirituality for both patients and nurses are evident throughout this study and apply to every area of nursing practice.

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Disclosure

Both authors confirm that we meet the ICMJE criteria for authorship credit, as both TG and PC has (1) substantial contributions to conception and design of, acquisition of data and analysis and interpretation of data, (2) drafting the article and revising it critically for important intellectual

content and (3) final approval of the version to be published.

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Conflict of interest

The authors declare that there is no interest of conflict.

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