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Attitudes towards spirituality and spiritual care among nursing employees in hospitals

Stališča do duhovnosti in duhovne oskrbe med zaposlenimi v zdravstveni negi v bolnišnicah

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ABSTRACT

Introduction: Understanding spirituality and spiritual care is a prerequisite for holistic care. The research goal was to describe nurses' attitudes towards spirituality and spiritual care.

Methods: The study was carried out between 2015 and 2016 using a quantitative non-experimental method. The *Spirituality and Spiritual Care Rating Scale Questionnaire* was given to a sample of 182 nursing care employees, mostly women (n = 153, 88.4 %), with completed higher (n = 93, 53.8 %) or secondary (n = 75, 43.4 %) education, from four Slovenian hospitals. The questionnaire had adequate internal consistency (Cronbach alpha = 0.83).

Results: The highest agreement ($\bar{x}$ = 4.27, s = 0.82) was reached on the statement which describes spiritual care as respecting patient's privacy, dignity, cultural and religious beliefs. Participants also agreed with the statement that they provide spiritual care by demonstrating kindness, care, and cheerfulness ($\bar{x}$ = 4.2, s = 0.76), but they expressed uncertainty about the statement that spirituality and spiritual care are fundamental aspects of nursing care ($\bar{x}$ = 2.88, s = 1.08).

Discussion and conclusion: Participants connect spirituality with an understanding of themselves and the world, rather than only with religion and sacral objects. The research has confirmed the findings of previous Slovenian studies that nurses give priority to meeting patients' physical needs before spiritual ones probably also as a result of a lack of knowledge and professional guidance on spiritual care.

IZVLEČEK

Uvod: Razumevanje duhovnosti in duhovne oskrbe je pogoj nudenja celostne oskrbe pacienta. Cilj raziskave je bil opisati stališča zaposlenih v zdravstveni negi do duhovnosti in duhovne oskrbe.

Metode: Raziskava je bila izvedena v letih 2015 in 2016, z uporabo kvantitativne neeksperimentalne metode. Na vzorcu 182 zaposlenih v zdravstveni negi iz štirih slovenskih bolnišnic, v katerem so prevladovale ženske (n = 153, 88,4 %) s končano visokošolsko (n = 93, 53,8 %) ali srednješolsko izobrazbo (n = 75, 43,4 %), je bil uporabljen vprašalnik *Spirituality and Spiritual Care Rating Scale*. Vprašalnik je imel ustrezno notranjo konsistentnost (Cronbach alfa = 0,83).

Rezultati: Najvišje strinjanje ($\bar{x}$ = 4,27, s = 0,82) so anketiranci podali za trditev, ki opisuje duhovno oskrbo z vidika spoštovanja zasebnosti, dostojanstva ter spoštovanja kulturnih in verskih prepričanj pacienta. Prav tako se strinjajo, da zagotavljajo duhovno oskrbo pacientov z izkazovanjem prijaznosti, skrbi in vedrine ($\bar{x}$ = 4,2, s = 0,76). Anketiranci so bili negotovi glede trditve, da sta duhovnost in duhovna oskrba temeljna vidika zdravstvene nege ($\bar{x}$ = 2,88, s = 1,08).

Diskusija in zaključek: Anketiranci duhovnost povezujejo predvsem z razumevanjem samega sebe in sveta, najmanj pa z religijo ter s sakralnimi objekti. Raziskava potrjuje ugotovitve predhodnih slovenskih raziskav, da dajejo zaposleni v zdravstveni negi pred duhovnimi potrebami prednost oskrbi fizičnih potreb, verjetno tudi zaradi pomanjkanja znanja o tem področju in ustreznih smernic.

The article is based on the master thesis of Tanja Montarič Starc *Nurse's knowledge, beliefs and attitudes towards sprituality and spiritual care* (2017). / Članek je nastal na osnovi magistrskega dela Tanje Montanič Starc *Znanje, prepričanja in stališča zaposlenih v zdravstveni negi do duhovnosti in duhovne oskrbe pacientov* (2017).

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Introduction

Nowadays, spirituality and spiritual care are important elements of holistic, bio- and psychosocial treatment of individuals (Caldeira, et al., 2014) since the time in one's life characterised by injuries, illnesses and especially dying is a time of uncertainty and distress that is beyond a person's bodily functions (Babnik & Karnjuš, 2014) and triggers questions of sense, hope, meaning, forgiveness and higher forces. Spirituality is a concept that brings together religion, religious rituals, transcendency, reciprocity, connection, peace, energy, meaning, purpose, beliefs, values, hope, motivation and love (Hsiao, et al., 2011). In nursing literature, there is no single definition of spirituality (Pike, 2011). In an attempt to define it, some authors have described it as an intra-mental dimension that includes existential principles and beliefs and guides an individual in their search of meaning and purpose in life as well as in creating positive relationships with others (Molzahn & Sheilds, 2008; Ellis & Narayanasamy, 2009). Slovenian author Skoberne (2002) writes about spirituality in a similar way. She published an article on spirituality and spiritual care in nursing care in Slovenia at a time when the field of spirituality in nursing care was only beginning to develop more intensely.

Also from a psychological point of view, spirituality is understood especially as a dynamic, motivational concept or an internal source (van Dierendonck & Mohan, 2006) that drives individuals in their search for meaning and strength. Paley (2008, 2010) states that the reason why there are often issues with the definitions related to spirituality in nursing is because the concept is relatively new and changes according to an individual's beliefs, especially their cultural and religious background and in accordance with the society that surrounds them. Gall and colleagues (2011) warn that definitions of spirituality are often unclear and complicated and generally reflect how researchers understand the concept and less frequently how individuals, that is respondents in studies, experience spirituality. One of the more frequent research subjects related to spirituality is the relationship between religion and spirituality or an explanation whether religion and spirituality are synonymous and whether patients who are not religious also have spiritual needs (Pike, 2011, p. 746). An answer to this question has been provided in the nursing literature by McSherry in Cash (2004) with their taxonomy of spirituality in health care. The taxonomy is a continuum of the meaning of spiritually and consists of spirituality defined exclusively on religious and theistic ideals at one end of the continuum, and spirituality based on secular, humanistic and existential elements, on the other end of the continuum. The explanation of spirituality in nursing is based primarily on the understanding of spirituality as a component of an individual's being, which includes the dimensions of immanence and transcendence, and that it can (or not) include religious beliefs and religious practice (Babnik & Karnjuš, 2014, p. 13).

In addition to spirituality, the concept of "spiritual needs" is also used extensively in nursing, although an appropriate definition of spiritual needs is difficult to find in the literature. Buck and McMillan (2012), and Nizon and colleagues (2013) provide a relevant definition by defining spiritual needs as something that a person wants or needs to find the purpose and meaning. Galek and colleagues (2005) list seven domains of spiritual needs: belonging, meaning, hope, morality, beauty and acceptance of death. Sharma and colleagues (2012) emphasise three categories of spiritual needs: psycho-social, spiritual and religious. Psychosocial spiritual needs are described as the needs for support and help from others; spiritual as related to transcendental questions (meaning, hope, forgiveness, peace), while religious spiritual needs comprise the needs for actively practising religion by reading religious texts, participating in religious rituals and talking to a priest or other religious leader (Sharma, et al., 2012).

Spiritual care of patients should lead to a patient's spiritual well-being in the worst moments of their life when because of an illness or injury, life may lose its purpose and meaning (Cook, et al., 2012). The literature does not give a unified answer to what spiritual care is. In professional literature, the distinction between spiritual care as a broader concept and religious care as its subcategory has been established, mainly because of the demands of the society for the equal treatment of patients, regardless of their religiosity (Gedrih & Pahor, 2009). The purpose of spiritual care is to help patients to achieve balance and a holistic understanding of their health condition, to help them in overcoming feelings of hopelessness and uselessness, and to give them support in finding meanings and purpose (Štrancar, 2009). One of the roles of implementing holistic nursing care is the identification of patient's spiritual needs, and planning and carrying out nursing care interventions, for example: help of a priest, ensuring privacy and a peaceful environment, providing the possibility of conversation, listening to a radio programme, music, and considering requests of spiritual and religious nature (special diet, performing religious rituals) (Skoberne, 2002; Karnjuš, et al., 2014). Health care employees are not synonymous in who is responsible for the spiritual care of patients (Babnik & Karnjuš, 2014), but it is probably nursing care employees who are the most suitable professionals to offer spiritual care due to the nature of their work, which requires an on-going contact with patients (Nixon, et al., 2013). Nursing care employees represent the link between the patient and other health care workers and encourage spiritual care in which all the persons who are important to the patient are included (Zakšek, 2010).

Nowadays, nursing care does not deal with the concept of spirituality and spiritual care only during palliative care and alleviation of suffering, but on all the areas of patient care. An example of such approach to spirituality is evident in Great Britain, which after 2010 (McSherry & Jamieson, 2011, 2013) began conducting intense research on the integration of spirituality and spiritual care in nursing care in general, regardless of the field of work and patients that nursing care employees care for. Based on research conducted on a small sample of nursing care employees in Slovenia, Babnik in Karnjuš (2014) have found that the respondents understand spiritual needs of patients and spiritual care as a part of their job since this role is also included in the *The code of Ethics* (Nurses and Midwives Association of Slovenia, 2014). The importance of spiritual care and consideration of the general spiritual dimension of an individual's actions have also been confirmed by the North American Nursing Diagnosis Association International [NANDA-I], which lists various aspects of an individual's well-being amongst the domain of "Life Principles". In this way, nursing diagnoses "Readiness for enhanced spiritual well-being" (p. 361), "Spiritual distress" (p. 372) and "Risk for spiritual distress" (p. 374) refer directly to recognising the spiritual dimension of one's actions on a person's well-being and their quality of life (Herdman & Kamitsuru, 2014). The concepts of spirituality and spiritual care are regularly found in contemporary textbooks on nursing as with theoreticians Betty Neuman, Margaret Newman, Rosemary Parse in Jean Watson (MacKinlay, 2002; Tanyi, 2002).

Aims and objectives

Spirituality and spiritual care in the field of nursing and health care are not well-researched in Slovenia nor abroad. The purpose of the research was to study the understanding of the concept of spirituality and spiritual care among the employees in nursing in Slovenia. Attitudes are also reflections of understanding a particular subject or a phenomenon, which is why the aim of our research was to study the beliefs and opinions of nursing employees regarding spirituality and spiritual care. Our focus were nursing employees in hospitals where the attention is mainly on treatment and rehabilitation. Such an environment features not only dying patients and terminally ill patients, but also people who have been hospitalised for a shorter or longer period of time. The following research questions were set:

– How do nursing employees understand the concept of spirituality and spiritual care?
– What are the attitudes of the nursing employees in hospitals regarding the need for training in the field of spirituality and spiritual care?
– Which organisations/institutions should offer appropriate support to nursing employees in offering spiritual care according to nursing employees?

Methods

A quantitative descriptive research method with a structured questionnaire was used.

Description of the research instrument

The Spirituality and Spiritual Care Rating Scale (SSCRS) (McSherry, et al., 2002) was used as the instrument for collecting data. The questionnaire is composed of three parts: i) the first one establishes how the respondents understand the concepts "spirituality" and "spiritual care" and what their attitudes towards these concepts are (17 statements); ii) the second part identifies the necessary measures in offering spiritual care to patients, especially in terms of the role of educational institutions and regulatory bodies in ensuring spiritual care to patients and the types of measures that would need to be implemented when offering spiritual care to patients (6 statements); iii) the purpose of the third part is to gather demographic data. The first and second parts of the questionnaire contain statements to which respondents responded (expressed their level of agreement) with a Likert type five-point scale (1 – strongly agree; 2 – agree; 3 – neutral; 4 – disagree; 5 – strongly disagree). The second part of the statements form part of the original scale as sent to us by the author (McSherry, et al., 2002). For the purposes of adjusting the questionnaire to the Slovene population, bodies that are used in regulating health care and nursing care in the Republic of Slovenia have been included in the formulation of the statements.

Seventeen statements from the first part of the SSCRS questionnaire measure four dimensions of attitudes towards spirituality and spiritual care (McSherry et al., 2002): i) spirituality, ii) spiritual care, iii) religiousness and iv) individualised personal care. In previous studies the first part of SSCRS showed appropriate and consistent level of reliability with values of Cronbach alpha for SSCRS dimensions between 0.64 (McSherry, 1998) and 0.84 (Khoshknab, et al., 2010). Internal scale consistency was calculated (Cronbach alpha) for the first part of the SSCRS questionnaire that is adequate and amounts to 0.83. Internal consistency of the scale (Cronbach alpha) that amounts to 0.38 was also calculated for the second part. The low internal consistency of the second part of the questionnaire was expected, since the second part is not based on statements intended to consistently describe the superior construct (this consistency would be reflected in high internal consistency or Cronbach alpha coefficient), but the statements are mainly specific beliefs regarding the possible approaches and conditions for the implementation of spiritual care.

Description of the research sample

A convenience sample was used, composed of nursing care employees in four Slovene hospitals. From the

total of 250 returned questionnaires, 173 were valid (70.7 % sample realisation). 153 women (88.4 %) and 20 men (11.6 %) participated in the study. Most respondents had a college or higher-education degree (n = 93, 53.8 %), followed by completed secondary education (n = 75, 43.4 %), five respondents (2.8 %) had a university degree or a master's degree or higher. 114 (65.9 %) of respondents classified themselves as religious and 59 (34.1 %) as non-religious. From the respondents that classified themselves as religious, 64 (56.1 %) practises their religion, while the other 50 (43.9 %) did not. As depicted in Table 1, the majority of the respondents were aged between 30 and 39 (n = 56, 32.4 %). The majority of the respondents have 11 or more years work experience (n = 103, 63.1 %). With regard to the field of work, employees at the department of surgery were the most responsive to the questionnaire (n = 125, 72.3 %).

Table 1: *Demographic data of the study participants*
Tabela 1: *Demografski podatki anketirancev*

Demographic data / Demografski podatki	***n***	***%***
Age group		
21 to 29 years	43	24.9
30 to 39 years	56	32.4
40 to 49 years	46	26.6
50 to 59 years	25	14.5
60 years or more	3	1.7
Total	173	100
Years of service		
Less than 1 year	8	4.6
1 to 5 years	31	17.9
6 to 10 years	25	14.5
11 to 25 years	66	38.2
25 years or more	43	24.9
Total	173	100
Field of work		
Surgery	125	72.3
Internal medicine	32	18.5
Paediatrics	7	4.0
Gynaecology	5	2.9
Anaesthesia	4	2.3
Total	173	100

Legend / Legenda: n – number / število; % – percentage / odstotek

Description of the research procedure and data analysis

Before conducting the research, we obtained an official consent from the author of the research works (McSherry, et al., 2002) on spirituality in nursing in Great Britain to use the above-mentioned instrument. We translated the questionnaire into Slovene, so that with statements that could be unclear the research authors translated the original statements into the Slovene language and then back-translated them to English. A review of both translations was performed by a translator. The statements in the second part ("I believe that Ministry of Health should provide clear guidance and support for nurses to deal with spiritual and religious issues", "I believe that Nurses and Midwives Association of Slovenia should provide clear guidance and support for nurses to deal with spiritual and religious issues.") we made adjustments according to the regulatory institutions for health care and nursing care in Slovenia. The survey was performed after obtaining consent from each institution – the hospital. Questionnaires were distributed in cooperation with the hospitals that approved the research. Every research participant had the possibility to withdraw from participation in the research if they wished and the respondents were assured anonymity in conducting the research and research reports.

The anonymity of the participants was assured by gathering a certain number of demographic variables, so only those that are necessary for a suitable description of the sample and were in previous studies (Kaddourah, et al., 2018; Kavosi, et al., 2018) identified as possible influencing factors on attitudes towards spirituality and spiritual care. We calculated descriptive statistics (frequency, mean value, standard deviation) and used statistical tests (ANOVA, t-test). Before conducting the tests, we calculated the mean value for the first part of SSCRS (attitudes towards spirituality and spiritual care) for each participant, thus designing a variable of composite value of attitudes towards spirituality and spiritual care. Levene's test was used to confirm the hypothesis on the homogeneity of variances and normality of the distribution of mean values in the first part of SSCRS (Kolmogorov-Smirnov Test), so we continued by conducting statistical inference tests (t-test, ANOVA). Statistical analyses were conducted by using the SPSS, ver. 23 statistical programme (SPSS Inc., Chicago, Illinois, ZDA). Values $p < 0.05$ were considered statistically significant.

The first step in data analyses was checking the reliability and construct validity (factor analysis) of the part of the instrument that refers to the attitudes of nursing care employees towards spirituality and spiritual care (the first part of SSCRS). Reliability and construct validity of the Slovene version of the SSCRS scale was checked with an analysis of the dimensional structure and with an analysis of the reliability of the entire scale and its dimensions (reliability as internal consistency – Cronbach alpha). Factor analysis was conducted on seventeen statements of the SSCRS scale. The accuracy of the correlation matrix of SSCRS statements for factor analysis was checked with a Bartlett's test of sphericity and with the Kaiser-Meyer-Olkin Measure of Sampling Adequacy (KMO) (Field, 2009) measure. Bartlett's test

of sphericity ($\chi^2 = 924.557$, $p < 0.01$) and measure KMO = 0.821 confirmed the accuracy of the correlation matrix for studying the dimensional structure. Factor analysis (main component method, varimax rotation) excluded 3 factors with eigenvalue value more than 1 that together explain the 51.7 % variance in the respondents' answers. In accordance with the McSherry and colleagues (2002) instrument validation procedure, the cut-off value of factor weights for determining the factor structure was determined with the value ≥ +/- 0.35. Factor matrix is depicted in Table 2. Dimensional structure of the SSCRS scale deviates from the four dimensions of attitudes towards spirituality and spiritual care identified by McSherry and colleagues (2002), especially from the

Table 2: *Factor matrix with descriptive statistics for the first part of SSCRS*
Tabela 2: *Faktorska matrika in deskriptivne statistike trditev prvega sklopa SSCRS*

Statements in the first part of SSCRS / Trditve prvega sklopa SSCRS	*n*	$\bar{x}$	*s*	*Factors / Faktorji*		
				Definition of spirituality / Opredelitev duhovnosti	*Spiritual care / Duhovna oskrba*	*Religion and spirituality / Religija in duhovnost*
I believe spirituality is a unifying force which enables one to be at peace with oneself and the world	172	4.08	0.74	0.85	0.04	0.13
I believe spirituality is about having a sense of hope in life	169	3.87	0.88	0.79	0.25	−0.09
I believe spirituality is to do with the way one conducts one's life here and now	171	3.68	0.97	0.78	0.17	−0.05
I believe spirituality involves personal friendships and relationships	171	3.43	1.03	0.61	−0.02	0.21
I believe nurses can provide spiritual care by having respect for the privacy, dignity and religious and cultural beliefs of a patient	171	4.27	0.82	0.57	0.21	0.23
I believe spirituality includes peoples' morals	171	3.79	1.04	0.49	0.28	0.17
I believe spirituality is about finding meaning in the good and bad events of life	173	3.75	0.97	0.46	0.36	0.15
I believe nurses can provide spiritual care by enabling a patient to find meaning and purpose in their illness	172	3.01	1.16	0.44	0.28	−0.45
I believe spirituality is concerned with a need to forgive and a need to be forgiven	170	3.72	1.06	0.39	0.61	−0.12
I believe nurses can provide spiritual care by spending time with a patient, giving support and reassurance especially in times of need	173	3.99	0.87	0.21	0.75	0.18
I believe nurses can provide spiritual care by showing kindness, concern and cheerfulness when giving care	172	4.20	0.76	0.08	0.72	0.20
I believe nurses can provide spiritual care by arranging a visit by the hospital chaplain or the patient's own religious leader if requested	172	4.08	1.00	0.08	0.66	−0.05
I believe nurses can provide spiritual care by listening to patients and giving them time to discuss and explore their fears, anxieties and troubles	172	3.83	0.90	0.51	0.38	−0.02
I believe spirituality only involves going to church/place of worship	173	1.73	0.97	0.05	0.15	0.80
I believe spirituality is not concerned with a belief and faith in God or a Supreme being	173	1.88	1.00	0.00	0.10	0.78
I believe spirituality does not include areas such as art, creativity and self-expression	173	2.33	1.13	0.11	0.01	0.59
I believe spirituality does not apply to Atheists or Agnostics	173	2.03	0.98	0.38	0.05	0.57
Percentage of explained variance	/	/	/	30.10	13.15	8.41
Coefficient of internal consistency Cronbach alpha (α)	/	/	/	0.82	0.66	0.69

Legenda / Legend: n – število / number; $\bar{x}$ *– povprečje / average; s – standardni odklon / standard deviation*

perspective of the fourth factor that these authors named "individualised personal care". This factor as an independent dimension has not been confirmed in our research. The internal consistency of each factor with the exception of the first is also lower and questionable (Gliem & Gliem, 2003). Due to a satisfactory level of internal consistency of the entire scale (Cronbach alpha = 0.83) we treated 17 statements as a one-dimensional measure of attitudes towards spirituality and spiritual care.

Results

In the first part of SSCRS the respondents expressed their understanding of the concepts of spirituality and spiritual care and their attitudes towards these concepts. Table 2 shows factors with corresponding statements of the first part of SSCRS, mean value ($\bar{x}$) and standard deviation (s) of the specific statements in the first part of SSCRS. As seen from Table 2, respondents agreed most with statements that define spiritual care of patients and their spirituality. The respondents agreed most ($\bar{x}$ = 4.27, s = 0.82) with the statement, "I believe nurses can provide spiritual care by having respect for the privacy, dignity and religious and cultural beliefs of a patient. "Respondents also agree that they provide spiritual care by means of their attitude towards their patients: "by showing kindness, concern and cheerfulness" ($\bar{x}$ = 4.2, s = 0.76). The respondents expressed the lowest level of agreement with statements that refer to defining spirituality only from the religious perspective: "I believe spirituality only involves going to church/place of worship" ($\bar{x}$ = 1.73, s = 0.97); "I believe spirituality is not concerned with a belief and faith in God or a Supreme being" ($\bar{x}$ = 1.88, s = 1.00); "I believe spirituality does not apply to Atheists or Agnostics" ($\bar{x}$ = 2.03, s = 0.98).

We were also interested in statistically significant differences between the average score in the first part of SSCRS and demographic data: (i) self-evaluation of respondents, whether they are religious or not (dichotomous variable); (ii) gender (dichotomous variable); (iii) age (age groups). Analysis showed statistically significant differences in the mean score in the first part of SSCRS for self-evaluation of respondents, whether (i) they are religious and (iii) whether they practice religion or not. The mean score in the first part of SSCRS for respondents who answered the question "Are you religious?" with "Yes." (n = 114, $\bar{x}$ = 3.48, s = 0.41) is statistically different from the mean score of the respondents who answered to this question with "No." (n = 58, $\bar{x}$ = 3.23, s = 0.41) as t = 3.76 and is significant on the level, $p < 0.001$. Among the respondents who answered the question "Do you practice religion?" with "Yes." (n = 64, $\bar{x}$ = 3.48, s = 0.39) and those who answered "No." (n = 102, $\bar{x}$ = 3.33, s = 0.43), there is a statistically significant difference in the evaluation of the statements on the scale (t = 2.32, p = 0.02). For demographic variables of sex and age no statistically significant differences were found for the mean score in the first part of SSCRS: sex (t = 0.13, p = 0.89) and age groups (F = 0.51, p = 0.73).

The second part of SSCRS was aimed at finding which measures should be introduced in relation to offering spiritual care to patients according to nurses. The part contained six statements that the respondents evaluated with a five-point Likert scale. The results are shown in Table 3.

As seen in Table 3, respondents show the highest agreement with the statement that during training they do not obtain enough education and training to provide spiritual care to patients ($\bar{x}$ = 3.50, s =1.06),

Table 3: *Descriptive statistics for the second part of SSCRS*
Tabela 3: *Deskriptivne statistike za trditve drugega sklopa SSCRS*

Statement in the second part of SSCRS / Trditve drugega sklopa SSCRS	*n*	*1 (n / %)*	*2 (n / %)*	*3 (n / %)*	*4 (n / %)*	*5 (n / %)*	$\bar{x}$	*s*
I believe that spirituality and spiritual care are fundamental aspects of nursing	170	21/ 12.4	42/ 24.7	52/ 30.6	48/ 28.2	7/ 4.0	2.88	1.08
I believe that nurses do not receive sufficient education and training in order to provide quality spiritual care to the patient	171	6/ 3.5	29/ 16.8	37/ 21.6	72/ 42.2	27/ 15.6	3.50	1.06
I believe that spirituality and spiritual care should not be addressed within programmes of nurse education	171	33/ 19.1	52/ 30.4	45/ 26.3	29/ 16.8	12/ 6.9	2.62	1.18
I believe that Ministry of Health should provide clear guidance and support for nurses to deal with spiritual and religious issues	171	10/ 5.8	19/ 11.1	56/ 32.7	57/ 33.5	29/ 16.8	3.46	1.08
I believe that Nurses and Midwives Association of Slovenia should provide clear guidance and support for nurses to deal with spiritual and religious issues	172	11/ 6.4	20/ 11.6	46/ 26.7	68/ 39.3	28/ 16.2	3.48	1.09
I believe that spiritual care should be an integral part of nursing lifelong education and mandatory content for the renewal of licenses	171	26/ 15	38/ 22.2	44/ 25.7	44/ 26.0	19/ 11.0	2.96	1.24

Legend / Legenda: n – number / število; $\bar{x}$ – average / povprečje; s – standard deviation / standardni odklon; 1 – strongly disagree / sploh se ne strinjam; 2 – disagree / se ne strinjam; 3 – uncertain / negotov; 4 – agree / se strinjam; 5 – strongly agree / zelo se strinjam

and also with the statements referring to the Nurses and Midwives Association of Slovenia ($\overline{x}$ = 3.48, s = 1.09) and the Ministry of Health of the Republic of Slovenia ($\overline{x}$ = 3.46, s =1.08) as those institutions that should set clear guidelines and offer suitable support to nursing care employees in dealing with spiritual and religious issues of patients. With regard to the statement that spirituality and spiritual care represent basic principles in nursing care, the majority (n = 53, 30.6 %) of respondents were undecided ($\overline{x}$ = 2.88, s = 1.08).

Discussion

The results of the study have shown that nursing care employees included in the study understand spirituality especially in connection to understanding oneself and the attitude a person has towards themselves and the outside world, with the ability to live one's life in every moment, and the least with religion, belief in God or another celestial being and visiting religious institutions. The study conducted by McSherry and Jamieson (2013) among nurses in Great Britain gave similar results. Our research has confirmed that the nursing care employees included in the study have a broad, eclectic and inclusive way of understanding the concept of spirituality, which means that they do not only connect spirituality with belief in God or some other celestial being, but understand it primarily as a motivational construct that guides an individual in their search for peace, hope, other human beings, sense and forgiveness. These are the key concepts that define spirituality (Hsiao, et al., 2011) and may, or may not include religion, religious rituals and objects (Pike, 2011). For some individuals spirituality is a recognition of the existence of a divinity or personal relationship with God, while for others spirituality is a reflection of the most honest Self or the internal being (Mayers & Johnston, 2008).

The mean scores of the first part of SSCRS have shown that the respondents do not understand the concept of spirituality as being the same as the concept of religion and do not strictly differentiate between the concepts of spirituality and religion, but connect them both in a common concept of spirituality. Excluding religion from the concept of spirituality in nursing care in Europe is, above all, a consequence of secularisation (Timmins & McSherry, 2012). Some authors tend to criticise such an approach to understanding the relationship between religion and spirituality (Pesut, 2008; Pike, 2011). By emphasising the separation of spirituality and religion, the literature in nursing wishes to bring attention to the fact that an individual spiritual dimension and spiritual needs should also be recognised with patients who do not define themselves as religious (Pesut, 2008; Gedrih & Pahor, 2009). Strict separation of the two concepts may bring about a belief that an individual is a "non-material being" (Pesut, 2008, p. 170), with a pronounced emotional dimension, without the behavioural dimension or without rituals, practices and spiritual objects that are most often associated with the concept of religion as an institutionalised and tangible spirituality. In this sense, religion may be understood as one of the forms of demonstrating an individual's spirituality, which should be taken into account in the holistic care of patients (Timmins & McSherry, 2012). The results of this research have also demonstrated the same understanding of the concept by the nursing care employees included in the study.

In a study carried out in one of the Slovenian general hospitals, Šolar and Mihelič Zajec (2007, p. 144) identifies the "shared opinions" of nursing staff about "that satisfying spiritual needs is a priority or that their implementation is only possible after performed other activities, which, according to respondents, are an advantage". Despite the fact that our research based on the evaluations of the statements of the first part of SSCRS has shown a broad understanding of the concept of spirituality, average evaluations of the statements of the second part of SSCRS show similar opinions of the interviewed nursing care employees as given by Šolar and Mihelič Zajec (2007), and Babnik and Karnjuš (2014). Regarding the statement that spirituality and spiritual care are the basic aspects of nursing care, the majority of the respondents were undecided, while about the same percentage disagreed or strongly disagreed with the statement. This means that spiritual care, according to the interviewed nursing care employees, is not one of the priority areas in nursing care. The fact that the majority of the respondents work in surgery hospital departments may have had an impact on the results. Their experience of providing spiritual care is restricted to clinical settings where patients after an operation do not stay in the hospital or the surgery department for a long time. The concepts of spirituality and spiritual care originate from the biopsychosocial model of health and illness (Borrell-Carrió, et al., 2004) and an upgrade of the latter with the biopsychosocial-spiritual model of care (Sulmasy, 2002). Some recent research (Babnik, et al., 2017) has shown that a holistic care of patients is not a generally accepted model of care in nursing. Spiritual care as the main component of the holistic care has not been given enough attention in practice (Battey, 2012), especially beyond palliative care, since spirituality is not only restricted to the time of dying (McSherry & Jamieson, 2011). The significance of spiritual care may have been diminished also due to the fact that the process of spiritual care has not been entirely defined. Some guidelines of practising spiritual care have been given in the literature after the evaluation of patients' spiritual care and spiritual needs (Elliott, 2011; Daly & Fahey-McCarthy, 2014), but there is a lack of clear guidelines for practising

interventions and their evaluations. The answers by the nursing care employees included in the study regarding the first part of SSCRS have shown an understanding of spiritual care in nursing especially as being kind, caring, spending more time with an individual patient, being supportive and respecting the patient's privacy, their dignity, and religious and cultural beliefs. Other research conducted by means of the SSCRS questionnaire in various cultural and religious environments has also shown that the nursing staff generally consider that the attitude towards patients (care, optimism, support) and therapeutic communication were the key elements of spiritual care in nursing (Kostak & Celikkalp, 2016; Kaddourah, et al., 2018) and in other health care fields such as occupational therapy (Mthembu, et al., 2016).

Half of the interviewed nursing care employees were undecided regarding the need for including spiritual care in nursing care training programmes. Similar results had been found by Babnik and Karnjuš (2014). Generally, the interviewed nursing care employees were quite in agreement that they had not obtained enough knowledge with respect to spiritual care as part of nursing care. Findings of other research (McSherry & Jamieson, 2011, 2013; Kostak, & Celikkalp, 2016; Murray & Dunn, 2017) have also shown that nursing care employees lack the knowledge on spirituality and meeting spiritual needs. Therefore, the need to introduce subjects that would deal with spirituality and spiritual care exists. Before taking this step, a clear definition of the process of implementation of spiritual care as part of nursing care is needed (Ramezani, et al., 2014), which the respondents confirmed by expressing the opinion that clear guidelines and instructions for offering suitable and high quality care of patients should be prepared.

The conducted research also has limitations, which refer especially to the psychometric characteristics of the used questionnaire and the size of the sample. The research did not confirm the dimensional structure of the first part of the SSCRS questionnaire. The factor analysis has shown that the statements of the dimension "individualised personal care" of the original questionnaire (McSherry, et al., 2002) connect in a broader superior concept of spiritual care and not in an independent dimension of spiritual care as it is true for the original questionnaire. The reasons for such deviation may be found especially in the way spirituality and spiritual care is understood among the respondents, which can be a consequence of a somewhat specific professional and/or broader cultural environment. Similar findings have been reported by Martins and colleagues (2015) who confirmed the reliability of the first part of the SSCRS questionnaire but not its dimensional structure. Two research works that described the psychometric characteristics of the SSCRS questionnaire do not report on the dimensional structure of this questionnaire (Khoshknab, et al., 2010; van Leeuwen & Schep-Akkerman, 2015). Confirmation of the dimensional structure of the first part of the SSCRS questionnaire requires additional, also intercultural, research. The other limitation refers to sample size. The research only included a small number of nursing care employees, so a national research should be conducted, which could provide a clearer view on the existing current knowledge and opinions of nursing care employees regarding spirituality and spiritual care. The obtained results could then influence the setting of clear guidelines and preparing instructions that would help nursing care employees in holistic care for their patients.

Conclusion

We have shown how a sample of nursing care employees understand the concept of spirituality and spiritual care and their role in recognising the spiritual needs of patients and providing adequate patient care. Results have shown that the respondents associate spirituality especially with understanding themselves and the attitude that they have towards themselves and the outside world, however they disagree that spirituality and religion may be regarded as the same. Understanding the concept of spiritual care is connected especially to respecting an individual person in all respects and by being kind and caring. The respondents are aware of the importance of spiritual care in a clinical environment, but are at the same time undecided whether spirituality and spiritual care are key aspects of nursing care. The latter shows that there is a lack of understanding of the concept of spirituality and spiritual care among the respondents. The reasons may be lack of knowledge; therefore the study programme syllabi of undergraduate and postgraduate courses should be upgraded by providing subjects that are related to spirituality and spiritual care.

Slovenian translation / Prevod v slovenščino

Uvod

Duhovnost in duhovna oskrba sta danes pomembna elementa celostne, bio- in psihosocialne obravnave posameznika (Caldeira, et al., 2014). Čas poškodb, bolezni, posebej umiranja, je namreč čas negotovosti in stisk, ki presežejo zgolj telesni vidik delovanja posameznika (Babnik & Karnjuš, 2014) in v njem sprožijo vprašanja smisla, upanja, pomena, odpuščanja, višje sile. Duhovnost je koncept, ki združuje številne pomene: religijo, verske rituale, transcendenco, vzajemnost, povezanost, mir, energijo, pomen, namen, prepričanja, vrednote, upanje, motivacijo, ljubezen (Hsiao, et al., 2011). V literaturi zdravstvene nege ni enotne definicije duhovnosti (Pike, 2011). Nekateri avtorji jo v poskusu opredelitve

označujejo kot intrapsihično dimenzijo, ki vključuje eksistencialna načela in prepričanja ter posameznika vodi v iskanju pomena in namena v življenju ter ustvarjanju pozitivnih odnosov z drugimi (Molzahn & Sheilds, 2008; Ellis & Narayanasamy, 2009). Podobno opiše duhovnost tudi slovenska avtorica Skoberne (2002), ki je objavila članek na temo duhovnosti in duhovne oskrbe v zdravstveni negi v Sloveniji v času, ko se je v tujini področje duhovnosti v zdravstveni negi šele pričelo intenzivneje razvijati. Tudi s psihološkega vidika duhovnost razumemo predvsem kot dinamični, motivacijski koncept ali notranji vir (van Dierendonck & Mohan, 2006), ki vodi posameznike v iskanju pomena in moči, še posebno v kriznih situacijah, kamor sodi tudi bolezen. Paley (2008, 2010) navaja, da so v zdravstveni negi težave pri opredelitvi duhovnosti predvsem, ker je ta koncept relativno mlad in se spreminja glede na prepričanja posameznika, zlasti glede na njegovo kulturno ali versko ozadje in v skladu z družbo, ki ga obkroža. Gall in sodelavci (2011) opozarjajo, da so definicije duhovnosti pogosto nejasne in zapletene in pretežno odražajo, kako raziskovalci razumejo ta koncept, redkeje pa to, kako posamezniki, anketiranci raziskav, doživljajo duhovnost. Ena od pogostejših tem proučevanja duhovnosti v zdravstveni negi je pojasnitev odnosa med religioznostjo in duhovnostjo oziroma pojasnitev, »ali sta religija in duhovnost sinonima in ali imajo pacienti, ki niso religiozni, tudi duhovne potrebe« (Pike, 2011, p. 746). Enega od odgovorov na vprašanje odnosa med duhovnostjo in religioznostjo sta v literaturi zdravstvene nege že leta 2004 ponudila McSherry in Cash (2004) s taksonomijo duhovnosti v zdravstvu. Taksonomija predstavlja kontinuum pomenov duhovnosti in seže od duhovnosti, opredeljene izključno na verskih in teističnih idealih, do duhovnosti, ki temelji na sekularnih, humanističnih in eksistencialnih elementih. Razlaga duhovnosti v zdravstveni negi temelji na prevladujočem razumevanju duhovnosti kot komponente posameznikove biti, ki vključuje dimenziji »imanence (neločljivosti) in transcendence (presežnosti, nadizkustvenosti), ter lahko (ali pa tudi ne) vključuje religiozna prepričanja in prakse« (Babnik & Karnjuš, 2014, p. 13).

Poleg pojma duhovnosti je na področju zdravstvene nege uveljavljen tudi pojem duhovnih potreb. V literaturi težko najdemo ustrezno definicijo duhovnih potreb. Usklajeno jih definirajo Buck in McMillan (2012) ter Nixon in sodelavci (2013): duhovne potrebe opredelijo kot nekaj, kar oseba želi ali potrebuje, da bi našla namen in pomen življenja. Galek in sodelavci (2005) izpostavljajo sedem domen duhovnih potreb, in sicer pripadnost, smisel, upanje, sveto, moralnost, lepoto in sprejetje umiranja. Sharma in sodelavci (2012) izpostavljajo tri kategorije duhovnih potreb: psihosocialne, spiritualne in religiozne. Psihosocialne duhovne potrebe opisujejo kot potrebe po podpori in pomoči drugih; spiritualne kot tiste, ki se nanašajo na transcendentna vprašanja (pomen, upanje, odpuščanje, mir); med religiozne duhovne potrebe pa uvrščajo potrebe po aktivnem izvajanju veroizpovedi z branjem verskih besedil, opravljanjem verskih obredov ali pogovorom z duhovnikom oziroma verskim voditeljem (Sharma, et al., 2012).

Duhovna oskrba pacientov naj bi vodila k duhovnemu blagostanju pacienta v najhujših trenutkih njegovega življenja, ko zaradi bolezni ali poškodbe izgubi smisel, pomen in namen življenja (Cook, et al., 2012). O tem, kaj je duhovna oskrba, v literaturi ne najdemo soglasja. V strokovni literaturi se je uveljavilo razlikovanje med duhovno oskrbo kot širšim pojmom ter versko oskrbo kot njeno podkategorijo predvsem zaradi zahtev družbe po enakovredni obravnavi vseh, tudi ateistov (Gedrih & Pahor, 2009). Namen duhovne oskrbe je pomoč pacientom, da dosežejo ravnovesje in celovitost pri razumevanju lastnega stanja; je pomoč pri premagovanju občutkov nesmiselnosti in nekoristnosti; je podpora pri iskanju pomenov in smisla (Štrancar, 2009). Ena od aktivnosti izvajanja celostne zdravstvene nege je tudi identifikacija duhovnih potreb pacienta ter načrtovanje in izvajanje intervencij, med katere sodijo na primer: pomoč duhovnika, zagotavljanje zasebnosti in mirnega okolja, možnosti pogovora, poslušanje radijskega programa, glasbe, upoštevanje želja duhovne in verske narave (dietni predpisi, izvajanje verskih obredov) idr. (Skoberne, 2002; Karnjuš, et al., 2014). Zdravstveni delavci nimajo enotnega mnenja o tem, kdo je odgovoren za duhovno oskrbo pacientov (Babnik & Karnjuš, 2014). Verjetno pa so zaposleni v zdravstveni negi tisti, ki so zaradi narave svojega odnosa in stalnega stika s pacientom najprimernejši strokovni profil za duhovno oskrbo (Nixon, et al., 2013). Zaposleni v zdravstveni negi so vez med pacientom in ostalimi zdravstvenimi profili ter spodbujajo duhovno oskrbo, v katero se vključujejo vse pacientu pomembne osebe (Zakšek, 2010).

Sodobna zdravstvena nega se s konceptom duhovnosti in duhovne oskrbe ne ukvarja le v povezavi s paliativno oskrbo in lajšanjem trpljenja, temveč je razširila ta koncept na vsa področja obravnave pacienta. Primer takega pristopa je viden v Veliki Britaniji, ki je v obdobju po letu 2010 (McSherry & Jamieson, 2011, 2013) intenzivno pristopila k proučevanju vpetosti duhovnosti in duhovne oskrbe v zdravstveno nego na splošno, ne glede na področje dela in paciente, ki jih zaposleni v zdravstveni negi oskrbujejo. Na podlagi raziskave, opravljene na manjšem vzorcu zaposlenih v zdravstveni negi v Sloveniji, Babnik in Karnjuš (2014) ugotavljata, da anketiranci prepoznavajo duhovne potrebe pacientov in duhovno oskrbo kot del svojega dela, saj je ta vloga zapisana tudi v Kodeksu etike v zdravstveni negi in oskrbi Slovenije (Zbornica zdravstvene in babiške nege Slovenije, 2014). Pomen duhovne oskrbe in upoštevanja duhovne dimenzije posameznikovega delovanja potrjuje tudi Severnoameriško združenje

za negovalne diagnoze (North American Nursing Diagnosis Association International [NANDA-I]), ki v domeni »Življenjska načela« vključuje različne vidike duhovnega blagostanja posameznika. Tako se na primer negovalne diagnoze »Pripravljenost za doseganje višje ravni duhovnega blagostanja« (p. 361), »Duhovna stiska« (p. 372) ter »Nevarnost za duhovno stisko« (p. 374) neposredno nanašajo na prepoznavanje pomena duhovne dimenzije individualnega delovanja za posameznikovo blagostanje in kakovost življenja (Herdman & Kamitsuru, 2014). Duhovnost in duhovna oskrba sta redno prisotni v sodobnih učbenikih zdravstvene nege (Pesut, 2008), vključeni pa sta tudi v temeljne teorije in modele zdravstvene nege, kot beremo pri teoretičarkah Betty Neuman, Margaret Newman, Rosemary Parse in Jean Watson (MacKinlay, 2002; Tanyi, 2002).

Namen in cilji

Duhovnost in duhovna oskrba sta na področju zdravstvene nege in zdravstva v tujini in pri nas še vedno slabše raziskani. Namen raziskave je bil proučiti razumevanje koncepta duhovnosti in duhovne oskrbe med zaposlenimi v zdravstveni negi v slovenskem prostoru. Stališča so eden od odrazov razumevanja določene teme ali fenomena, zato smo si kot cilj raziskave zadali proučiti prepričanja in stališča zaposlenih v zdravstveni negi do duhovnosti in duhovne oskrbe. Pri tem smo se usmerili na zaposlene v zdravstveni negi v bolnišničnem okolju, kjer je zdravstvena nega usmerjena tako v kurativo kakor tudi v preventivo in rehabilitacijo. V takem okolju niso le umirajoči pacienti ali pacienti z neozdravljivo boleznijo, ampak tudi osebe, ki morajo biti zaradi zdravstvenega stanja hospitalizirane za krajše ali daljše časovno obdobje. Zastavili smo si naslednji raziskovalni vprašanji:

- Kako zaposleni v zdravstveni negi razumejo koncept duhovnosti in duhovne oskrbe?
- Kakšno je stališče zaposlenih v zdravstveni negi v bolnišničnem okolju do potreb po izobraževanju na področju duhovnosti in duhovne oskrbe?
- Katere organizacije / institucije bi po njihovem mnenju morale zaposlenim v zdravstveni negi pri izvajanju duhovne oskrbe nuditi ustrezno podporo?

Metode

Uporabljena je bila kvantitativna opisna metoda raziskovanja z uporabo strukturiranega vprašalnika.

Opis instrumenta

Kot instrument zbiranja podatkov smo uporabili »Vprašalnik za oceno duhovnosti in duhovne oskrbe« (*Spirituality and Spiritual Care Rating Scale* [SSCRS]) (McSherry, et al., 2002). Vprašalnik je sestavljen iz treh sklopov: i) prvi ugotavlja, kako ankentiranci razumevajo pojma »duhovnosti« in »duhovne oskrbe« ter kakšno stališče vzpostavljajo do njiju (17 trditev); ii) drugi sklop meri zaznavanje potrebnih ukrepov na področju nudenja duhovne oskrbe pacientov, predvsem v smeri vloge izobraževalnih ustanov in regulatornih organov pri zagotavljanju duhovne oskrbe pacientov in vrste ukrepov, ki bi jih bilo treba uvesti na področju nudenja duhovne oskrbe (6 trditev); iii) tretji sklop je namenjen pridobivanju demografskih podatkov. Prvi in drugi sklop vprašalnika vsebujeta trditve, na katere so anketiranci odgovarjali (izražali stopnjo strinjanja) s petstopenjsko Likertovo lestvico (1 – sploh se ne strinjam; 2 – se ne strinjam; 3 – sem negotov; 4 – se strinjam; 5 – se zelo strinjam). Drugi sklop trditev je sestavni del izvorne lestvice, kot nam jo je posredoval avtor (McSherry, et al., 2002). Za namene prilagoditve vprašalnika slovenski populaciji smo v formulacijo trditev vključili telesa, ki jih ima za namene reguliranja zdravstvene oskrbe in zdravstvene nege Republika Slovenija (RS).

Sedemnajst trditev prvega sklopa vprašalnika SSCRS meri štiri dimenzije stališč do duhovnosti in duhovne oskrbe (McSherry et al., 2002): i) duhovnost, ii) duhovno oskrbo, iii) religioznost in iv) individualizirano duhovno oskrbo. V dosedanjih raziskavah je prvi sklop SSCRS pokazal ustrezno in konsistentno raven zanesljivosti z vrednostmi dimenzij Cronbach alfa od 0,64 (McSherry, 1998) do 0,84 (Khoshknab, et al., 2010). Za prvi sklop vprašalnika SSCRS smo izračunali notranjo konsistentnost lestvice (Cronbach alfa), ki je ustrezna in znaša 0,83. Tudi za drugi sklop SSCRS smo izračunali notranjo konsistentnost lestvice (Cronbach alfa), ki znaša 0,38. Nizka notranja konsistentnost sklopa je pričakovana, saj drugi sklop ne temelji na trditvah, katerih namen bi bil konsistentno opisati nadredni konstrukt (ta skladnost pa bi se odražala v visoki notranji konsistentnosti oziroma Cronbach alfa koeficientu), temveč so trditve zgolj posamična prepričanja o možnih pristopih in pogojih k implementaciji duhovne oskrbe v prakso.

Opis vzorca

Uporabljen je bil priložnostni vzorec, sestavljen iz zaposlenih v zdravstveni negi v štirih slovenskih bolnišnicah. Od skupno 250 posredovanih vprašalnikov smo prejeli 173 veljavnih vprašalnikov (70,7 % realizacija vzorca). V raziskavi je sodelovalo 153 žensk (88,4 %) in 20 moških (11,6 %). Večina anketirancev je imela končano višjo oziroma visokošolsko izobrazbo (n = 93, 53,8 %), sledila je srednješolska izobrazba (n = 75, 43,4 %), pet anketirancev (2,8 %) je imelo univerzitetno izobrazbo oziroma strokovni magisterij ali več. Med anketiranci se jih je 114 (65,9 %) opredelilo za verne in 59 (34,1 %) za neverne. Od anketirancev, ki so se opredelili za verne, 64 (56,1 %) prakticira

svojo veroizpoved, ostalih 50 (43,9 %) pa ne. Kot je razvidno iz Tabele 1, je bilo največ anketirancev iz starostne skupine med 30 in 39 let (n = 56, 32,4 %). V skladu s starostno strukturo ima največ anketirancev 11 in več let delovnih izkušenj (n = 103, 63,1 %). Glede na področje dela so se na povabilo k anketiranju v največji meri odzvali zaposleni na oddelku kirurgije (n = 125, 72,3 %).

Tabela 1: *Demografski podatki anketirancev*
Table 1: *Demographic data of the study participants*

Demografski podatki / Demographic data	*n*	*%*
Starostna skupina		
21 do 29 let	43	24,9
30 do 39 let	56	32,4
40 do 49 let	46	26,6
50 do 59 let	25	14,5
60 let in več	3	1,7
Skupaj	173	100
Delovna doba		
Manj kot 1 leto	8	4,6
1 do 5 let	31	17,9
6 do 10 let	25	14,5
11 do 25 let	66	38,2
25 let in več	43	24,9
Skupaj	173	100
Področje dela		
Kirurgija	125	72,3
Interna	32	18,5
Pediatrija	7	4,0
Ginekologija	5	2,9
Anestezija	4	2,3
Skupaj	173	100

Legenda / Legend: n – število / number; % – odstotek / percentage

Opis poteka raziskave in obdelave podatkov

Pred začetkom raziskave smo za uporabo omenjenega instrumenta pridobili uradno soglasje avtorja raziskav (McSherry, et al., 2002) o duhovnosti v zdravstveni negi v Veliki Britaniji. Vprašalnik smo prevedli v slovenski jezik tako, da so avtorji raziskave pri tistih trditvah, ki bi bile lahko manj jasne, prevedli izvorne angleške trditve v slovenski jezik in nazaj v angleški jezik. Pregled obeh prevodov je opravil prevajalec. Trditve drugega sklopa SSCR vprašalnika (»Ministrstvo za zdravje RS bi moralo zagotoviti jasne smernice glede nudenja duhovne oskrbe pacientov, ki bi bile v pomoč medicinskim sestram pri obravnavi duhovnih in verskih vprašanj«; »Zbornica zdravstvene in babiške nege Slovenije bi morala postaviti jasne smernice in zagotoviti ustrezno podporo medicinskim sestram pri obravnavi duhovnih in verskih vprašanj pacientov«) smo prilagodili glede na regulatorne institucije za zdravstveno nego in zdravstveno oskrbo v Sloveniji. Anketiranje smo izvedli po pridobitvi soglasja s strani posamezne ustanove – bolnišnice. Razdelitev vprašalnikov smo izvedli v sodelovanju z bolnišnicami, ki so odobrile izvedbo raziskave. Vsak sodelujoči v raziskavi je lahko od te odstopil, če je to želel, prav tako pa je bila anketirancem zagotovljena anonimnost pri izvedbi raziskave in poročanju o njej.

Anonimnost udeležencev smo zagotovili z zbiranjem omejenega števila demografskih spremenljivk, torej le tistih, ki so potrebne za zadosten opis vzorca in preverjanje njihove vloge v stališčih do duhovnosti in duhovne oskrbe znotraj nekaterih sodobnejših raziskav (Kaddourah, et al., 2018; Kavosi, et al., 2018). Izračunali smo opisne statistike (frekvenca, povprečna vrednost, standardni odklon) in uporabili statistične teste (ANOVA, t-test). Pred izvedbo testov smo izračunali povprečno oceno za prvi sklop SSCRS (stališča do duhovnosti in duhovne oskrbe) za posameznega udeleženca in s tem oblikovali spremenljivko kompozitna ocena stališč do duhovnosti in duhovne oskrbe. Z Levenovim testom smo potrdili predpostavko o homogenosti varianc ter normalnost distribucije povprečnih dosežkov v prvem sklopu SSCRS (Kolmogorov-Smirnov test), zato smo v nadaljevanju izvedli inferenčne statistične teste (t-test, ANOVA). Statistične analize smo izvedli s pomočjo statističnega programa SPSS, verzija 23 (SPSS Inc., Chicago, Illinois, ZDA). Vrednosti p < 0,05 so veljale za statistično značilne.

Prvi korak v analizi podatkov je bilo preverjanje zanesljivosti in konstruktne veljavnosti (faktorska analiza) dela instrumenta, ki se nanaša na stališča zaposlenih v zdravstveni negi do duhovnosti in duhovne oskrbe ter na njuno razumevanje (prvi sklop SSCRS). Zanesljivost in konstruktno veljavnost slovenske verzije lestvice SSCRS smo preverili z analizo dimenzionalne strukture ter z analizo zanesljivosti celotne lestvice in njenih dimenzij (zanesljivost kot notranja skladnost – Cronbach alfa). Na sedemnajstih trditvah lestvice SSCRS smo izvedli faktorsko analizo. Ustreznost korelacijske matrike trditev SSCRS za faktorsko analizo smo preverjali z Bartlettovim testom sferičnosti in z mero Kaiser-Meyer-Olkin Measure of Sampling Adequacy (KMO) (Field, 2009). Bartlettov test sferičnosti (χ^2 = 924,557, p < 0,01) in mera KMO = 0,821 sta potrdili ustreznost korelacijske matrike za proučevanje dimenzionalne strukture. Faktorska analiza (metoda glavnih komponent, varimax rotacija) je izločila 3 faktorje z lastno vrednostjo več kot 1, ki skupaj pojasnijo 51,7 % variance v odgovorih anketirancev. Kot presečno vrednost faktorskih uteži za določitev faktorske strukture smo, v skladu s postopkom validacije instrumenta po McSherryiju in sodelavcih (2002), določili vrednost ≥+/- 0,35. Faktorsko matriko prikazujemo v Tabeli 2. Dimenzionalna struktura lestvice SSCRS odstopa

od štirih dimenzij stališč do duhovnosti in duhovne oskrbe, ki so jih identificirali McSherry in sodelavci (2002), predvsem z vidika četrtega faktorja, ki so ga ti avtorji poimenovali »individualizirana osebna oskrba«. Ta faktor v naši raziskavi kot samostojna dimenzija ni bil potrjen. Tudi notranji konsistentnosti posameznega faktorja, z izjemo prvega, sta nižji in vprašljivi (Gliem & Gliem, 2003). Zaradi manj zadovoljive stopnje notranje konsistentnosti dveh od treh izločenih dimenzij lestvice SSCRS in zaradi dobre notranje konsistentnosti celotne lestvice (Cronbach α = 0,83) smo v nadaljnjih analizah 17 trditev obravnavali kot enodimenzionalno mero stališč do duhovnosti in duhovne oskrbe.

Tabela 2: *Faktorska matrika in deskriptivne statistike trditev prvega sklopa SSCRS*
Table 2: *Factor matrix with descriptive statistics for the first part of SSCRS*

				Faktorji/Factors		
Trditve prvega sklopa SSCRS / Items of the first part of SSCRS	***n***	$\bar{x}$	***s***	***Opredelitev duhovnosti / Definition of spirituality***	***Duhovna oskrba / Spiritual care***	***Religija in duhovnost / Religion and spirituality***
Duhovnost je povezovalna sila, ki omogoča posamezniku iskanje miru pri samem sebi in v povezavi z zunanjim svetom.	172	4,08	0,74	0,85	0,04	0,13
Duhovnost je imeti občutek upanja v življenju.	169	3,87	0,88	0,79	0,25	−0,09
Duhovnost je povezana s sposobnostjo živeti v sedanjosti, tukaj in sedaj.	171	3,68	0,97	0,78	0,17	−0,05
Duhovnost vključuje osebna prijateljstva in ljubezenska razmerja.	171	3,43	1,03	0,61	−0,02	0,21
Medicinske sestre lahko zagotavljajo duhovno oskrbo, tako da spoštujejo pravico do zasebnosti, dostojanstva ter da spoštujejo kulturna in verska prepričanja pacienta.	171	4,27	0,82	0,57	0,21	0,23
Duhovnost vključuje človeško moralo.	171	3,79	1,04	0,49	0,28	0,17
Duhovnost je iskanje smisla v vsem, kar nam prinaša življenje, dobro in slabo.	173	3,75	0,97	0,46	0,36	0,15
Medicinske sestre lahko zagotavljajo duhovno oskrbo tako, da pomagajo pacientu najti smisel njegove bolezni.	172	3,01	1,16	0,44	0,28	−0,45
Duhovnost vključuje potrebo, da ti je odpuščeno in da odpuščaš.	170	3,72	1,06	0,39	0,61	−0,12
Medicinske sestre lahko zagotavljajo duhovnost s tem, da pacientu posvetijo čas in nudijo podporo, ko jo pacient potrebuje.	173	3,99	0,87	0,21	0,75	0,18
Medicinske sestre v času obravnave lahko zagotavljajo duhovno oskrbo pacientu z izkazovanjem prijaznosti, skrbi in vedrine.	172	4,20	0,76	0,08	0,72	0,20
Medicinske sestre lahko zagotavljajo duhovno oskrbo pacientu tako, da organizirajo obisk duhovnika oziroma duhovnega vodje drugih veroizpovedi, če pacient za to zaprosi.	172	4,08	1,00	0,08	0,66	−0,05
Medicinske sestre lahko zagotavljajo duhovno oskrbo s poslušanjem pacienta in z omogočanjem, da razpravlja o svojih strahovih, bojaznih in težavah ter jih raziskuje.	172	3,83	0,90	0,51	0,38	−0,02
Duhovnost vključuje le obiskovanje cerkev oziroma drugih sakralnih objektov.	173	1,73	0,97	0,05	0,15	0,80
Duhovnost je omejena le na prepričanje oziroma vero v Boga ali drugo višje bitje.	173	1,88	1,00	0,00	0,10	0,78
Umetnost, ustvarjalnost in samoizražanje niso del duhovnosti.	173	2,33	1,13	0,11	0,01	0,59
Ateisti in agnostiki se ne srečujejo z duhovnostjo.	173	2,03	0,98	0,38	0,05	0,57
Odstotek pojasnjene variance	/	/	/	30,10	13,15	8,41
Koeficient notranje konsistentnosti Cronbach alfa (α)	/	/	/	0,82	0,66	0,69

Legenda / Legend: n – število / number; $\bar{x}$ *– povprečje / average; s – standardni odklon / standard deviation*

Rezultati

V prvem sklopu SSCRS so anketiranci odgovarjali na trditve o tem, kakšno je njihovo razumevanje pojmov duhovnost in duhovna oskrba ter kakšna so njihova stališča do njiju. Tabela 2 prikazuje faktorje s pripadajočimi trditvami prvega sklopa SSCRS, povprečno vrednost ($\bar{x}$) in standardni odklon (s) ocen posamezne trditve prvega sklopa SSCRS. Kot je razvidno iz Tabele 2, so anketiranci izrazili najvišjo stopnjo strinjanja pri trditvah, ki se nanašajo na opredelitev duhovne oskrbe pacienta in njegove duhovnosti. Anketiranci so ocenili najvišje povprečno strinjanje ($\bar{x}$ = 4,27, s = 0,82) s trditvijo »Medicinske sestre lahko zagotavljajo duhovno oskrbo, tako da spoštujejo pravico do zasebnosti, dostojanstva ter da spoštujejo kulturna in verska prepričanja pacienta«. Prav tako se anketiranci strinjajo s trditvijo »Medicinske sestre v času obravnave lahko zagotavljajo duhovno oskrbo pacientu z izkazovanjem prijaznosti, skrbi in vedrin« ($\bar{x}$ = 4,2, s = 0,76). Najnižjo stopnjo strinjanja so anketiranci izrazili za trditve, ki se nanašajo na opredelitev duhovnosti zgolj z vidika religioznosti: »Duhovnost vključuje le obiskovanje cerkev oz. drugih sakralnih objektov« ($\bar{x}$ = 1,73, s = 0,97); »Duhovnost je omejena le na prepričanje oz. vero v Boga ali drugo višje bitje« ($\bar{x}$ = 1,88, s = 1,00); »Ateisti in agnostiki se ne srečujejo z duhovnostjo« ($\bar{x}$ = 2,03, s = 0,98).

V nadaljevanju so nas zanimale statistično pomembne razlike med dosežkom v prvem sklopu trditev SSCRS in demografskimi podatki: (i) samoocena anketirancev, ali so verni/religiozni ali ne (dihotomna spremenljivka); (ii) spol (dihotomna spremenljivka); (iii) starost (starostne kategorije). Analiza je pokazala statistično pomembne razlike v povprečnem dosežku v prvem sklopu SSCRS za samooceno anketirancev, ali (i) so verni/religiozni in ali (ii) prakticirajo veroizpoved ali ne. Povprečni dosežek v prvem sklopu SSCRS za anketirance, ki so na vprašanje »Ali ste verni / religiozni?« odgovorili »Da« (n = 114, $\bar{x}$ = 3,48, s = 0,41), se statistično pomembno razlikuje od povprečnega dosežka anketirancev, ki so na to vprašanje odgovorili »Ne« (n = 58, $\bar{x}$ = 3,23, s = 0,41), saj znaša t = 3,76 in je pomemben na ravni tveganja, p < 0,001. Med anketiranci, ki so na vprašanje »Ali prakticirate veroizpoved?« odgovorili »Da« (n = 64, $\bar{x}$ = 3,48, s = 0,39), in tistimi, ki so odgovorili »Ne« (n = 102, $\bar{x}$ = 3,33, s = 0,43), obstaja statistično pomembna razlika v ocenjevanju trditev lestvice (t = 2,32, p = 0,02). Za demografski spremenljivki spol in starost nismo ugotovili statistično pomembnih razlik v povprečnem dosežku v prvem sklopu SSCRS: spol (t = 0,13, p = 0,89) in starostne kategorije (F = 0,51, p = 0,73).

Drugi sklop SSCRS je ugotavljal, katere ukrepe bi bilo treba po mnenju zaposlenih v zdravstveni negi uvesti na področju nudenja duhovne oskrbe pacientov. Sklop je vseboval 6 trditev, ki so jih anketiranci ocenjevali s pomočjo petstopenjske Likertove lestvice. Rezultati so prikazani v Tabeli 3.

Kot je razvidno iz Tabele 3, se anketiranci najbolj strinjajo s trditvijo, da med izobraževanjem ne pridobijo dovolj znanja za nudenje duhovne oskrbe ($\bar{x}$ = 3,50, s = 1,06), ter tudi s trditvami, v sklopu katerih sta Zbornica zdravstvene in babiške nege Slovenije ($\bar{x}$ = 3,48, s =1,09) in Ministrstvo za zdravje RS ($\bar{x}$ = 3,46, s =1,08) tisti instituciji, ki bi morali postaviti smernice in zagotoviti ustrezno podporo zaposlenim v zdravstveni negi pri

Tabela 3: *Deskriptivne statistike za trditve drugega sklopa SSCRS*
Table 3: *Descriptive statistics for the second part of SSCRS*

Trditve drugega sklopa SSCRS / Items of the second part of SSCRS	*n*	*1 (n / %)*	*2 (n / %)*	*3 (n / %)*	*4 (n / %)*	*5 (n / %)*	$\bar{x}$	*s*
Duhovnost in duhovna oskrba sta temeljna vidika zdravstvene nege.	170	21/ 12,4	42/ 24,7	52/ 30,6	48/ 28,2	7/ 4,0	2,88	1,08
Medicinske sestre med študijem ne pridobijo dovolj znanja in niso dovolj usposobljene, da bi lahko nudile kakovostno duhovno oskrbo pacientu.	171	6/ 3,5	29/ 16,8	37/ 21,6	72/ 42,2	27/ 15,6	3,50	1,06
Duhovnosti in duhovne oskrbe pacienta ni treba obravnavati v okviru programa izobraževanja medicinskih sester.	171	33/ 19,1	52/ 30,4	45/ 26,3	29/ 16,8	12/ 6,9	2,62	1,18
Ministrstvo za zdravje RS bi moralo zagotoviti jasne smernice glede nudenja duhovne oskrbe pacientov, ki bi bile v pomoč medicinskim sestram pri obravnavi duhovnih in verskih vprašanj.	171	10/ 5,8	19/ 11,1	56/ 32,7	57/ 33,5	29/ 16,8	3,46	1,08
Zbornica zdravstvene in babiške nege Slovenije bi morala postaviti jasne smernice in zagotoviti ustrezno podporo medicinskim sestram pri obravnavi duhovnih in verskih vprašanj pacientov.	172	11/ 6,4	20/ 11,6	46/ 26,7	68/ 39,3	28/ 16,2	3,48	1,09
Izobraževanja s področja duhovne oskrbe bi morala biti nujen sestavni del izobraževanj za podelitev licenčnih točk.	171	26/ 15	38/ 22,2	44/ 25,7	44/ 26,0	19/ 11,0	2,96	1,24

Legenda / Legend: n – število / number; $\bar{x}$ – povprečje / average; s – standardni odklon / standard deviation; 1 – sploh se ne strinjam / strongly disagree; 2 – se ne strinjam / disagree; 3 – negotov / uncertain; 4 – se strinjam / agree; 5 – zelo se strinjam / strongly agree

obravnavi duhovnih in verskih vprašanj pacientov. V zvezi s trditvijo, da sta duhovnost in duhovna oskrba temeljna vidika zdravstvene nege, je bilo največ (n = 53, 30,6 %) anketirancev negotovih ($\bar{x}$ = 2,88, s = 1,08).

Diskusija

Rezultati raziskave so pokazali, da anketirani zaposleni v zdravstveni negi povezujejo duhovnost predvsem z razumevanjem samega sebe in odnosom do sebe ter zunanjega sveta, s sposobnostjo živeti življenje v vsakem trenutku, najmanj pa z religijo, z vero v Boga ali drugo višje bitje ter z obiskom sakralnih objektov. Podobne rezultate je pokazala raziskava, ki sta jo izvedla McSherry in Jamieson (2013) med medicinskimi sestrami v Veliki Britaniji. Naša raziskava potrjuje, da imajo anketirani zaposleni v zdravstveni negi širok, eklektičen in inkluzivni način dojemanja koncepta duhovnosti, kar pomeni, da duhovnosti ne povezujejo izključno z vero v Boga ali drugo višjo silo, temveč jo pojmujejo predvsem kot motivacijski konstrukt, ki posameznika vodi in usmerja pri iskanju miru, upanja, bližine drugega, smisla, odpuščanja. To so ključni pojmi, ki opredeljuje duhovnost (Hsiao, et al., 2011) in lahko, ali pa tudi ne, vključujejo religijo, verske rituale in objekte (Pike, 2011). Za nekatere posameznike pomeni duhovnost priznanje obstoja božanstva ali osebnega odnosa z Bogom, za druge pa je duhovnost izraz najbolj iskrenega sebstva ali notranjega bitja (Mayers & Johnston, 2008).

Iz povprečnih ocen prvega sklopa SSCRS je razvidno, da anketirani ne enačijo pojma duhovnosti s pojmom religije, kot tudi ne ločujejo strogo pojma duhovnosti in religije, temveč ju povezujejo v enoten koncept duhovnosti. Ločevanje ali izvzemanje religije iz koncepta duhovnosti je prisotno v zdravstveni negi v evropskem prostoru predvsem kot posledica sekularizacije (Timmins & McSherry, 2012). Nekateri avtorji tak pristop k razumevanju odnosa med religijo in duhovnostjo kritizirajo (Pesut, 2008; Pike, 2011). S poudarjenim ločevanjem duhovnosti in religije se želi v literaturi zdravstvene nege poudariti, da je treba tudi pri pacientih, ki se ne opredelijo kot verni oziroma religiozni, prepoznavati individualno duhovno dimenzijo in duhovne potrebe (Pesut, 2008; Gedrih & Pahor, 2009). Strogo ločevanje obeh konceptov lahko uveljavi predstavo o posamezniku kot »nematerialnem bitju« (Pesut, 2008, p. 170), s poudarjeno čustveno dimenzijo, brez vedenjske dimenzije delovanja oziroma brez ritualov, praks in duhovnih objektov, ki se najpogosteje povezujejo s konceptom religije kot institucionalizirane in opredmetene duhovnosti. V tem pogledu lahko religijo razumemo kot eno od oblik izkazovanja posameznikove duhovnosti, ki jo pri izvajanju celostne oskrbe pacienta moramo upoštevati (Timmins & McSherry, 2012). Tako razumevanje med anketiranimi zaposlenimi v zdravstveni negi nakazujejo tudi rezultati naše raziskave.

V raziskavi, opravljeni v eni od slovenskih splošnih bolnišnic, Šolar in Mihelič Zajec (2007, p. 144) ugotavljata »deljena mnenja« zaposlenih v zdravstveni negi o tem, »da je zadovoljevanje duhovnih potreb prioriteta oziroma da se njihovo izvajanje omogoči šele po opravljenih ostalih aktivnostih, ki imajo po mnenju anketirancev prednost«. Kljub temu da naša raziskava na podlagi ocen trditev prvega sklopa SSCRS nakazuje široko razumevanje koncepta duhovnosti, povprečne ocene trditev drugega sklopa vprašalnika nakazujejo podobna stališča anketiranih zaposlenih v zdravstveni negi, kot jih navajata Šolar in Mihelič Zajec (2007), pa tudi Babnik in Karnjuš (2014). Glede trditve, da sta duhovnost in duhovna oskrba temeljna vidika zdravstvene nege, je bilo največ anketiranih negotovih, približno enak delež pa se jih s to trditvijo ni strinjalo oziroma sploh ni strinjalo. To pomeni, da duhovna oskrba po prepričanju anketiranih zaposlenih v zdravstveni negi ni eno od prednostnih področij zdravstvene nege. K takim rezultatom verjetno prispeva tudi dejstvo, da je največ anketiranih zaposlenih na kirurških oddelkih bolnišnic. Njihove izkušnje iz kliničnega okolja z obravnavo duhovnih potreb pacientov so predvsem vezane na paciente, ki so po operativnem posegu zelo kratek čas v bolnišnici oziroma na oddelku. Koncepta duhovnosti in duhovne oskrbe izhajata iz bio- in psihosocialnega modela zdravja in bolezni (Borrell-Carrió, et al., 2004) ter nadgradnje tega z bio- in psihosocialno-duhovnim modelom (Sulmasy, 2002). Nekatere dosedanje raziskave (Babnik, et al., 2017) nakazujejo, da celostna obravnava posameznika še ni povsem uveljavljena v predstavi o zdravstveni negi. Duhovni oskrbi kot sestavnemu delu celostne obravnave je v praksi namenjeno premalo pozornosti (Battey, 2012), še posebno izven paliativne oskrbe, saj se pomen duhovnosti ne izraža zgolj v času umiranja (McSherry & Jamieson, 2011). K dajanju manjšega pomena duhovni oskrbi verjetno prispeva tudi dejstvo, da proces duhovne oskrbe v zdravstveni negi še ni v celoti opredeljen. Nekatere konkretne usmeritve izvajanja duhovne oskrbe so v literaturi podane za fazo ocene duhovnega stanja in duhovnih potreb pri pacientih (Elliott, 2011; Daly & Fahey-McCarthy, 2014), primanjkuje pa jasnih usmeritev za izvajanje intervencij in njihove evalvacije. Odgovori anketiranih zaposlenih v zdravstveni negi na prvi sklop SSCRS kažejo razumevanje duhovne oskrbe v zdravstveni negi predvsem kot izražanje prijaznosti, skrbi, posvečanje časa pacientu, podpore ter spoštovanja zasebnosti pacientov, njihovega dostojanstva ter verskih in kulturnih prepričanj. Tudi druge raziskave, opravljene v različnih kulturnih in verskih okoljih z vprašalnikom SSCRS, kažejo prevladujoče prepričanje zaposlenih v zdravstveni negi, da sta odnos do pacienta (skrb, izražanje pozitivnih čustev, podpora) in terapevtska komunikacija ključna elementa duhovne

oskrbe v zdravstveni negi (Kostak & Celikkalp, 2016; Kaddourah, et al., 2018), pa tudi v drugih zdravstvenih strokah, na primer v delovni terapiji (Mthembu, et al., 2016).

Polovica anketiranih zaposlenih v zdravstveni negi je bila negotovih v zvezi s potrebo po vključevanju duhovne oskrbe v izobraževanje v zdravstveni negi. Podobno ugotavljata tudi Babnik in Karnjuš (2014). Anketirani zaposleni v zdravstveni negi so imeli bolj izraženo mnenje glede tega, da med študijem ne pridobijo dovolj znanja za nudenje duhovne oskrbe. Tudi ugotovitve drugih raziskav (McSherry & Jamieson, 2011, 2013; Kostak, & Celikkalp, 2016; Murray & Dunn, 2017) kažejo, da zaposleni v zdravstveni negi nimajo dovolj znanja o duhovnosti in zadovoljevanju duhovnih potreb. To nakazuje na potrebo po uvedbi predmetov, ki bi v času formalnega izobraževanja obravnavali pojem duhovnosti in duhovne oskrbe. Pred tem korakom je potrebna jasna opredelitev procesa izvajanja duhovne oskrbe v sklopu zdravstvene nege (Ramezani, et al., 2014), kar anketirani v raziskavi potrjujejo s stališčem, da bi bilo treba pripraviti jasne smernice in navodila za nudenje ustrezne in kakovostne duhovne oskrbe pacientov.

Predstavljena raziskava ima tudi svoje omejitve, ki se nanašajo predvsem na psihometrične značilnosti uporabljenega vprašalnika in na velikost vzorca. V raziskavi ni bila potrjena dimenzionalna struktura prvega sklopa vprašalnika SSCRS. V raziskavi opravljena faktorska analiza je pokazala, da se trditve dimenzije »individualizirana osebna oskrba« izvornega vprašalnika (McSherry, et al., 2002) združujejo v širši nadrejeni koncept duhovne oskrbe in ne v samostojno dimenzijo duhovne oskrbe, kot to velja za izvorni vprašalnik. Razloge za tako odstopanje lahko iščemo predvsem v pojmovanju duhovnosti in duhovne oskrbe med anketiranimi, kar je lahko posledica nekoliko specifičnega poklicnega in / ali širšega družbenega kulturnega okolja. Podobno ugotavljajo tudi Martins in sodelavci (2015), ki so sicer potrdili zanesljivost prvega sklopa vprašalnika SSCRS, ne pa tudi njegove dimenzionalne strukture. Dve raziskavi, ki sta opisovali psihometrične značilnosti vprašalnika SSCRS, o dimenzionalni strukturi tega vprašalnika ne poročata (Khoshknab, et al., 2010; van Leeuwen & Schep-Akkerman, 2015). Potrditev dimenzionalne strukture prvega sklopa vprašalnika SSCRS zahteva dodatne, tudi medkulturne, raziskave. Druga omejitev zaključevanja se nanaša na velikost vzorca. V raziskavo smo zajeli le majhen vzorec zaposlenih v zdravstveni negi. Smiselno bi bilo narediti raziskavo na nacionalni ravni, s pomočjo katere bi lahko pridobili jasnejši pogled na trenutno znanje in stališča zaposlenih v zdravstveni negi do duhovnosti in duhovne oskrbe. S pomočjo dobljenih rezultatov bi lahko vplivali na postavitev jasnih smernic in navodil, ki bi bile zaposlenim v zdravstveni negi v pomoč pri izvajanju celostne oskrbe pacienta.

Zaključek

Predstavili smo, kako vzorec zaposlenih v zdravstveni negi razume koncept duhovnosti in duhovne oskrbe ter kakšna je njihova vloga pri prepoznavanju duhovnih potreb pacientov ter nudenju ustrezne duhovne oskrbe. Rezultati so pokazali, da anketirani pojem duhovnosti povezujejo predvsem z razumevanjem samega sebe in odnosom, ki ga imajo do sebe in zunanjega sveta, ne strinjajo pa se, da lahko duhovnost in religijo / vero enačimo. Razumevanje koncepta duhovne oskrbe povezujejo predvsem s spoštovanjem posameznika v vseh pogledih ter z izkazovanjem prijaznosti in skrbi. Anketirani v raziskavi se zavedajo pomena duhovne oskrbe pacientov v kliničnem okolju, hkrati pa izražajo negotovost glede tega, da sta duhovnost in duhovna oskrba temeljna vidika zdravstvene nege. Slednje nakazuje pomanjkanje razumevanja koncepta duhovnosti in duhovne oskrbe med anketiranci. Vzroke je mogoče iskati v pomanjkanju znanja, torej primanjkljaju na področju izobraževanja, zato bi bilo treba v študijske programe na dodiplomskem in podiplomskem študiju uvesti vsebine, ki obravnavajo duhovnost in duhovno oskrbo.

Conflict of interest / Nasprotje interesov

The authors declare that no conficts of interest exist. / Avtorji izjavljajo, da ni nasprotja interesov.

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The study was conducted in accordance with the Helsinki-Tokyo Declaration (World Medical Association, 2013) and the Code of Ethics for Nurses and Nurse Assistants of Slovenia (2014). / Raziskava je pripravljena v skladu z načeli Helsinško-Tokijske deklaracije (World Medical Association, 2013) in v skladu s Kodeksom etike v zdravstveni negi in oskrbi Slovenije (2014).

Author contributions / Prispevek avtorjev

All three authors planned the survey. The second and the third author translated and adapted the instrument used for the Slovene population. The first author collected data. The second and the third authors participated in the data analysis. All three authors contributed to the preparation of the article: Introduction, Method, Results, Discussion and Conclusion. / Vsi trije avtorji so načrtovali raziskavo, drugi in tretji avtor sta prevedla in priredila za slovensko populacijo uporabljen instrument. Prva

avtorica je zbirala podatke, drugi in tretji avtor pa sodelovala v analizi podatkov. Vsi trije avtorji so prispevali k pripravi vsebine in zapisa delov članka: Uvod, Metoda, Rezultati, Diskusija in Zaključek.

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