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EMPIRICAL RESEARCH QUANTITATIVE

Frequency of nurse-provided spiritual care: An international comparison

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Abstract

Aims and objectives: To compare the frequency of nurse-provided spiritual care across diverse cultures.

Background: Given an ethical imperative to respect patient spirituality and religiosity, nurses are increasingly taught and expected to provide spiritual care. Although nurses

report positive attitudes toward spiritual care, they typically self-report providing it infrequently. Evidence about the reported frequency of spiritual care is constrained by substantial variation in its measurement.

Design: This cross-sectional, descriptive study involved secondary analysis of data collected in multiple sites globally using one quantitative instrument.

Methods: Data were collected from practicing nurses using the *Nurse Spiritual Care Therapeutics Scale* and analysed using descriptive statistics and a meta-analysis procedure with random-effect modelling. Datasets from 16 studies completed in Indonesia, Iran, Malaysia, Philippines, Portugal, Taiwan, Turkey and the United States contributed to a pooled sample ($n = 4062$). STROBE guidelines for cross-sectional observational studies were observed.

Results: Spiritual care varied between countries and within countries. It was slightly more frequent within Islamic cultures compared with predominantly Christian cultures. Likewise, frequency of spiritual care differed between nurses in palliative care, predominantly hospital/inpatient settings, and skilled nursing homes. Overall, "Remaining present…" was the most frequent therapeutic, whereas documenting spiritual care and making arrangements for the patient's clergy or a chaplain to visit were among the most infrequent therapeutics.

Conclusions: In widely varying degrees of frequency, nurses around the world provide care that is cognisant of the spiritual and religious responses to living with health challenges. Future research should be designed to adjust for the multiple factors that may contribute to nurses providing spiritual care.

Relevance to clinical practice: Findings offer a benchmark and begin to inform nurse leaders about what may be normative in practice. They also encourage nurses providing direct patient care that they are not alone and inform educators about what instruction future nurses require.

KEYWORDS
cross-cultural comparison, nursing, religion, spiritual therapies

Around the world, nurses recognise the recipients of their care are spiritual, as well as psychological, social and physical beings (American Holistic Nurses Association, 2019). Most nursing theories identify a spiritual dimension and include this aspect of personhood as a part of the focus for nursing care (Martsolf & Mickley, 1998). They accept that ethical and effective nursing care entails respecting patient spirituality and religiosity (International Council of Nurses, 2021). Given this imperative, nurses are increasingly taught and expected to provide spiritual care that assesses and addresses the spiritual distress and challenges of patients and their family caregivers (McSherry et al., 2020). Although evidence is meagre regarding what are the outcomes of nurse-provided spiritual care, some findings suggest it does contribute to patient satisfaction and psychological and spiritual well-being (Dos Santos et al., 2022; Hodge et al., 2016).

Several studies document how nurses have considerable positive attitude toward including spiritual care within their nursing care (Badanta et al., 2021; Chew et al., 2016; Gallison et al., 2013; McSherry & Jamieson, 2011; O'Brien et al., 2019; Ramondetta et al., 2013). Findings from these studies, however, also indicate that

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

- Within and across countries, differences in the frequency of spiritual care were observed.
- Nurses, internationally, recognise they provide spiritual care; in this study, the most frequently provided included remaining present after a task, assessing spiritual or religious beliefs and practices, and listening for either spiritual themes in patient stories or spiritual concerns.
- Some spiritual care therapeutics, however, were rarely or never provided (e.g. documenting spiritual care, making a referral).

in spite of this positive attitude, nurses perceive they infrequently provide spiritual care. This infrequent practice is often attributed to a lack of education, skill or knowledge, as well as lack of time, personal discomfort and fears (Atarhim et al., 2019; McSherry and Jamieson (2011); Zakaria Kiaei et al., 2015).

Although nurses hold positive attitudes about providing spiritual care, there is a paucity of evidence to directly guide that spiritual care provision. Before understanding what are best practices and outcomes of spiritual care, nurses can benefit from answering the elementary questions of: What spiritual care is offered to patients? and How frequently is it provided? Although there are several qualitative studies describing nurse-provided spiritual care, there are few studies that quantify frequency and types of spiritual care. This collection of studies is plagued by small, localised samples and diverse approaches to measurement that prevent comparison. For example, Epstein-Peterson and colleagues (2014) obtained self-reports from 114 nurses about how frequently they provided 1 of 8 spiritual care interventions during nursing care for their previous three patients. In contrast, more commonly used scales measure a nurse's self-reported perception of competence with various spiritual care-related activities (van Leeuwen et al., 2009) or agreement with six items about what a nurse can do to provide spiritual care (McSherry & Jamieson, 2011).

Thus, this current study will examine data from several studies around the world that used the same scale to measure frequency of various types of nurse-provided spiritual care. This study will begin to document not only what nurses are doing in this regard and how frequently, but also examine whether practices vary by cultural context. Given variation likely exists in what spiritual care interventions nurses use and how frequently these are provided, the purpose of this study was to compare across diverse countries the frequency of spiritual care using the NSCTS. The following research questions were addressed: Do differences in frequency of nurse-provided spiritual care exist within countries? Do they differ between countries? What spiritual care therapeutics are most common? What therapeutics are least common? Findings can begin to provide a benchmark for frequency and types of spiritual care nurses provide and understanding about how spiritual care may vary across international boundaries.

1 | BACKGROUND

What do nurses consider spiritual care to be? A recent literature synthesis of 59 empirical and theoretical nursing articles identified eight categories of "spiritual care interventions" (Ghorbani et al., 2021). These included: assessing and diagnosing spiritual concerns, being a healing presence, using oneself therapeutically, intuitively and empathically perceiving patient receptivity and need, orienting care to be patient-centric, meaning making interventions, creating a spiritually supportive environment, and evaluating and documenting patient status. These categories of spiritual care align with a recent definition of nurse-provided spiritual care offered by a consortium of European nurse scholars:

> (Spiritual care) recognises and responds to the human spirit when faced with life-changing events (such as birth, trauma, ill health, loss) or sadness, and can include the need for meaning, for self-worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener. Spiritual care begins with encouraging human contact in compassionate relationship and moves in whatever direction need requires. (McSherry et al., 2020)

This definition reflects other scholarly discourse on the topic.

When nurses are asked to describe spiritual care, they often give broad responses. Often nurses state that it involves showing kindness, respect and dignity; therapeutic communication that includes empathic listening; spending time and being present (including touch); fostering hope, meaningfulness, humour and positive thinking; and supporting religious beliefs and practices (e.g. Chew et al., 2016; Hu et al., 2019; Melhem et al., 2016; Musa, 2016; Riklikiene et al., 2016). Indeed, these practices comprise the content of scales measuring beliefs about what constitutes spiritual care (Labrague et al., 2016; McSherry & Jamieson, 2011; Tiew & Creedy, 2012). Although some might argue these practices are simply good nursing care, findings from a number of studies around the world using these scales indicate that nurses are in concordance about these practices comprising spiritual care (e.g. Kaddourah et al., 2018 [Saudi Arabia]; Labrague et al. [Philippines]; Ross et al., 2018 [8 European countries];). Thus, spiritual care practices continue to reflect both what the nurse can do (e.g. facilitate rituals) and be (e.g. present, compassionate).

Evidence from studies about how nurses provide spiritual care, however, does document additional specific practices. For example, nurses may pray with patients (O'Connell-Persaud et al., 2019), read holy Scripture to patients (Schoenbeck, 2016) and refer or collaborate with chaplain/clergy (Kim et al., 2017). An Iranian study of how many of these practices were implemented to successfully diminish pain during dressing changes on burn patients illustrates how nurses in that country provide spiritual care: nursing therapeutics included engaging Muslim clergy and patients' family members, establishing warm and respectful relationships, playing recordings of the Quran, encouraging prayer, helping patients to find meaning, and encouraging patients to "repent for his/her sins" (Keivan et al., 2019).

After critiquing eight existing tools for quantifying nurses' spiritual care attitudes and provision, Garssen et al. (2016) concluded that the *Nurse Spiritual Care Therapeutics Scale* (NSCTS) developed by Mamier and Taylor was the only "satisfactory" instrument measuring the frequency of nurse-provided spiritual care interventions. Using this scale, several studies in the United States have documented the frequency with which nurses provide 17 therapeutics considered to be spiritual care interventions. Taylor and colleagues (2017) combined the data from four studies (n = 1030) that collected data with the NSCTS. In the Taylor et al. study, the sample of palliative care nurses scored substantially higher than the other three samples that included acute care nurses. Psych/mental health nurses (n = 171)

in another study (Neathery et al., 2019) and 382 nurses enrolled in a post-licensure program at a public university in the "Bible Belt" (Green et al., 2019) also were observed to have higher scores on the NSCTS. Findings from these US studies indicated nurses reported on average providing each of the 17 therapeutics between 1–2 *times* and 3–6 *times* during the previous 72–80 h of providing patient care, with total sum scores above 40. In contrast, findings from a study of Taiwanese long-term care nurses documented frequency of spiritual care using the NSCTS as less frequent (sum total score of 30.5) (Chen et al., 2020). Although no standards exist to determine what is an appropriate frequency for spiritual care, these findings indicate frequency and practices may substantially vary.

2 | METHODS

This cross-sectional, descriptive study involved secondary analysis of data collected in multiple nations using one quantitative instrument. Although Institutional Review Board (ethics) approval was not required for this study, each primary study generating these data did gain IRB approval from the respective university where the research was conducted. In deference to the respective researchers who have or may publish their own findings, no demographic or work-related variables were acquired for this secondary analysis. The STROBE guidelines for cross-sectional observational studies guided this report (File S1).

2.1 | Samples and settings

The sample (n = 4062) was derived from 16 sites representing the cultures within 8 nations. Whereas most nurses recruited to participate in these respective studies worked in an adult medical/surgical and hospital setting, a few exceptions are noted (i.e. 2 studies involved primarily palliative care nurses, and 1 study involved nurses employed in long-term care facilities). While most participants were recruited directly by the respective investigators, several involved regional or national recruitment; some required online completion of the questionnaire. Table 1 provides further information about the diverse samples, settings and process for translation of the NSCTS.

2.2 | Instrument

The *Nurse Spiritual Care Therapeutics Scale* (Mamier & Taylor, 2015) measures the "frequency of nurse activities specifically intended to support patient spiritual integration … (that is,) the incorporation of spirituality into all aspects of life" (Taylor, 2014). Items were originally developed after a comprehensive review of pertinent nursing literature (Taylor, 2008); items were intended to reflect spiritual therapeutics that would be universally appropriate, rather than religious interventions that would be appropriate only for religious patients. Furthermore, the items avoided therapeutics that were arguably reflective of "good nursing care" or even psychosocial care. Likewise, items selected were conceptualised to be appropriate for any nurse to provide. To establish content validity, the original 29 items drafted were submitted to nine nurse scholars who had published on the topic (Taylor). This process led to the 17-item version with a scale CVI of .88. The 17 NSCTS items have the response options of *Never*, 1–2 *times*, 3–6 *times*, 7–11 *times*, and *at least* 12 *times*. Thus, when summed, scale scores can range from 17 (lowest) to 85 (highest).

Using a sample of 554 nurses employed at a fith-based university hospital in the United States of America (USA), subsequent psychometric evaluation indicated the instrument possessed strong attributes (Mamier & Taylor, 2015). Exploratory factor analysis suggested a one-dimensional solution accounting for 49.5% of the variance; individual factor loadings ranged between .41 and .84. Further support for the validity of the NSCTS was evidenced when significant but low correlations were observed between indicators of religiosity and NSCTS (Mamier & Taylor, 2015 Mamier et al., 2019; Taylor et al., 2017).

Psychometric evaluation of the NSCTS in Iran, Taiwan and Turkey have been published, and indicate strong support for its validity and reliability (respectively, Merati-Fashi et al., 2021; Chen et al., 2020; Aslan et al., 2020). In each of the non-English speaking samples included in this present study, the investigators used a forward-back translation process to convert the NSCTS into the target language. Sometimes the instrument author (Taylor) was consulted to refine or verify the back-translation.

The reliability coefficient for the NSCTS with the combined samples in this study was .95. The Cronbach's alpha ranged from .88–.97 among the sites, regardless of whether the alpha was calculated with all 17 items or with only the 15 items which one study used.

2.3 | Analysis

Using SPSS (Version 28; IBM Corporation, 2021), descriptive statistics (i.e. frequencies and percentages for categorical variables, measure of central tendency for continuous variables) were computed for each item and the scale total, for data from each site and each country. Given data from two studies omitted 1–2 items about making a referral to spiritual care or religious experts, these items were not included in the within or between country analyses when these sites were included. These items were omitted by the respective researchers who believed them to be culturally irrelevant.

To estimate the overall pooled average of Nurse Spiritual Care Therapeutics score, with 95% confidence interval, and determine appropriateness to conduct subgroup analyses for various characteristics (i.e. country, predominant religion of the country [or region within a country], year of data collection and clinical setting), a meta-analysis procedure with random-effect modelling was conducted using STATA, version 17.0 (StataCorp LP, College Station) (Merlo et al., 2005). These findings suggested further analyses to compare whether there was a significant difference in NSCTS total scores by

TABLE 1 Samples and settings

Investigator/s (year/s data collected)	Sample location (religion of local region)	Percent that site sample contributes to pooled sample	Sample characteristics and size	Recruitment strategies	Translation methods
Juniarta, Walangitan, Sitorus, & Yuyun (2019)	Indonesia (majority Christian and Catholic, some Muslim, Hindus, Buddhists)	5.1	208 hospital nurses with a minimum of a 3-year diploma	National online survey	Forward and back translation processes with modification after review by scale developer
Permatasari (2017)	South Borneo, Indonesia (mostly Muslim)	2.6	106 nurses from 6 diverse wards in one general, government hospital	Questionnaires distributed in person	Forward translated by sworn translator
Merati-Fashi et al. (2019–20)	Iran (mostly Muslim)	4.7	188 nurses from 4 districts in Iran working on adult wards; 60% female	In-person and online data collection	Forward and back translation processes each completed by 2 translators
Atarhim, Manap, Mastor, & Yusuf (2020)	Malaysia (mostly Muslim)	8.3	336 Muslim nurses from a university hospital in a state practicing Islamic governance	Stratified random sampling to select RNs from 8 units or subspecialities within the hospital	Forward and back translation processes each completed by a different translator; reviewed by experts; piloted
Pariñas (2019)	Philippines (mostly Christian)	21.8	886 RNs from a Christian healthcare system with 10 hospitals across the country	Questionnaires distributed in person	N/A
Angeles (2019)	Philippines (mostly Christian/ Catholic)	7.4	300 nurses in public and private urban hospitals	Questionnaires distributed in person with use of intermediary	N/A
Odonel (2018–2019)	Philippines (mostly Christian/ Catholic)	4.3	173 med/surg and ICU RNs from 1 government and 2 private hospitals in Negros Oriental	Quota sampling; in-person delivery and pick-up of questionnaires	N/A
Soriano et al. (2019)	Philippines (mostly Christian)	3.1	124 med/surg RNs in 3 Manila training hospitals	Questionnaires distributed in person	N/A
Caldeira (2017–2018)	Portugal (mostly Christian/ Catholic)	2.2	88 graduate students in nursing, 91% trained in palliative care	Recruited current or former MSN students from one university plus snowball sampling; data collected via online survey	Sousa & Rojjanasrirat's 7-step methodology including forward and backward translation; linguistic equivalency and cross-cultural adaptation obtained
Chen (2018)	Taiwan (majority Buddhism or Taoism)	5.0	202 RNs from 11 long-term nursing care facilities	Questionnaires distributed in person	Translation and back-translation by one linguist; panel of 5 reviewed to determine CVI; trialled in preliminary testing ($N = 30$)
Aslan, Aktürk, & Erci (2018)	Turkey (mostly Muslim)	6.1	249 Muslim nurses employed by one hospital; 63% with at least a BS degree	Face-to-face meetings to introduce the study	Translation and back-translation by three linguists; reviewed for cultural validity; trialled in preliminary testing ($N = 15$)

(Continues)

TABLE 1 (Continued)

Investigator/s (year/s data collected)	Sample location (religion of local region)	Percent that site sample contributes to pooled sample	Sample characteristics and size	Recruitment strategies	Translation methods
Ricci-Allegra (2014)	USA (mostly Christian)	2.6	104 hospice and Palliative Care Nurses Association members	National online survey	N/A
Foith et al. (2015–2016)	USA (mostly Christian)	2.3	93 mostly ICU RNs working in Ohio	Online survey	N/A
Mamier et al. (2008)	USA (mostly Christian)	13.6	554 faith-based university hospital RNs	Email with link to online survey sent to all RNs; flyers and in-person interactions to remind	N/A
Neathery et al. (2017)	USA (mostly Christian)	4.2	171 psych-mental health nurses	Approaches included soliciting professional organisation members online or while attending annual conference	N/A
Taylor et al. (2015)	USA (mostly Christian)	6.9	279 RNs providing direct patient care	Online survey found on home page of *Journal of Christian Nursing*	N/A

type of nursing care provided (i.e. palliative care, skilled nursing facility [SNF] and general hospital), and by whether the country was predominantly Christian or Muslim; thus, one-way analyses of variance (ANOVA) with Tukey post hoc analysis was completed. The significance level for alpha being set at <.05. Lastly, because findings from the random effects models demonstrated wide variation in NSCTS scores between sites, item-by-item analysis was conducted to obtain a more nuanced understanding of nurses' spiritual care practice. To facilitate this, the five response options were re-categorised as 0 *or* 1–2 *times*, *about* 3–6 *times* and >6 *times*.

3 | RESULTS

The report of findings is presented by the questions posed for this secondary analysis.

3.1 | Do differences in frequency of nurse-provided spiritual care exist within countries?

Without exception in the three countries where multiple studies obtained data using the NSCTS, differences appeared to exist in the frequency of spiritual care (Figures 1 and 2). In Indonesia, respondents to a national survey provided spiritual care substantially more often than did those in the sample from one public hospital. In the Philippines, 1 of the 3 hospital nurse samples reported substantially more frequent spiritual care. Surprisingly, the sample collected across a Christian faith-based healthcare system reported the lowest frequency of spiritual care. In the US samples, while the palliative care (and mostly advanced practice) nurses provided considerably more spiritual care than the others, the mental health nurses also provided more frequent spiritual care than the remaining samples comprised of predominantly hospital-based nurses.

3.2 | Do they differ across countries?

Overall, significant differences were observed between the countries ($Q_b[7] = 795.3$, $p < .001$). Some samples between some countries, however, appeared to not differ from each other: Iran and Taiwan nurses, US and Turkish nurses, Filipino and Indonesian nurses, and Portuguese and Malaysian nurses. Figure 2 provides a visual picture of how the means for each country sample compared, and Table 2 provides numeric evidence.

3.3 | What spiritual care therapeutics are most common? What therapeutics are least common?

When examining the combined data, only four items had a median of 3 (aligning with the response option of 3–6 *times* during the previous 72–80 h of patient care); the remaining therapeutics were

provided less often. The more frequent therapeutics included: presence ($M = 2.9$), assessing spiritual or religious beliefs and practices ($M = 2.7$), and listening for either spiritual themes in patient stories ($M = 2.9$) or spiritual concerns ($M = 2.8$).

Several therapeutics nearly tied for occurring most infrequently. The least common therapeutics provided included: offering to read a spiritually nurturing passage ($M = 2.0$); arranging for patient's clergy ($M = 2.0$) or a chaplain visit ($M = 2.2$); and documenting spiritual care ($M = 2.1$). Other rather infrequent therapeutics with means around 2.3 included: asking how to support their spiritual or religious practices, telling patients about spiritual resources, encouraging patients to talk about spiritual challenges, and discussing spiritual care for a patient with colleagues.

When examining the percentages of therapeutics provided *never*, 42% never recently documented spiritual care; likewise, many never made arrangement for the patient's clergy to visit or offered to read spiritually inspiring material. Even the most frequent therapeutic of "remaining present" was never done by 13% of these nurses; likewise, only 13% did it 12 *or more times*. Of note because of the frequency with which it is identified in the spiritual care literature, is the finding that offering to pray for a patient was reported by 7.3% to have occurred at least a dozen times. See Table 3 for further information.

3.4 | Additional observations

Although multivariate analyses proved elusive, close examination of the descriptive findings offers additional insight. When comparing the frequencies for each item between samples from predominantly Muslim and predominantly Christian cultures, with only one exception, the differential was always <12%; although a small difference, the trend was consistently in the direction indicating that nurses in Muslim cultures provide spiritual care more frequently. The one exception was for Item 17 (*remained present*): 50% of those in Muslim contexts never/rarely did it and 27% frequently did it, whereas 35% of those in Christian contexts never/rarely did it and 36% frequently did it. Mysteriously, 79% of the Portuguese palliative care nurses reported they never/rarely *remained present to show caring*. ANOVA confirmed these findings in that when comparing Muslim

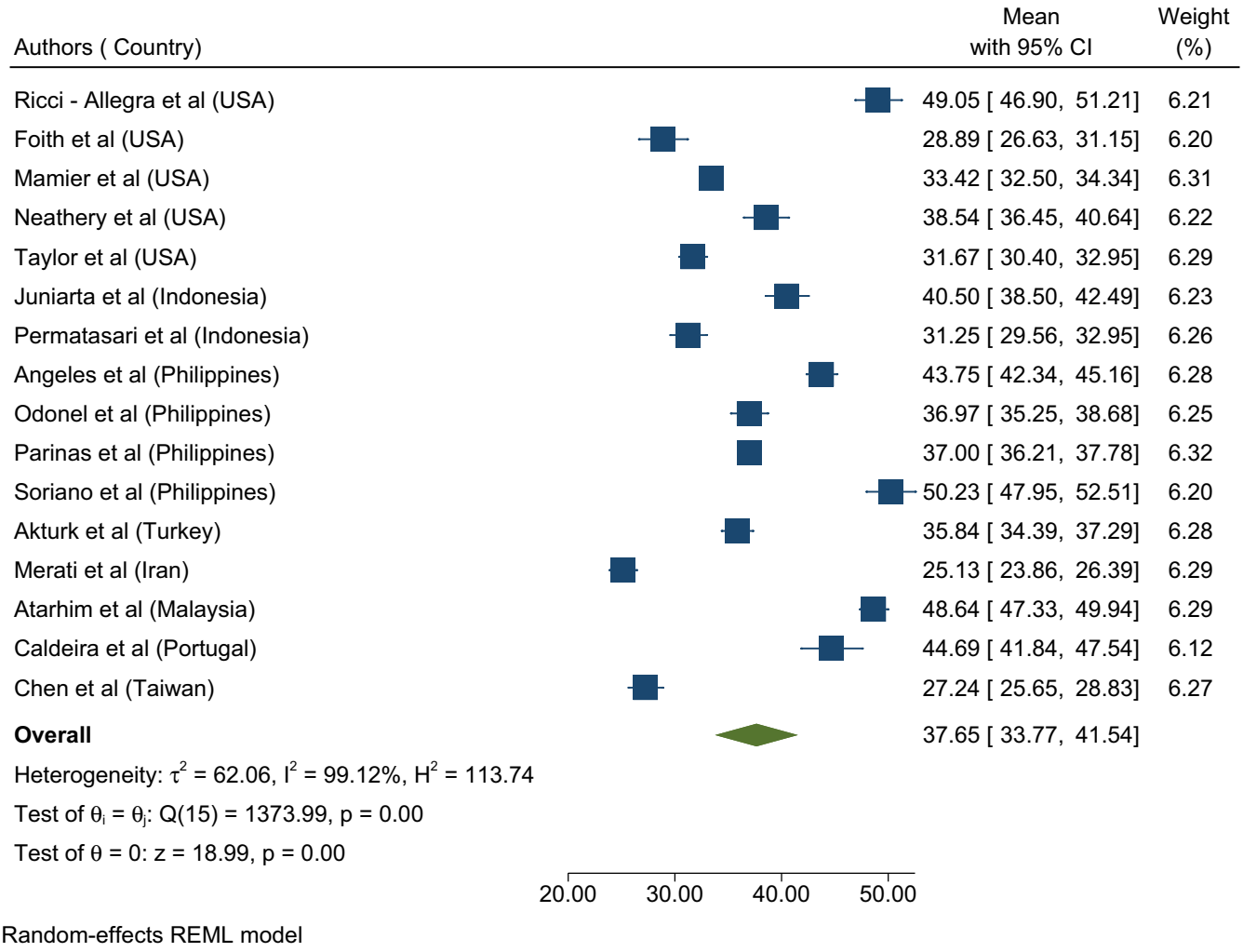

FIGURE 1 REML model including all sites [Colour figure can be viewed at wileyonlinelibrary.com]

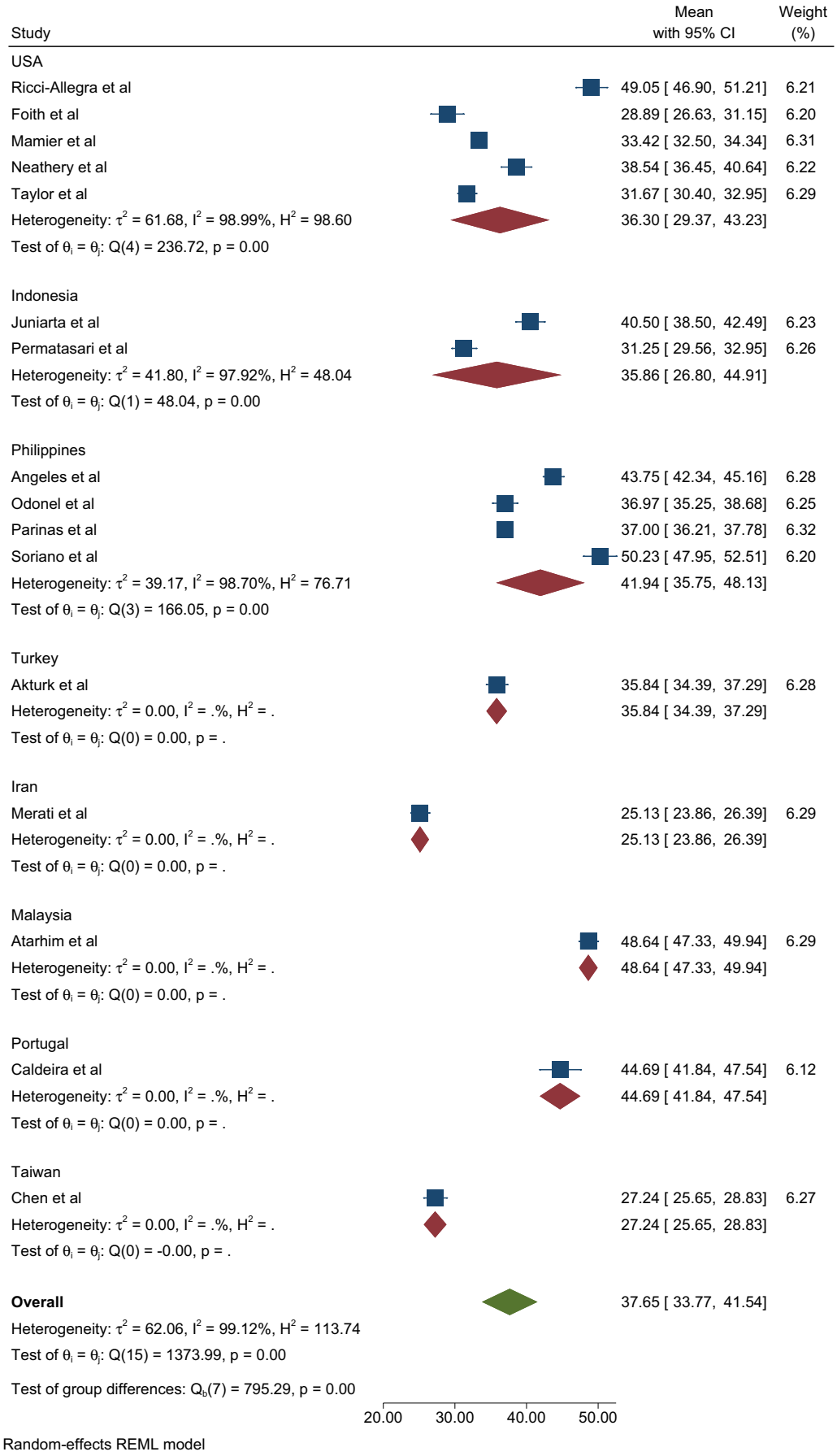

FIGURE 2 REML model sorted by country [Colour figure can be viewed at wileyonlinelibrary.com]

TABLE 2 NSCTS scale sums and means by site and country[a]

Researchers	NSCTS scale sum totals (*SD*)	Mean of NSCTS item means (*SD*)
Indonesia ($n = 311$)[b]		
Juniarta, Walangitan, Sitorus, & Yuyun	45.33 (16.26)	2.67 (.96)
Permatasari[b]	31.25 (8.78)	2.08 (.97)
Iran ($n = 189$)		
Merati-Fashi et al. (2021)	27.32 (9.17)	1.61 (.54)
Malaysia ($n = 326$)		
Atarhim et al. (2019)	54.08 (13.82)	3.18 (.81)
Philippines ($n = 1180$)[c]		
Angeles[c]	43.75 (12.55)	2.92 (.83)
Odonel	42.17 (12.92)	2.48 (.76)
Pariñas	41.48 (13.36)	2.44 (.79)
Soriano et al. (2019)	56.93 (14.05)	3.35 (.83)
Portugal ($n = 87$)		
Caldeira	50.61 (14.55)	3.00 (.86)
Taiwan		
Chen et al. (2020)	30.51 (12.80)	1.80 (.75)
Turkey ($n = 249$)		
Aslan et al. (2020)	38.43 (11.89)	2.26 (.70)
United States of America		
Ricci-Allegra (2018)	55.36 (11.87)	3.26 (.70)
Foith	32.58 (12.06)	1.92 (.71)
Mamier et al. (2019)	36.98 (12.01)	2.18 (.71)
Neathery et al. (2019)	42.98 (15.28)	2.53 (.90)
Taylor et al. (2017)	34.82 (11.69)	2.05 (.69)
All Countries ($N = 4062$)		
Total	41.07 (14.99)	2.42 (.88)

[a]Sums and means were only computed for cases with responses to all 17 items.

[b]The Indonesian Permatasari study did not include NSCTS items 10–11. Thus, study means are based on a 15-item NSCTS.

[c]The Filipino Angeles study excluded Item 10. Thus, study means are based on a 16-item NSCTS.

and Christian samples with data from all 17-items, there was no significant difference ($p = .09$); however, when including all the sites and comparing NSCTS scores without the two items about making a referral, then Muslim nurses reported significantly more frequent spiritual care than did Christian nurses ($p = .02$).

Likewise, ANOVA revealed that significant differences occurred in frequency of spiritual care by setting ($p = <.001$). That is, palliative care nurses ($M = 46.9$) provided spiritual care more frequently than nurses primarily working in hospital/inpatient settings ($M = 37.3$), who provided spiritual care more frequently than the nurses in a skilled nursing facility ($M = 27.2$).

Examination of the descriptive data provided further illumination. Except for the samples of American mental health nurses and one Filipino sample in a predominantly Christian culture, within each study there was consistency with responses to items indicating either nearly all fairly high or all low frequency of spiritual care. Countries with the highest frequencies across all items were Portugal and Malaysia: Except for Item 17, the samples in these countries consistently reported >25% indicating they implemented all the interventions *>6 times*. In contrast, at least 74% of the nurses in Iran and Taiwan reported *never/rarely* for each of the therapeutics.

4 | DISCUSSION

This study is the first to our knowledge to offer international benchmarking data on how frequently nurses provide spiritual care. The use of the *Nurse Spiritual Therapeutics Scale* after careful cross-cultural validation processes allowed for this international comparison and benchmarking. While many nurse investigators have empirically researched spiritual care in many countries, these findings are rarely compared. Indeed, measurement of the frequency of spiritual care practices is much less studied than are other constructs related to spiritual care in nursing. Comparison of spiritual care frequency is difficult given most existing instruments quantify nurse attitudes about providing it, perceptions of barriers to providing it,

TABLE 3 Responses to NSCTS items for combined sample ($n = 4062$)

NSCTS item *During the past 72 (or 80) h of providing patient care, how often have you:*	Item mean (SD)	Frequency (%) reporting *"0 times"*	Frequency (%) reporting *"At least 12 times"*
1. Asked a patient about how you could support his or her spiritual or religious practices	2.34 (1.09)	959 (23.6)	171 (4.2)
2. Helped a patient to have quiet time or space for spiritual reflection or practices	2.56 (1.14)	797 (19.6)	244 (6.0)
3. Listened actively for spiritual themes in a patient's story of illness	2.91 (1.19)	502 (12.4)	460 (11.3)
4. Assessed a patient's spiritual or religious beliefs or practices that are pertinent to health	2.71 (1.17)	670 (16.5)	337 (8.3)
5. Listened to a patient talk about spiritual concerns	2.80 (1.14)	526 (13.0)	352 (8.7)
6. Encouraged a patient to talk about how illness affects relating to God—or whatever is his or her Ultimate Other or transcendent reality	2.52 (1.18)	929 (22.9)	271 (6.7)
7. Encouraged a patient to talk about his or her spiritual coping	2.50 (1.18)	984 (24.2)	252 (6.2)
8. Documented spiritual care you provided in a patient chart	2.10 (1.16)	1692 (41.7)	181 (4.5)
9. Discussed a patient's spiritual care needs with colleague/s (e.g. shift report, rounds)	2.34 (1.15)	1135 (28.0)	188 (4.6)
10. Arranged for a chaplain to visit a patient[a]	2.23 (1.20)	1324 (36.3)	179 (4.9)
11. Arranged for a patient's clergy or spiritual mentor to visit[a]	2.04 (1.14)	1717 (43.5)	131 (3.3)
12. Encouraged a patient to talk about what gives his or her life meaning amidst illness	2.46 (1.16)	972 (24.0)	228 (5.6)
13. Encouraged a patient to talk about the spiritual challenges of living with illness	2.36 (1.15)	1130 (27.8)	190 (4.7)
14. Offered to pray with a patient	2.41 (1.23)	1191 (29.3)	297 (7.3)
15. Offered to read a spiritually nurturing passage (e.g. patient's holy scripture)	2.01 (1.11)	1782 (43.9)	120 (3.0)
16. Told a patient about spiritual resources	2.35 (1.14)	1112 (27.4)	186 (4.6)
17. After completing a task, remained present just to show caring	2.94 (1.24)	542 (13.4)	542 (13.4)

[a]Note that 412 cases were missing for Item 10 and 117 cases were missing for Item 11, as two sites determined these items were not applicable.

perceived comfort and competency with providing it, and perceptions of personal spirituality/religiosity (Garssen et al., 2017; Harrad et al., 2019).

Findings from this study indicate that while the frequency of spiritual care is not measurably different between some countries, it is different between some. More surprising perhaps is that frequency varies within countries. Within 14 of the 16 samples, however, the nurses rated the frequency with which they delivered these 17 therapeutics rather consistently (i.e. all items receiving comparatively similar responses).

One factor found associated with frequency was care setting. Palliative care is, by nature, overtly supportive of spiritual care provision (Balboni et al., 2017). Thus, it is unsurprising that the two studies of palliative care nurses obtained similar results. It is unknown, however, if the infrequency of spiritual care observed in the Taiwanese study of nurses in SNFs is related to the religiosity within that country or because of the understaffing commonly found at SNFs. The diversity in frequency among hospital-based nurses is noted. Although there are not enough settings to draw conclusions, there do not appear to be any trends between faith-based hospital nurse reports (i.e. Pariñas' and Mamier et al.'s studies) and those working in non-religious hospital settings, even though supportiveness of employer has been found to substantially explain frequency of spiritual care (Taylor et al., 2017).

Another factor found to be associated with spiritual care frequency was the predominant religion of the country (or region), with Muslim nurses providing spiritual care more slightly more frequently than Christian nurses. Islam was the predominant religion of four of these countries (i.e. Indonesia, Iran, Malaysia and Turkey), yet the frequency of spiritual care varied between these countries. Similarly, frequency of spiritual care varied between the predominantly Christian countries of Portugal, the Philippines and the USA. Although religious culture of a country may explain variation in nurse-provided spiritual care, it likely is better explained via more nuanced phenomenon such as how religiously adherent respondents are or cultural mores about integrating spirituality and healthcare (Chiang et al., 2020; Cooper et al., 2020; Taylor et al., 2017).

Study limitations must frame the interpretation of these findings. It is a secondary analysis and there is no measured evidence

regarding the context of the contributing datasets. Future research should be designed to adjust for the multiple factors that may contribute to nurses providing spiritual care. As with most nursing research, all but the Foith sample was one of convenience. Although the NSCTS has received substantial support for internal reliability and structural validity in diverse cultures, less is known about other psychometric properties. Furthermore, the psychometric performance of the NSCTS is unknown for some of the datasets contributed.

5 | CONCLUSION

While there were significant differences in frequency of provision, there are spiritual care therapeutics recognised and implemented by nurses in parts of Asia, Europe, the Middle East and North America. Ultimately, these findings provide evidence that nurses around the world do, to some degree, provide care that is sensitive to the spiritual and religious experiences of living with health challenges. The goal of making nursing practice holistic is pursued.

6 | RELEVANCE TO CLINICAL PRACTICE

We proposed that these data would offer a benchmark of how frequently nurses provide spiritual care. Indeed, they do provide a valid measure of the frequency of various spiritual care therapeutics from over 4000 nurses in diverse settings and cultures against which comparisons can be made. Yet, findings could be interpreted as an infrequency of spiritual care, with total sample means for each of the 17 therapeutics being less than 3 (3–6 *times* during the previous 72–80 h of patient care). This "infrequency" may reflect nurses' ethical decisions to not provide inappropriate spiritual care, or a lack of ability, resources or comfort with doing so (Burkhart & Hogan, 2008; Pfeiffer et al., 2014). While these benchmark data reflect current practice in nursing, they may or may not portray what an ideal holistic nursing practice might provide.

These study findings inform nurse leaders about what may be normative in practice and may encourage nurses providing direct patient care that they are not alone in this endeavour. Findings can also inform educators about what instruction to present and what future nurses require. For example, if these findings are generalisable, many nurses never or infrequently screen or assess patient health-related spiritual or religious beliefs and practices (see findings regarding NSCTS Items 1 and 4 in Table 3). Thus, nurse educators have much to teach nurses about screening for spiritual distress, never mind how to deeply listen for spiritual themes, document spiritual care, facilitate meaningful rituals and so forth (Attard et al., 2019; Green et al., 2019). These findings also generate more research questions than they answer: What factors are associated with provision of spiritual care? What accounts for the variations observed in this pooled dataset? Indeed, evidence to guide the provision of nurse-provided spiritual care is minimal. Even patients and their family carers want their healthcare providers to competently provide spiritual care (e.g. Selman et al., 2018); thus, much scholarship is needed to support the effective and ethical implementation of spiritual care within nursing practice.

NO PATIENT OR PUBLIC CONTRIBUTION

This study involved secondary data collected from nurses, as this was what allowed the research aim to be met. No public or patient advisory council provided input during the research process.

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CONFLICT OF INTEREST

None to declare.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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