Spiritual Care in Healthcare: A Critical Realist Investigation into General Practice Nurses' Perceptions and Practices

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Abstract

This thesis offers a sustained enquiry into the perceptions and practices of GP nurses in relation to the concepts of spirituality and of spiritual care. This is an under researched constituency in relation to an emerging topic of interest across the healthcare sector. The aim of the thesis is to investigate GP nurses' perceptions and practices in the provision of spiritual care, to identify how the context of general practice might impact their practices, and the implications of these practices for GP settings. Informed by a review of literature investigating the phenomena of spirituality and spiritual care in healthcare, this thesis employs Bhaskar's theory of critical realism as the theoretical framework and a mixed methods methodology gathering both quantitative and qualitative data. The study drew on data from an online questionnaire to investigate GP nurses' underlying perceptions of these concepts, and semi-structured interviews with ten GP nurses to identify their practices and experiences in the provision of spiritual care. The analysis from both data sets reflected the influence of applied critical realism on the research design. The study found that certain approaches in the provision of spiritual care were common among the GP nurses. An understanding around these values seemed to permit GP nurses to downplay any differences in spiritual care outcome values. While the GP nurses applied a common sense approach in the provision of spiritual care, the differences in outcome values disproved claims of neutrality. The thesis identifies and presents GP nurse patterns or commonalities in the provision of spiritual care and proffers five influential dimensions for practitioners and educational developers to draw upon in the professional development of GP nurses. It also evaluates these dimensions in relation to critical realism by considering where they lie within Bhaskar's stratified domains of *real, actual* and *empirical.* This study offers three original contributions to knowledge: it is the first study to have carried out a systematic literature review of the extant literature on spiritual care in relation to GP Nursing, establishing that there is a gap in relation to spiritual care focusing solely GP nurses in the UK; the first study to gather a substantial body of primary quantitative and qualitative data on GP nurses' perceptions and provision of spiritual care from which five influential dimensions were extrapolated to develop a model of GP nurses' provision of spiritual care; and, the study applies Bhaskar's theory of critical realism in healthcare research in the provision of spiritual care. The thesis concludes by indicating the potential for further research using critical realism and mixed methods in this area of educational and nursing research.

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Abbreviations

CR	Critical Realism/Realist
DH	Department of Health
GDPR	General Data Protection Regulation
GP	General Practice Doctor
GP nurse	General Practice Nurse
GP practice	General Practice Surgery/Practice
GP setting	General Practice Setting
GP staff	General Practice Staff
HEE	Health Education England
NHS	National Health Service
NMC	Nursing and Midwifery Council
CQC	Care Quality Commission
QOF	Quality and Outcomes Framework
RCN	Royal College of Nurses
SSCRS	Spirituality and Spiritual Care Rating Scale

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Chapter One: Introduction

> Despite all the attention and proliferation in research in this area [provision of spiritual care], nurses are still calling for further guidance and more educational preparation. The evidence suggests that some UK Government Health Departments, NMC and RCN need to take a more coordinated approach and a collective responsibility in providing clearer guidance and resources to nurses so that they can deal more effectively and confidently in this area.
>
> (McSherry and Jamieson, 2011, p.1765).

In recent years, the application of the concepts of spirituality and spiritual care has become increasingly salient within the UK healthcare sector. Current concerns about poor care, for example the 2008 report into deficient care in Mid-Staffordshire NHS Trust (Francis, 2013) by different groups of healthcare professionals, caused the government to implement initiatives to improve care. These initiatives prompted increased consideration for care that incorporated the spiritual aspect found in holistic care (NHS England, 2016b), and person-centred care (NHS Education for Scotland, 2009; McSherry and Jamieson, 2015), extending to considerations of patients' spiritual wellbeing (NHS England, 2016a). Promoting the importance of spiritual care via nursing commissioning has been a mandatory requirement since January 2019. This was when the Nursing and Midwifery Council (NMC), the regulatory body for nursing and midwifery professionals in the UK and nursing associates in England, published its updated code. According to policy advice in force from this date, all registered nurses must be competent in assessing patients' spiritual needs (NMC, 2018) and take cognisance of these in their provision of care to the patient. This requirement extends to nurses working in general practice, an area of healthcare which is under increasing pressure from the NHS to provide more care closer to home.

Given that these provisions are only recently instated, it is perhaps unsurprising that there is still a lack of a complete critical grasp of what spirituality or the provision of spiritual care might mean in practical terms in healthcare (van Leeuwen and Cusveller, 2004; Baldacchino, 2006). Spirituality is described as different from other aspects of care because it is difficult to define (Oxhandler, 2017). Spiritual care, the cognisance of the patients' own (if any) spiritual preferences and sensibilities in the provision of care, has long been an issue (which is discussed in Chapter Two), yet the language and practice around this is emergent and tentative as a fundamental part of nursing (Timmins and Caldeira, 2017). A common misconception seems to be that the term 'spiritual' in the context of providing spiritual care indicates a specific faith position of a codified set of religious beliefs (Narayanasamy and Owens, 2001), while instead the term indicates

much broader notions of an individual's sense of wellbeing, belonging and discernment of patterns of meaning in their life experiences (Withers, Zuniga and van Sell, 2017).

It is increasingly accepted in the nursing research community that if nurses are assisted in developing their knowledge of spirituality, a term often used in its broadest sense to refer to these dimensions of 'meaning' and 'purpose', then they will become more confident in the provision of spiritual care (Delgado, 2005; Sartori, 2010; McSherry and Jamieson, 2011; Timmins et al., 2015). Professional education, therefore, is fundamental in supporting nurses to articulate and develop their conceptions of the nature of healthcare practice in this relatively uncharted domain of spirituality and spiritual care, to increase their competence and confidence in the provision of spiritual care. Thus Delgado (2005, p.157) avers how a truly holistic mode of practice: 'recognizes that the stress of acute or chronic illness may cause persons to engage in a search for meaning and purpose in life' and insists: 'As a holistic discipline with a professional practice component, nursing must study all aspects of the person. [...] All are intertwined and necessary.' Likewise, Timmins et al. (2015, p.486) consider that: 'Key to developing spiritual care competence is the fostering and development of spiritual awareness through the transmission of education', while Sartori (2010, p.25) suggests: 'Incorporating spiritual care into pre- and post-registration education will enhance nurses' confidence and improve patient wellbeing and satisfaction.'

To date, the literature shows limited agreement as to what is meant by 'meaning', 'purpose' or 'spiritual care' and offers limited guidance on integrating spirituality and spiritual care into diverse healthcare environments, particularly where differing organisational restrictions apply. Nevertheless, the provision of spiritual care is a vital component in promoting the wellbeing of patients, and according to Frouzandeh, Aein and Noorian (2015, p.2) 'By creating a healing environment and emphasising the spiritual health needs of patients, the nurses can help patients to get better.' NHS Education for Scotland (2009, p.4) suggests 'Spiritual care in the NHS must be both inclusive and accepting of human difference. [...] [spiritual care by NHS staff] is the very essence of their work and it enables and promotes healing in the fullest sense to all parties, both giver and receiver, of such care.' The ambiguity as to what precisely is meant by 'healing' in these examples, and the paucity of primary research to evidence significant outcomes are illustrative of the tentative and emergent nature of spiritual care within contemporary nursing practice. Furthermore, the concept highlights the current limitations faced by nurses striving to provide spiritual care, as they must rely on broad and general guidelines without specific clarification regarding the practical implications and potential outcomes of their contributions.

Perhaps as a consequence of this ambiguity and the relatively recent emergence of the spiritual care agenda, we also commonly see general hesitation among nurses when it comes to the provision of spiritual care, according to the Royal College of Nursing (RCN), a membership organisation, trade union and nursing professional body, required to deliver high-quality patient care in their role (RCN, 2011b, 2017b). The implementation of an understanding of spirituality and the provision of spiritual care has the potential to benefit various stakeholders, including the NHS, private healthcare organisations, nurses caring for diverse patient populations, patients themselves, and their families. However, the fact is that the concepts of spirituality and spiritual care are sometimes regarded as potentially fraught and challenging because of the ambiguous nature of their meaning and application, and tend to be excluded or a neglected element of delivering quality care. Three possible reasons for this may be that: nurses may lack confidence to support its delivery (Sartori, 2010); there may be patients who will only engage in clinically focused discussions and will not participate in dialogue that is outside their medical requirements; and/or that some patients will be non-receptive to such discussions and might even regard them as intrusive. Thus Timmins et al. (2015, p.490) assert that in a complex and multifaith society: 'nurses' lack of education in this area, means that nurses, when faced with patients' spiritual needs, may find themselves at a loss.' Similarly, McSherry and Jamieson (2011, p.1765) consider that: 'Educational preparedness was a major concern with many nurses, indicating that they feel inadequately prepared to deal with spiritual issues', while Rogers and Wattis (2015, p.51) suggest: 'Spirituality is an important aspect of holistic care that is frequently overlooked. This is because of difficulties in conceptualising spirituality and confusion about how it should be integrated into nursing care.' The first two quotes centre more upon education deficits whilst the third one, perhaps more interestingly, suggests the challenges of conceptualising and integrating.

Even in the event that the provision of spiritual care is being carried out in healthcare, there is as yet limited clarification on the provision of spiritual care and what outcomes would be expected from it. In a review of literature on the provision of spiritual care that summarises nurses' perspective about their role, the RCN (2011b, p.27) reports that 'there is an acceptance and endorsement that spirituality is an essential and integral part of their role and duty of care'. However, in discussing the benefit of this professional attitude, they stated that they 'still feel hesitant and lack confidence in dealing with spiritual issues' (RCN, 2011b, p.27). Equally, another study on spirituality and the implementation of spiritual care reinforces the significance of spirituality and spiritual care for patients and argues for the importance of educational development that is 'explicit

and continuous throughout nursing programmes' to develop nursing competence (Cone and Giske, 2013, p.1952).

The epigraph at the beginning of this chapter reflects the uncertainty around the provision of spiritual care by healthcare professionals in the UK's healthcare system. Nurses working within the UK have been presented with the notion by the nursing community and professional body that there is an underlying connection between the provision of spiritual care, quality care and improved patient wellbeing. However, the nursing community has not as yet been adequately explicit about how nurses might deliver this, what the provision of spiritual care entails and how the possible outcomes can be achieved. Moreover, such guidance as does exist, tends to be directed at nurses working in hospital settings or hospices and other palliative care settings (see further Chapter Two) excluding nurses such as those working in GP practices, the constituency under focus in the current study. This lack of certainty requires attention if nurses are to trust in the effectiveness of the approaches they use and if the spiritual dimensions of person-centred care are indeed to be harnessed as an important part of the role of healthcare professionals.

In order to address this uncertainty as to how the provision of spiritual care might be delivered, what this delivery might entail, and what possible outcomes might ensue, it is reasonable to anticipate that there must be appropriate primary research on the question as a preliminary to providing educational and professional development initiatives to support and develop practitioners to engage with this emerging agenda. Qualitative studies can be conducted to examine nurses' confidence and level of comfort in providing spiritual care. Additionally, comparative studies can explore the effects of well-defined professional development programs on spirituality and spiritual care, while considering various training approaches. These research endeavours have the potential to create supportive professional development contexts that enable nurses to cultivate deeper understandings of what it means to provide spiritual care. In turn these studies could enable nurse-educators to make informed choices about how best to address spirituality and spiritual care in their programmes. However, even in studies where the primary objective is to investigate the provision of spiritual care, which often investigates nurses and nursing students in general, sources of information about primary research in general practice are evidently lacking (Vermandere et al., 2011). Thus, even though the nursing community acknowledges the need to address spirituality and spiritual care in nursing, the lack of educational information on how this could be implemented in general practice may be due to an avoidance of understanding these concepts.

All of the foregoing issues are particularly salient in the case of the professional group forming the subject of this study: GP nurses. There are approximately 24,000 registered nurses working in GP practices (NHS, 2020). This number is a growing one since recent government policy would require an increase in GP nurses (NHS England, 2017b). The NHS aims to increase this number to help provide more care closer to home, and to make up the shortfall of GP nurses expected to leave their post in 2020 because of an expressed intention to retire (approximately a third of GP nurses) (Bradby and McCallum, 2015). GP nurses routinely deliver personal care to a registered list of patients with different demographics who present a variety of conditions, in 'a growing and ageing population with multiple complex health conditions' (NHS England, 2017b, p.4). Therefore, according to Bradby and McCallum (2015, p.33), GP nurses have the wide-ranging potential to fill the requirements of the UK healthcare population: 'in promoting health, supported self-care, illness prevention, early identification of health issues, referral to other services, management of long-term conditions, and holistic support for the individual, family and carer.'

The vital role of GP nurses in the UK underscores the importance of nurturing and advancing this specialised professional group within the nursing workforce, while recognising the unique demands and dynamics of the GP setting. The (NHS England, 2017b, p.5) describes general practice as the 'largest branch of healthcare and [the NHS] is admired around the world.' Thus, the GP nurse as a nurse working in general practice is not a nursing anomaly of interest to only GP practices. The development of GP nurses is an essential part of nursing care in the UK. GP nurses have the responsibility of managing care in the community (NHS England, 2017a), yet knowledge about their work is more generally associated with the work of nurses employed in hospitals (Marshall, 2015) as there appears to be little research about GP nurses. Despite recognising the existing challenges in healthcare practices regarding spirituality and spiritual care as documented in literature and research studies (Koenig, 2012), the current body of literature on spiritual care provision indicates a lack of specific guidance on how GP nurses and other GP staff can conceptualise and effectively fulfil their responsibilities in delivering spiritual care (Vermandere et al., 2011). In the case of GP nurses as a research population, there are no substantive studies of these questions at all (see further Chapter Two). This absolute absence of commentary on GP nurses in particular indicates that researchers are yet to examine comprehensively how GP nurses could deliver quality, person-centred care to meet patients' spiritual needs as a fundamental part of their role.

GP nurses thus operate in a context where they are increasingly expected to engage with notions of spirituality and to practise with the understanding and knowledge to effectively address their patients' care needs. The provision of spiritual care for some patients will be profoundly determined by how well GP nurses understand their care needs and how well they are able to address those needs. Assuming, as has been proposed, that the provision of spiritual care is 'clinically relevant' and that general practice is devoted to delivering care which is centred around the patient (Hvidt et al., 2016, p.385), it is reasonable to propose that the provision of spiritual care in general practice should help patients receive quality, person-centred care, which in turn implies that all GP nurses and their patients stand to gain from how this can be achieved.

The aim of this current study is thus to look at GP nurses' perceptions and practices of spirituality and spiritual care in order to address this knowledge gap. It is hoped that in addition to gaining insights on GP nurses' perceptions and experiences, a number of implications for professional development can be identified to help GP nurses develop this dimension of their practice. While GP nurses are diverse individuals, their provision of spiritual care is required to transcend different cultures, beliefs and experiences within a diverse UK population. Thus, provisions that could enable them to develop this aspect of their role could potentially aid them in providing greater patient care.

As we shall see in the literature review that forms the subject of Chapter Two, most of the existing literature on nurses and spirituality primarily focuses on the traditional model of hospital-based adult branch nurses, assuming it as the standard norm, considering all nurses as one homogenous group, for example research conducted by the RCN in 2010 (RCN, 2011b) examining the provision of spiritual care by nurses. By concentrating on nursing issues in this way, it implicitly assumes that all nurses face the same issues or have the same concerns. Furthermore, concerns relating to particular dominant groups of nurses, such as managers, hospital staff, and specialists tend to over-shadow the concerns raised by nurses delivering care in general practice (Marshall, 2015). In response to this lacuna in the literature, this study aims to give substantive consideration to GP nurses' perceptions and practices in the spirituality and spiritual care debate by looking at patterns or commonalities in their provision of spiritual care.

In addressing these research questions, this study explores the tension between GP nurses' knowledge of spirituality and spiritual care, which is shaped by their personal beliefs and interactions with patients. It also investigates the impact of these beliefs and interactions on GP nurses' practices and level of confidence in providing spiritual care. Chapter Two reviews literature on spirituality and spiritual care in healthcare. It chronicles

the origins of contemporary conceptions of spirituality by providing an outline of the different stages of organised healthcare, which began with changes to the large, religious institutions that were providing healthcare in the 1700s, and goes on to include the development of general practice and thus locally run GP practices to date (Goodwin et al., 2011). This is to further place the study in the context of healthcare, and to highlight the different ways that GP nurses are involved, or not, in the delivery of healthcare initiatives. Chapter Three is the methodology chapter which sets out the theoretical framework and presents the research questions resulting from the gap identified in the literature. It specifies that this study is carried out with a GP nurse population in one of the NHS regions in the UK. This mixed methods study incorporates both quantitative and qualitative data to examine the perceptions and practices of GP nurses regarding the provision of spiritual care. The quantitative data focuses on the perceptions of GP nurses, while the qualitative data primarily explores their actual practices. The study aims to investigate the relationship between GP nurses' confidence in delivering spiritual care and the influence of the general practice context on their practices. By utilising both quantitative and qualitative approaches, a comprehensive understanding of the subject matter can be achieved. Bhaskar's theory of critical realism is applied to explain the connection between GP nurses' practices, generated from personal experiences and beliefs, and their awareness of organisational directives, and is used as an illuminating frame of reference for analysing the data. In addition, the chapter provides a justification and rationale for the chosen study design. In Chapter Four, the findings and analyses of the quantitative and qualitative data are first presented separately before being combined and interpreted as a whole. The chapter concludes by surmising five influential dimensions that GP nurses' use in the provision of spiritual care. Chapter Five considers how far these dimensions align or contrast with extant research from the literature to address how GP nurses' beliefs and organisational factors affect their practices and confidence. In addition, the analysis of the findings, based on socio-cultural factors, considers how far these findings enable us to address the research questions when considered in dialogue with Bhaskarian critical realism. Finally, based on the analysis of the findings in the general practice context, the implications suggest the need for further research to identify the educational needs of nurses in order to improve spiritual care provision. This research would enable the development of tailored recommendations for spiritual care education specifically designed for GP nurses.

Summary

The debate about spirituality and spiritual care in healthcare raises timely questions about what constitutes person-centred and holistic care in the UK in the twenty-first century. The general practice context was fundamental in shaping the focus of this study,

by prompting questions about what the perceptions of spiritual care are, what might be required in the provision of spiritual care, how it might be created, who could find it useful, and the potential influence organisational directives might have in developing those perceptions and practices. The aims of the study having been established in this chapter, the following chapter presents a literature review that researches current healthcare and academic understandings of these questions.

Chapter Two: Literature Review

Introduction

This chapter aims to provide a comprehensive overview of the current and dominant perceptions of spiritual care amongst healthcare professionals as expressed in the literature. Furthermore, the chapter considers whether extant literature offers insight into the spiritual care practices of GP nurses in the UK to determine possible development needs in the provision of spiritual care. The chapter is comprised of three main parts: part 1 outlines the concept of spiritual care and its historical affiliations with religion in healthcare, as well as providing an outline of the historical shift from healthcare in large, religious institutions to locally run GP practices in a more secular society. Part 2 presents an exploration of the concepts of spirituality and spiritual care, drawing upon a thorough review of the most current literature reviews and surveys of the field of spirituality in healthcare (NHS Education for Scotland, 2009; RCN, 2011b; Appleby, Wilson and Swinton, 2018), the parameters of the literature search were established. With these parameters established, part 3 provides a more focused literature search strategy and selected research around spiritual care, nursing and general practice. The chapter then outlines the evolution of care towards a person-centred approach, and the ways in which GP nurses are involved, or not, in the delivery of healthcare initiatives.

Part 1: Development of Healthcare

There is evidence that suggests that historically, spiritual care has been understood in different ways within healthcare (Koenig, 2012). However, debates over spiritual care in healthcare (Swinton, 2006) have recently brought about an increased focus on concerns about increasing secularisation (Paley, 2008) and the decline in traditional religious customs, such as attending church (Carr, 2001). While some cross-sector insights might be yielded by exploring spiritual dimensions of practice in other professions (for example, Mthembu, Roman and Wegner (2015) on Higher Education or Senreich (2013) on Social Work), perhaps the best means of gaining a more nuanced picture of the role of spiritual care in modern day healthcare is by broadening our awareness of the history of healthcare. This chapter aims to explore the historical roots of spiritual care within nursing in order to get a better picture of the shift from a specifically Christian-influenced practice of spiritual care to a broader, more contemporary interpretation.

The first documented nursing care in the British Isles has ecclesiastical and monastic origins, having been provided by monks and nuns (Koenig, 2012). Christian values were integral in the provision of care for the sick, with an emphasis on spiritual rather than physical care, and, from the beginning, one of the main purposes of these groups was

the moving of care outside of the family circle (Bradshaw, 2000). Nurses would provide food and water, including prayer, as social and cultural conceptions of illness and disease were seen as the work of demons and spirits (Mohr and Huguelet, 2004). Religious groups remained the only providers of organised and systematic care up until the 1700s (Greenstreet, 1999). However, in the first half of the eighteenth century, more scientific investigations and models of illness emerged, which posed a secular challenge to the established treatment of care (Greenstreet, 1999).

For centuries, the links between religion and nursing care were generally accepted without question, however, the Enlightenment age, which began in the seventeenth and eighteenth centuries, was marked by a trust in science, focus on the value of reason and increasing contestation of traditional religious principles (Greenstreet, 1999). Yet an overtly faith-based approach to care was to endure well into the nineteenth century due to the need for a broader religious discourse which incorporated religious and non-religious beliefs. Florence Nightingale, a devout Christian who believed that her calling from God was to be a nurse, became renowned for leading nurses in the Crimean War (Dunphy, 2010). An explicit sense of Christian mission and ministry guided Nightingale in her work and so she was an advocate of the provision of spiritual care, albeit of a particular doctrinal tradition (McDonald, 2019). Due to the changing nature of warfare and political organisation in Europe, Nightingale was put in charge of nursing care in the Crimean War (1854–1856). In order to provide sufficient care, she needed to recruit many women as nurses; although Nightingale was accredited with incorporating clear spiritual values in nursing practice with scientific principles (Macrae, 1995), she was also influential in secularising nursing.

The establishment of the Florence Nightingale nursing school at St Thomas Hospital London in 1860, heralded a shift to secularise nursing to meet this shortage (McDonald, 2019) with the potential for further new nursing schools to be set up (RCN 2017a). Florence's school was to be opened to women of any faith or no faith; despite recruiting different types of women, nursing schools were respected because of their focus on the moral development of their students (McDonald, 2019). In addition, the school had a curriculum based on practical experiences taught by fully trained nurses to bring the 'true nursing outlook' (Bradshaw, 2000, p.322). However, whilst Nightingale created the first nursing school in England to permit women to train and work as nurses, these women were expected to possess a 'character' based on Judeo-Christian ethics and morals (Greenstreet, 1999, p.652). These requirements helped to alleviate concerns relating to whether women could be deemed suitable to work as a nurse if they did not have a faith (Greenstreet, 1999). Although this appears to be a broadly non-denominational/humanistic approach, in reality it remains firmly linked to Judeo-Christian

beliefs as a framing of spirituality. Furthermore, the foundation of the General Nursing Council and introduction of the Nurses Registration Act in 1919, together sought to further regulate nurse training in England and Wales to improve standards for educational development in nursing courses (Bradshaw, 2000). Nursing was once characterised as an unsuitable job for women of stature. The nursing role was viewed as a job rather than a profession, which as a profession would have carried a status of superiority and importance within a division of work (McEwen, 2019). However, Nightingale's fame, along with standardised nurse training, examination and the opportunity to gain the professional qualification of State Registered Nurse, nursing began to be seen as a suitable job for women (RCN, 2017a). This was accomplished by the introduction of a national training syllabus, which expressed clear attainable and measurable competency standards and examinations, and which candidates would be certified as having a good character as well as having gained experience of nursing the sick (Bradshaw, 2000).

From the late nineteenth to the late twentieth century, nurses played a vitally important role in the care of the sick. The outbreak of war during this period (1914-1918 and 1939-1945) saw nurses playing a crucial role in caring for wounded soldiers. Many nurses were required to take personal risks to provide care and a number of them died doing so (Birkwood, 2018).The necessity to carry out key tasks, for instance removing pieces of shrapnel and carrying out minor surgical procedures, meant that the role of nurse became temporarily blurred (Birkwood, 2018). It is likely that the pressures of war and the urgency to save life meant that this became the immediate priority and led to a diminished emphasis on spiritual care in healthcare. Advances in technology and in medicine increased life expectancy and shifted the focus from 'a caring, service-oriented model to a technological, cure-oriented model' (Puchalski, 2001, p.352). The literature suggests healthcare interventions focused more on the pathological and clinical facets of care and less on the personal aspect. Despite this, nurses remained widely, and suggestively for our topic. Their strength in attending to patients during wartime, particularly wounded soldiers in field hospitals close to the frontline (Birkwood, 2018), meant nurses continued to be portrayed as 'angels' (a term used since the Crimean war), maintaining their roles as compassionate carers of others, and improving patient care (RCN, 2017a). By contrast, mid-twentieth century cinema, television and other media increasingly portrayed nurses as, for example, a 'naughty nurse' or the tyrannical 'battle-axe', and nursing was stereotyped as 'women's work' (RCN, 2017a, p.4).

Spiritual dimensions of healthcare again received increasing attention from the 1980s, in an era of postmodernism, which increasingly questioned the assumption that modern

science has absolute knowledge (Weinblatt and Avrech-Bar, 2001). An increased questioning of medical discourses accompanied the postmodernist proposed that individuals largely construct their own truth. Healthcare in postmodern Britain questioned assumptions relevant to health and medicine, arguing that 'doctors tried to force their truths on patients who just have a truth of their own' (Weinblatt and Avrech-Bar, 2001, p.166). Whilst the scientific approaches and paradigms were considered beneficial for investigating some aspects of healthcare, many healthcare professionals increasingly argued for the importance of balancing care to serve the whole person (physical, emotional, spiritual, mental, social, and environmental needs (NHS England, 2016a)) as a necessary part of the healing process, as well as an expansion of the patient-professional relationship (Puchalski, 2001).

This importance led to a structured review of the NHS in the late 1990s and the creation of a new nationwide healthcare strategy (Greengross et al., 1999). The subsequent implementation of the framework's key principles saw a drive towards improving care by locating it increasingly in the community, and promoting local responsibility for leading the delivery of care (Greengross et al., 1999). Primary Care Groups and Trusts (PCG/T) were established in the 2000s as a result of significant upheaval. The aim of these new organisations was to reform the NHS by bringing together local health providers within the primary care remit such as GP practices and community health services (Glendinning and Dowling, 2003). Previously, GP practices could opt out of new reforms, however, this new approach made PCG/Ts responsible for the local commissioning (procurement and planning) of services including those in GP practices (Glendinning and Dowling, 2003). Consequently, a new relationship was established under the 'GP contract' which brought changes to GP workloads and provided GP practices with cash incentives based on working relationships with other local health providers (The *Guardian*, 2003; Department of Health (DH), 2004, p10). This initiative could arguably be seen as to anticipate the location of person-centred care at the GP practice level as there was already a move to establish care that incorporated different aspects of patients' wellbeing.

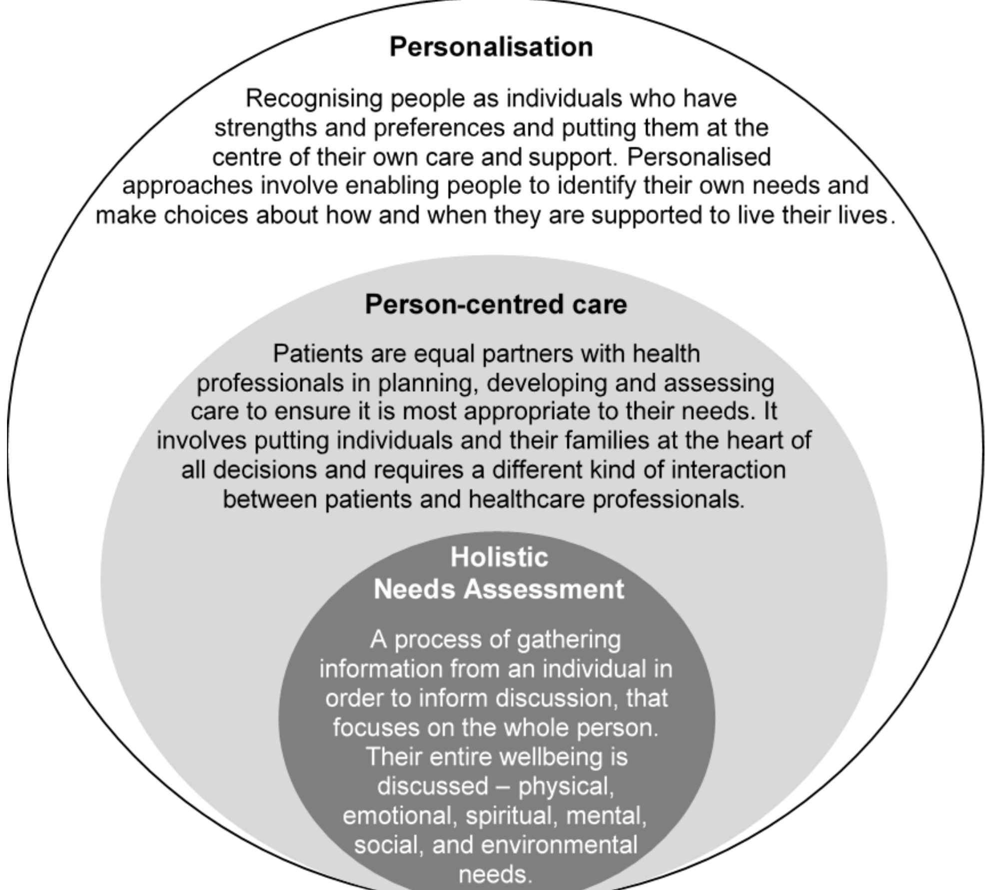
General Practice in Healthcare

Our compressed historical overview of spiritual dimensions of healthcare thus brings us to consider the current situation in general practice, where spiritual considerations increasingly feature as part of the wider discourse on care quality and personalisation of provision. The evolving nature of general practice (as a core element of primary care) has resulted in a model whereby what was once independent practitioners working from home now effectively operate as multidisciplinary businesses based in local health

centres (Baird, et al., 2018). Despite the significant changes to general practice in the UK at the beginning of the 21st Century, in 2008, Lord Darzi carried out a review of the NHS and made recommendations on how to drive improvements in the quality of care, highlighting the need to move from a 'focus on increasing the quantity of care to one that focuses on improving the quality of care' (DH, 2008, p.8). According to Griffiths et al. (2010), quality of care in GP practices is reliant on the size of the GP practice and the total number of full-time equivalent GP staff. Nonetheless, in 2004, the Quality and Outcomes Framework (QOF) (a voluntary reward and incentive programme for GP practices in England), was introduced to improve patient care.

With additional requirements to improve quality standards, the Care Quality Commission (CQC), an independent health and social care regulator, introduced the CQC's *Raising Standards, Putting People First Strategy for 2013 to 2016*; high-quality care became of national importance, with the need for both health and social care improvements, and patient involvement being cited as the main aims of the strategy (CQC, 2013). In order to improve services and patient care outcomes and experiences, NHS England (responsible for commissioning in England) showed commitment to meeting patients' needs with the introduction of the *Five-Year Forward View* (NHS England, 2014) strategy 2014–19. An aspect of the NHS's strategy was to create new care models, one of which was vanguards. Vanguards (individual organisations and partnerships) were funded to develop integrated primary and acute care systems, such as collaboration between GPs and hospitals, to promote patient care that is person-centred (NHS England, 2016a). In NHS England's (2016b, p.6) *Personalised Care and Support Planning Handbook*, long-term conditions, which cannot be cured, are said to 'be managed or improved through person-centred approaches', which are considered a cost-effective way to assist in addressing the requirements of a population that is ageing. Figure 1 identifies the relationship between different types of care referred to in this study.

Figure 1: Related key care terms (Taken from NHS England (2016b, p.29 & p.31))



During the last five years (2014–2019), the focus on delivering person-centred care, which focuses on the whole person — physical, emotional, spiritual, mental, social, and environmental needs (NHS England, 2016a) has remained a high priority, underpinned by claims that:

> Person-centred care supports people to develop the knowledge, skills and confidence they need to more effectively manage and make informed decisions about their own health and healthcare. (The Heart Foundation, 2016, p.3).

Although a lack of research has made establishing the impact of person-centred care on society or the effect on staff of implementing changes during 2015 and 2016 more difficult (Humphrey and Cleaver, 2018), in 2017, three years into the *NHS Five Year Forward View* (5YFV) plan, NHS England (2017a, p.4) set out *Next Steps*, 'a two-year health service improvement plan'. In order to assess progress of the 5YFV plan, the *Next Steps* recorded service performance, enabling NHS England (2017a) to produce data on the plan's performance in delivering care. Assessments were carried out in three key areas: better health, better care and financial sustainability (NHS England, 2017a).

While a robust case for such interventions was persuasively made, they have arguably resulted in the structure of general practice as being seen as unstable, demanding and critical, from that of 20 years ago (Baird et al., 2016). Changes within GP settings have resulted in added pressures for GP staff in relation to the NHS initiative to move care closer to home into general practice to relieve hospitals of patients with long-term conditions. Furthermore, GP nurses have additional pressures due to nurse shortages, lone-working and part-time working. Despite the many interventions and policy initiatives designed to introduce models of care in the UK, general practice is rarely involved in these initiatives. There is no routine public reporting of quality of care in GP practices (Marshall, 2015) and no standardised national dataset (Baird et al., 2016). The only accessible data is secondary analysis data which is limited and taken from restricted general practice clinical systems (Baird et al., 2016) or focused on the more governmentally charged hospital sector (Marshall, 2015). Furthermore, over recent decades, sporadic initiatives such as models of performance, community services and commissioning led by primary care groups, have arguably failed to offer a clear vision for care in general practice; they have 'failed to engage either healthcare professionals or the public with a coherent, comprehensive vision' (Marshall, 2015, p893). In order to achieve a clear vision for care, the NHS recognised the need to develop general practice and to expand its workforce.

GP Nurses in Healthcare

The necessity to develop general practice was also a principal theme of the *NHS Five Year Forward View* (5YFV) plan, and NHS England placed a particular emphasis on this policy platform by creating a *General Practice Forward View* planning document to support GP practices in delivering the 5YFV (NHS England, 2016c; While and Webley-Brown, 2017). In particular, NHS England argued that not only would the document lead in facilitating the expansion of the GP workforce, but that GP practices would also benefit from valuing GP nurses and the changes they can make in GP practice (While and Webley-Brown, 2017). This plan could lead to the employment, retention and return of GP nurses, to improve and deliver personal care, facilitating access to more care in the community (NHS England, 2017a).

As with healthcare, GP policy has, primarily, encompassed doctors and allied practitioners. However, the value and importance of GP nurses in GP practices has been increasingly recognised, primarily due to the complexity of the role; many are lone practitioners and work part-time, which adds to isolation in the role compared to many other nursing roles in other settings (While and Webley-Brown, 2017). In 2017, NHS

England developed a *Ten Point Action Plan* (10AP) specifically for GP nurses to enable them to hire and train a sufficient number of them to take on the challenges that lie ahead. The plan states that:

> GPNs [GP nurses] teams are a key component of the general practice workforce. They provide care and treatment across the life course and increasingly work in partnership with people with acute illness and with complex undifferentiated conditions. GPNs must be in the forefront of leading change by delivering better health outcomes in primary care, and by making primary care 'the place to be' for ambitious nurses who deliver world class care and support our population to live well (NHS England, 2017b, p.9).

Guidance on expanding the number of GP nurses emerged from nursing organisations in order to support GP practices. For example, the RCN has ensured that a variety of development programmes are available to all nurses who are new to general practice, such as employer-led inductions and continuous professional development (NHS England, 2017b).

However, this 10AP has arisen solely from the increasing awareness by the government of the advantages which can be achieved from valuing GP nurses. The 10AP has also arisen from a growing awareness that GP practices are key places within which to best manage an increasing and ageing population, many of whom have multiple complex health conditions (Walsh, 2017). Thus, the 10AP has been led by NHS England with the support of NHS Health Education England (HEE), a DH-sponsored non-departmental public organisation, who provide funding for the provision of healthcare as well as improvements for staff members working in public health and healthcare. NHS England have put strategies in place to 'develop confidence, capability and capacity in nursing', to attract new GP nurses, including facilitating greater support for existing GP nurses and, consequently, increase the number of GP nurses who return to GP practices (NHS England, 2017b, p.6).

However, of even greater importance to policymakers than the need to increase and retain the number of nurses, has been the growing fear that general practice is in crisis (Baird et al., 2016) and GP nurses may not be adequately prepared or trained to deliver the enhanced services of care now required in general practice (Walsh, 2017), for example long-term conditions (the management of health problems over several years) which present in about 50% of all GP practices' appointments (The King's Fund, 2019). This may be due in part to the isolation of many GP nurses in general practice many of whom are part-time, which means that they may miss out on opportunities for clinical supervision and mutual professional support (Walsh, 2017; While and Webley-Brown,

2017); this can cause some GP practices to perform poorly, for example in managing infection control (CQC, 2019). Improving patient experiences and healthcare outcomes are key elements of patient safety programmes and nursing competency to provide quality patient care, a key part of the RCN's nursing principles (2017b).

Despite the fact that worries about poorly or inadequately qualified medical staff are not new, they have drawn increasing attention since the Mid-Staffordshire NHS Foundation Trust inquiry, which found serious care failures and the need for fundamental change (NHS, 2013). Since then, and not surprisingly, nurses and other health and social care staff have been constantly in the news, and many discussions about 'failings' are now widespread: claims that there were 'inadequately trained staff who were too few in number' (*The Guardian*, 2013a), and that 'the system as a whole failed in its most essential duty – to protect patients from unacceptable risks of harm' (*The Psychologist*, 2014, p16), run alongside accusations that the 'public's trust in the NHS had been 'betrayed'' and a change of culture was needed to 'make sure that patients come first' (BBC, 2013), and that 'an institution which was supposed to care for the most vulnerable instead became a place of danger' (*The Telegraph*, 2013).

Increasingly, nursing staff including GP nurses, are presented as the possible reasons for poor care, rather than victims of an under-funded system (*The Guardian*, 2013b; Walsh, 2017). Professor Steve Field, Chief Inspector of General Practice for the CQC, stated in *The Guardian* (2014), GP practices are subject to several factors that negatively impact on practice and patient care. For example, the pressures of a stretched workforce, lack of effective leadership, and the lack of training and development (CQC, 2019). However, it is not only the media that is exacerbating fears about poor care in healthcare particularly by nurses. The CQC (2013) produced a report calling for improvements in standards of nursing care.

In response, healthcare organisations have reacted to what they regard as a profound period of change within health and social care by promoting a person-centred approach to care (NHS England, 2016b; The Heart Foundation, 2016; Baird et al., 2018): the NHS Long Term Plan (2019), which builds on the policy platform explained in the 5YFV, gives direction on workforce education and training. In this new climate of more holistic and person-centred care, the place of spiritual care is once again being considered and explored. However, spiritual care as a fundamental element of person-centred care (NHS Education for Scotland, 2009; McSherry and Jamieson, 2015) confuses and challenges many healthcare staff over its meaning and practical application (McSherry, 2007). In

order to delineate these critical concepts, there is a more detailed account of spirituality and spiritual care in the following section.

Part 2: Understanding the Concepts of Spirituality and Spiritual Care

Part 1 investigated some of the historical issues associated with spiritual care in healthcare. Part 2 investigates the concept of spirituality and the concept of spiritual care in healthcare. Additionally, there will be a brief consideration of the philosophy of science.

As we have seen, the UK has a strong history of spirituality in healthcare (RCN, 2017a); however, the concept of spirituality has frequently been associated with religion and religious beliefs and practices, particularly within the Christian tradition. This interchangeable usage has been observed in various contexts (Greenstreet, 1999; Narayanasamy and Owens, 2001). The term 'spirituality' has its etymological roots in the Latin word *spiritus*, which signifies the 'breath of life.' The concept of spirituality goes beyond the concepts of organised religious practice (Delgado, 2005), and relates to all patients, regardless of any avowed or espoused faith position (Koenig, 2012). Thus, the path to truly understanding its meaning indicates that it needs to be disassociated from religion. The significance of this attitude towards separating religion and spirituality might explain the reasons for the need in nursing/healthcare to introduce a terminology that embraces all aspects of spirituality, that considers modern and postmodern interpretations, and reflects what Carr (2001, p 21) refers to as a 'contemporary non-theistic spirituality'. Separating spirituality and religion may be a good idea, because the patient population that is likely to be present in a contemporary GP practice will arguably be a representation of a range of faiths and of none; thus, understanding the human condition takes more than science and a secular culture (Harris, 2015). The definitions used in the present study to describe spirituality and spiritual care are in the Conceptual Framework section in Chapter Three. However, in this section, other definitions have been included to show similarities and variations of the concepts most of which share common features such as the pursuit of meaning and purpose in life, a sense of connectedness to a higher power, and the experience of inner peace.

Spirituality can be comprehended as the individual and emotional dimension of establishing a connection with oneself, the surrounding environment, and a higher power (where appropriate, one's concept of the divine) (Koenig, 2012). It has an impact on underlying factors linked to motivations and resilience, leading to the cultivation of hope through a system of faith (Koenig, 2012). Spirituality can be seen as an integral part of a belief system that conceives of a ‘Divine Being, commonly referred to as God, that in fact exists independently of human perceptions and who is actively involved in human

existence' (Hodge, 2000, p.10). According to Pesut et al. (2008), religion and spirituality are connected as a transcendental force that develops virtues, such as compassion and tolerance in people (where tolerance is a value of liberal democracy as much as it is a spiritual value) so that they can relate to others in society. The definition which follows embraces spirituality, although it is not deployed in this study:

> Spirituality can be defined as the search for meaning and purpose in life, which may or may not relate to a belief in God or some form of higher power and/or by one's relationships with self, others or nature. For those with no conception of supernatural belief, spirituality may relate to the notion of a motivating force, which involves an integration of the dimensions of mind, body and spirit. (Johnston and Mayers, 2005, p.386)

In 2010, the RCN (RCN, 2011b) commissioned a survey that utilised the Spirituality and Spiritual Care Rating Scale (SSCRS), developed by Professor Wilf McSherry, to explore nurses' perceptions of spirituality and spiritual care. The survey succeeded in advancing knowledge of spirituality in nursing in two key ways: first, the findings helped to establish the Spirituality in Nursing Care: A Pocket Guide (RCN, 2011a) which presented the key ways available to nurses and policymakers for delivering spiritual care throughout the UK; and second, the findings identified research participants' opinions on spirituality and spiritual care in the UK. The RCN's (2011b) research found that broad and eclectic understandings of spirituality were clearly articulated among research participants from all nursing groups, while amongst some respondents, spirituality was deemed to stem from a religious belief and faith. Imposing their own personal faith and values were real concerns for many members, whilst some members also reported lacking confidence and feeling hesitant in managing spiritual considerations. In addition, some members called for further training and guidance, including greater confidence in addressing matters of spirituality. It is apparent from this study that professional development is required with the aim of increasing nurses' confidence in the provision of spiritual care.

In 2015, NHS England produced a document, drawing on evidence from practice, to promote pastoral and spiritual care. The document responds to both the need for guidance in managing the changes in UK society and the 'widening understanding of spiritual, religious and pastoral care' for chaplains and clinical leaders (NHS England, 2015, p.5). The resulting report noted the growing body of evidence linking spirituality and patient wellbeing, commenting that:

> The provision of chaplaincy in the NHS has historically favoured facilities offering inpatient care. As the NHS undergoes a process of transformation with renewed emphasis on primary care it is important to address pastoral, spiritual or religious needs in these settings (NHS England, 2015, p.20).

The report also points out:

> It is important to note that chaplains are not alone in providing pastoral or spiritual care and the nursing profession has a long established role in supporting the spiritual well-being of patients (NHS England, 2015, p.7).

At the same time as the NHS were reporting, the standards of proficiency for registered nurses were updated and published (January 2019), outlining the mandatory requirement of all nurses to take into account patients' spiritual needs (NMC, 2018). However, as detailed above, spirituality is often conflated with religion (for example in Oxhandler and Parrish, 2018) and, as such, can be confusing and challenging for nursing staff (McSherry and Jamieson, 2011). Palliative care nurses, in contrast, are increasingly represented as specialist in managing patients' spiritual needs; for example, *The Guardian* reported on the career of a nurse who specialised in palliative care within eighteen months of commencing her nursing career; she states:

> It is uncommon for newly qualified nurses to be attracted to the role. Traditionally, the specialism appeals to more experienced nurses who may be disillusioned with "high tech care" and want to get back in touch with the "art of nursing" (The Guardian, 2013c).

Research collated by Ross et al. (2014), summarising evidenced-based studies by nursing academics, highlighted the rising challenges in the provision of spiritual care, particularly, because of a lack of clarity in its meaning and application in developing competencies for practice. Despite two decades of policy and practice framed to promote spirituality to improve care, research suggests that the provision of spiritual care is still challenging many healthcare staff.

These challenges are, perhaps, greater for staff working in general practice than other healthcare settings due to shorter patient contact times. Furthermore, the historical concerns that GP nurses' have regarding staff shortages, pay and professional development suggest that they are further disadvantaged. Since the *Agenda for Change* (AfC) was implemented in 2004, GP nurses would receive performance-related pay in line with QOF (Ashwood et al., 2018). These contracts increased the percentage of GP nurses employed to care for an ever-growing management of long-term conditions in the general practice population. However, the majority of GP practices did not adopt the agreement leaving many GP nurses without a defined pay scale and forcing them to individually negotiate salary and terms and conditions (Ashwood et al., 2018). Therefore, since many GP nurses work for small, independent GP practices, it is perhaps unsurprising that their practices and experiences have been largely ignored or forgotten.

This suggests that if GP nurses' competences have been forgotten then development opportunities may well be scarce or overlooked. Research by the Queen's Nursing Institute (a registered charity committed to enhancing nursing care for patients in the community and at home) identified that 43.1% of GP nurses did not feel their team has sufficiently trained and qualified staff to meet patients' needs, furthermore, by 2020, approximately 33.4% of GP nurses are expected to retire (Bradby and McCallum, 2015). These findings are significant regarding patient care because according to the CQC's (2019) 'State of Care' annual assessment 2018/19, workforce problems directly impact patient care. As previously mentioned, the provision of spirituality is challenging so additional concerns regarding staff shortages and professional development have the potential of having an adverse effect on patient care particularly the spiritual aspect of person-centred care. In response to the new obligations outlined earlier, GP nurses must be confident, knowledgeable and have the necessary skills to assess spiritual care as part of person-centred care (NMC, 2018). Therefore, improving services and providing high quality, person-centred care, requires staff to be able to have access to professional development which focuses on their specific needs, and a workforce that is operating well CQC's (2019).

Part 3: Frontline Search Strategy

This part of the study examines a literature review of spirituality and spiritual care from which GP nurses' perceptions stem and how their practices in the provision of spiritual care have become the main driving force for patient care of the nation.

There is scant research on GP practices in general, and a variety of reasons that add to this dearth of research. In the UK, the Department of Health has long argued for the importance of improving patient care through research (Harrison, 2005). Since most care in the UK is provided by primary care and more specifically general practice (NHS England, 2017a), clearly there is the opportunity to make a significant improvement in the delivery of care to patients if more research is carried out in GP practices; the 'frontline' for the NHS (Williams et al., 2012). However, research in general practice is limited (Harrison, 2005), dominated by research carried out in hospitals (Graffy et al., 2009), and in particular, few have observed the organisational perspective of managing primary care at a local level (Harrison, 2005).

Within the literature, primary care staff are viewed, by the UK Department of Health, as having a critical role in 'increasing the amount of appropriate health services research and developing a research culture' (Harrison, 2005, p.185). A qualitative analysis by Harrison (2005, p.186) reported that particular groups of health and social care staff,

many of whom were primary care professionals, are confused by the term ‘research’, in that research is seen as not ‘quite the real world’, and/or routinely forms part of a postgraduate qualification. Research is also regarded as being an add-on activity rather than a fundamental part of daily work (Harrison, 2005). Perhaps, these perceptions of research by primary care staff are part of the reason there is little research on GP practices.

It is unsurprising, therefore, that primary care professionals, in particular, claim the value of ‘knowing from experience what to do’, characterising research as a pointless exercise where ‘the results are always changing’ (Harrison, 2005, p.186); choices are made based on the culture of the organisation (Graffy et al., 2009); or face opposition as staff are required to carry out research without protected time (Graffy et al., 2009). Nevertheless, despite the increasing challenges posed by a growing and ageing population with complex long-term conditions, limited research opportunities exist for certain general practice staff to actively engage in studies focusing on their roles and practices. Those who have participated have mainly been GPs and/or their patients (The Academy of Medical Sciences, 2009). Indeed, there has been little research conducted from one of the largest groups of GP staff, that of nurses.

Although there have been theoretical publications (for example Miner-Williams, 2006), there is little practice-based research. Where studies with GPs have taken place, they are mostly international (such as those discussed by Appleby, Wilson and Swinton, 2018). A possible reason for this is that many GP practices in the UK work independently and have a small number of staff so allocating time for research may not be feasible. However, this means that much research concentrates on the generalised subset of healthcare professionals and thus the voices and practices, for example, of GP nurses and doctors remain under-presented across general practice research literature.

As we have seen, the history of spiritual care in nursing has gone through various phases and it has resulted in the moving of the provision of care from within the family circle to external religious groups; there has been a change of focus from spiritual care to physical care, but attention is once again focused on the need for the provision of spiritual care particularly by nurses; and there are closer working relationships among healthcare professionals in an attempt to integrate and improve healthcare services in the UK.

In order to better comprehend the experiences of GP nurses in the provision of spiritual care, a search strategy, which involved a more comprehensive literature review, was undertaken of books, academic journals and governmental reports. Due to the difficulties with defining spirituality and its conflation with religious beliefs that were raised in this

literature review, it seemed possible that this might complicate the search terms. While every attempt has been made, as part of the search strategy, to take cognisance of the wider literature on spirituality and healthcare, so substantial is the field that the literature review necessarily had to be selective. The crucial thing was to capture all literature bearing on the specific GP nurse role in relation to spirituality - the wider context was acknowledged and explored where it directly impinged on GP nurse practice such as, holistic and person-centred care, but otherwise it had to be selective. As the review will reveal, research into questions of spiritual care in healthcare and the role of GP nurses is particularly neglected.

Database Searches

Acknowledging the significance of conducting a comprehensive literature review in research, as it can contribute to a deeper understanding of the subject matter under investigation, the initial step to defining the aims of this study effectively was to carry out electronic searches. Based on their data reviews pertaining to healthcare and nursing, a literature review and search within databases for this thesis were carried out in Cumulative Index to Nursing and Allied Health Literature (CINAHL) — a repository with a 'grey' literature database (dissertations, conference papers and publications not published in mainstream journals) and includes both international and national literature; British Nursing Database (BND) — a national nursing, community and midwifery database which incorporates some international journals; and PubMed — an extensive nursing and medical database which incorporates another global database, Medical Literature On-Line (MEDLINE).

Once the appropriate databases were identified, combinations of search terms (nurs* AND (spirituality OR spiritual care) AND (general practice OR family practice OR primary care OR health centre OR health center) were used in order to make the search strategy as comprehensive as possible and to enable studies relating to advanced nurse practitioners and international studies that use different terminology regarding family practices. As there was a good deal of literature yielded by the search, a further search was made this time with keywords and phrases to exclude student or pre-registration (pre-reg*) nurses. Searches were truncated with the use of an asterisk to the stem of a word to enable different endings to be identified. Additionally, Boolean operators 'and' and 'or' were included in different terms, see Appendix 1. All sources had to be in English and peer-reviewed in order to meet the inclusion requirements for all searches, and included articles and evidence based healthcare literature; I did not feel it necessary to restrict the date of the studies since my initial reading and hand search had confirmed there is little knowledge about spiritual care in GP settings (Vermandere et al., 2011).

Although the term ‘religion’ may have been conflated with spirituality in some studies, it was deemed not necessary to be included in the search. Religious studies would necessarily have been more focused on religion, and any studies that do refer to spirituality in healthcare would have been identified. In a similar way, the databases used in this study search the title as well as the contents of papers so the key search terms for this study would have been identified in papers that have creative or ambiguous titles. Nevertheless, during the search, several papers were excluded because they were duplicated on the different databases. Following a meticulous selection process, relevant papers were chosen based on their alignment with the research terms, and the abstracts were carefully examined to determine their suitability for inclusion in the review. While some papers initially appeared promising, they were later excluded due to their unsuitability or duplication. The outcomes of the search are presented in a PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) flow diagram, depicted in Figure 2, to provide a visual representation of the search process.

Figure 2: PRISMA flow diagram of selected studies

BND: 1693
CINAHL: 264
PubMed: 1079
Discarded 932
Discarded 192
Discarded 891
Results after a further search
Unsuitable or duplicates 760
Unsuitable or duplicates 70
Unsuitable or duplicates 188
Selected: 1
Selected: 2
Selected: 0
Total Selected: 3

These searches provided a variety of information. They identified previously investigated studies, data sources used by other researchers, and helped to identify a gap within the area of research that had not previously been investigated. Where research into the

practices of nurses and spiritual care exists, it investigates the perceptions and practices of nursing staff working in different environments such as acute care or palliative care as one homogeneous group (for example, RCN, 2011b), and nursing students (for example, Ross et al., 2014). Where general practice is specified at all in the literature, this is mainly in relation to the GPs themselves (for example, Baird et al., 2016; Humphrey and Cleaver, 2018), however, three studies were found relating to GP nurses. One was a multinational study (DeKoninck et al., 2016) which included both GP nurses and advanced nurses working in six countries and therefore, did not focus solely on GP nurses in the UK. The other two studies focused on advanced nurses in the UK (namely, Collins-McNeil et al., 2015; Rogers, Hargreaves and Wattis, 2020). In contrast to GP nurses, advanced nurses undergo additional training in clinical assessment, which encompasses skills such as comprehensive history-taking and physical examination, and thus have the advantage of being ‘uniquely positioned to harness the ambiguity and diversity of spiritual experience into guidelines, policy and practice toward enhancing patient care’ (Collins-McNeil et al., 2015, p. 75). Furthermore, GP nurses have different working patterns and different organisational directives, compared to nurses working in other environments, which might restrict or limit their practice, for example short patient contact times. These restrictions, usually specific to the general practice context, will have some degree of impact on GP nurses provision of care.

The literature review conducted for this study revealed a dearth of academic research addressing the perceptions and delivery of spiritual care in the context of general practice relating to GP nurses in the UK as a specific population. I was only able to find studies which explored the understanding and practices of GPs, which were mostly studies from outside of the UK (such as Appleby, Wilson and Swinton, 2018), or advanced nurses in the UK (Collins-McNeil et al., 2015; Rogers, Hargreaves and Wattis, 2020) or a combination of both advanced nurses and GP nurses in a multinational study (DeKoninck et al., 2016). The results from the search are shown in Appendix 1. In contrast, most of the studies identified pertaining to spiritual care in nursing, related to spiritual care incorporating all groups of nursing staff working in different environments: while this may have included GP nurses, findings were reported synoptically and were not disaggregated by nursing branch, specialism or setting. Martins, Romeiro and Caldeira (2017) also recognised the dominance of a limited number of publications within the field, and a brief review of this literature is warranted as context for the present study’s specific research with UK only based GP nurse population.

Research on the Provision of Spiritual Care by Nurses in General

Evidently, no research has been conducted that focuses on the experiences and practices of UK based GP nurses in the provision of spiritual care. The RCN's (2011b) report on spiritual care found that of member respondents, which includes GP nurses: 95% considered that the quality of nursing care is enhanced by providing spiritual care, more than 95% said they had come in contact with a patient who had needs that were of a spiritual nature during nursing practice and a significant majority of the respondents (more than 92%) expressed the sentiment that they were often unable to fulfil the spiritual needs of their patients. Furthermore, regarding the spiritual element in patient care, most respondents stated that they needed further instruction and training (RCN, 2011b; McSherry and Jamieson, 2015). Whilst the study incorporated nurses from different groups and had a low response rate of 1%, the total number of members that completed the survey was 4,054. This report demonstrates that amongst respondents, there is at least some evidence which highlights that some nurses believe spiritual care is essential to delivering quality care and identifies the need for training.

It is not clear from the report what percentage of the findings relate specifically to GP nurses. In fact, little is understood with regard to the spiritual care provided by GP nurses, how the general practice context impacts on their practices, and the implication of their practices for GP settings. This may, in part, be because GP nurses are a less easily accessible group than nurses that work in a large working environment for example, in hospitals, particularly since many of them work part-time and alone. Furthermore, as stated by Perfect (2011), discerning an individual's spirituality is more difficult than if we were aiming to establish other characteristics such as their gender. According to Delgado (2005), some definitions of spirituality may be influenced in part by social and cultural environments that some would call 'spiritual' even though they include religious beliefs and practices for example, a definition that describes the universe as being created by God but would disregard Buddhism, a non-theistic religion.

The absence of research may be due to the fact that spirituality is often identified, not as a part of connected systems, but as a connecting category that can be easily changed or formed by people depending on context, not in its own standalone category, such as those used in intersectional research for example, religion and spirituality. In consequence, as Delgado (2005, p.157) states:

> The interaction of multiple systems creates holism [...] [which is] more than the sum of many parts, and differs from wholism which suggests an aggregate of their subsystems, or the whole of their constituent parts.

And as Greenstreet (1999, p.649) argues:

> Contemporary nursing philosophy embracing holism demands that nurses learn the appropriate skills to enable them to provide care in all domains, including the spiritual.

The reason might also be, in part, due to the NHS commitment to person-centred care within healthcare services. Most of the studies reviewed for this chapter were conducted on what researchers perceive as the important connection between spirituality and health (Narayanasamy and Owens, 2001; Weinblatt and Avrech-Bar, 2001; Delgado, 2005), to increase awareness and understanding of the concept of spirituality and the concept of spiritual care (Withers et al., 2017), or as a way to promote the voices of healthcare staff, for example Appleby, Wilson and Swinton's (2018, p.1108) research with GP staff, where the rationale for carrying out a literature review is that:

> Guidance for medical staff reminds employees of the responsibility to deliver spiritual care in its broadest sense [...] This is no small or simple task, and although GPs (family practitioners) have been encouraged to deliver spiritual care, we suggest this is proving to be challenging and needs further careful debate.

Conducting research that focuses on healthcare staff in general and aims to address the concepts of spirituality and spiritual care, as well as incorporating staff voices, is considered an appropriate and valuable approach to increasing awareness of the link between spirituality and health, the same investigators may not feel the same about carrying out research specifically with staff in GP settings, described the 'jewel in the NHS crown' (Roland and Everington, 2016, p.1). For some academics, carrying out research in GP settings means that recruitment can vary and can be a burden to GP staff (Graffy et al., 2009). Carrying out research with GP nurses would give validity to their views on the concept of spiritual care; instead, rather than investigating the perspectives and practices of all types of nursing staff working in different healthcare environments, GP nurses' perceptions and practices ought to be considered by academics as a voice for one of the largest groups of GP staff (Roland and Everington, 2016).

Nonetheless, the limited number of studies into the perceptions and practices of GP nurses is a habitual oversight of an increasingly important dimension of healthcare. Other possible reasons why GP nurses are understudied could be because they are less visible as they often work alone and part-time or they might be less valued. The role of a nurse is seen as 'women's work' (RCN, 2017a, p.4) which is stereotyped as supportive, and helps other members of the team (Peters, 2017) and thus arguably appears less important or interesting. As highlighted above, for many GP nurses, their perceptions and provision of spiritual care may not be wholly positive; their views will continue to

remain unheard, and for many GP nurses, spirituality is potentially confusing. However, as with other groups of healthcare staff, spirituality is of as much importance in delivering high quality person-centred care as the mental, physical, cognitive, behavioural and social aspects of care (NMC, 2019). For example in the RCN (2011b) research, data indicated that 83% of nurses described spirituality and spiritual care as the principal elements of nursing care; Strack et al.'s, (2002, p.16) research also highlighted the importance of spiritual care to healthcare leaders, highlighting that 'effective leaders use their spiritual wisdom, intelligence, and power to benefit others and achieve outstanding results for the organisation'; whilst undergraduate nurses in Ross et al.'s, (2014, p.701) study, for the most part, defined themselves not in terms of spirituality but the specific faith tradition of Christianity, and 'held a broad view of spirituality and spiritual care, and they perceived themselves to be competent in the provision of spiritual care, particularly in the humanistic aspects'. Thus, it is crucial for nurses to recognise the expanding scope of patients' needs encompassed within the concepts of spirituality and spiritual care, which have become more diverse over time. With the nursing population consisting of individuals with varied religious and non-religious beliefs, it is important to ensure that such diversity does not compromise the quality of care, including spiritual care, provided to patients, even within an increasingly secular society.

The lack of research means, however, little is understood regarding the perceptions and provision of spiritual care by GP nurses; little is known about whether, in a more secular society, the provision of spiritual care and the GP setting conflict, or how this might impact on the work of GP nurses in GP practices in a more secularised UK population; and, little is known about the implications of their practices for GP settings.

Gaps in the Existing Literature

The preceding review of literature has established four gaps within the discourses relating to general practice, spiritual care, GP nurses in the UK, and training and guidance: first, despite spirituality being considered an increasingly important part of GP nurses' role, this aspect of their role has been either forgotten, overlooked, or considered less important than other clinical aspects of care; second, even though a growing body of evidence suggesting that GP nurses acknowledge the significance of spiritual care in their practice, the voices of GP nurses are predominantly silent, and little is known about their practices; third, although the role of spiritual care in healthcare is of increasing interest, the practices and experiences of GP nurses are rarely used as evidence for policy-makers; and fourth, despite growing evidence that some nurses lack confidence in the provision of spiritual care, there appears to be little training or guidance available for GP nurses and no resources specifically available for them.

Therefore, evidence has identified the need for specialised, practice-based research (Martins, Romeiro and Caldeira, 2017), in the context of nurses in general practice, because they are an under-researched population, to give them a voice that presents a clearer understanding of their perceptions and practices in the provision of spiritual care. Thus, the aims of this study are to investigate GP nurses' perceptions of spiritual care; to identify how the context of general practice impacts on their provision of spiritual care; to explore patterns or commonalities in their practices; and, to determine the implications of these practices for GP settings within the UK. From the data, it is hoped that implications for professional development can be identified to help GP nurses in their provision of spiritual care.

Summary

This chapter provided an overview of spirituality in healthcare along with the place that GP nurses occupy within it. The main findings from the literature review identified that GP nurses often find themselves being forgotten or ignored within the healthcare system, highlighting the significance of their awareness, understanding, and proficiency in addressing spirituality and spiritual care in order to promote patient well-being. Furthermore, the chapter emphasised the fact that research into their practices is sparse, it puts forward possible reasons for this, and ascertained the necessity for more research into the perceptions and provision of spiritual care by GP nurses.

To accomplish my aims of understanding, rather than merely reporting, the practices of GP nurses, my research needed to be based within a theoretical framework. In the chapter that follows, I outline three conceptual and theoretical frameworks which have been applied to studies investigating spiritual care, before justifying my final decision of using Bhaskar's critical realism theory. Therefore, in Chapter Three, the research methodology and data collection tools are established helping me to realise my research aims and questions with the use of critical realism.

Chapter Three: Methodology

Introduction

Following on from the literature review, this chapter consists of three parts that provide an account of the methodology adopted in this study. Part 1 starts by describing the theoretical framework that was adopted early in the research design process in recognition that only a highly theorised approach to understanding experience could elicit rich insights on GP Nurses' engagement with spiritual conceptions of care.

Accordingly, in choosing the most suitable approach, there were three important considerations: first, could an investigation into GP nurses' perceptions and practices in the provision of spiritual care be made; second, would it be possible investigate how the general practice setting impacts GP nurses' practices; and, third, would it be possible to identify the implications of GP nurses' practices for GP settings? Of the number of theoretical approaches which could have been applied, Bhaskar's (2008) notion of a stratified reality was selected as the appropriate tool in helping to conceptualise the project and interpret my findings, and to achieve the reseach's aims; the chapter continues by outlining the reasons for this choice.

Part 2 identifies the research questions and presents a conceptual framework which underpins the research aims and the questions. In part 3, the mixed method section, I explain why I chose to use this approach as the most suitable methodology including the reasons for using an online questionnaire and semi-structured interviews as data collection methods; in addition, I review the challenges and tensions I confronted in establishing my research methodology. I introduce the research site and the sample population (39 respondents, ten of which went on to participate in interviews) to contextualise my research, and I explain why I applied a thematic analysis approach to my research, within the theoretical framework, in order to accomplish the study's aims and address the research questions. Furthermore, I outline issues arising from ethical and methodological considerations, including my approach to dealing with concerns of complexity, understanding and representation to make sure that the reported views and practices of GP nurses are appropriately portrayed. At the end of the chapter, I describe my process of analysing and presenting GP nurses' perceptions and provision of spiritual care.

Part 1: Theorising Spiritual Care in Healthcare

This current investigation aims to collect data which could help in addressing these research considerations. Consequently, different models of nursing were considered in

order to establish the perceptions and practices of GP nurses. For example, according to Peplau, nursing-client relationships are at the heart of interpersonal relations theory with the aim of nursing to ‘promote forward movement of personality in the direction of creative, constructive, productive, personal, and community living’ (McCarthy and Aquino-Russell, 2009, p34). Essentially, Peplau’s theory focuses on the therapeutic effects that nurses’ conversations could have on patients’ wellbeing. This includes nurses’ self-reflection and self-awareness of their participation in the relationship, but also the expectation of patients to reflect on their own thoughts and feelings; effectively, the nurse’s ultimate aim is to support the patient’s wellbeing and health (McCarthy and Aquino-Russell, 2009). This theory has been interestingly applied by Deane and Fain (2015) in a study of nursing students understanding holistic communication skills and by Hagerty et al. (2017) in a study of nursing’s contribution to the experiences of hospitalised patients. Thus, Peplau’s theory has been used to explore the nurse-patient relation through conversation. However, despite the fact that the theory as a possible framework could assist in educating nurses in holistic communication (for example Deane and Fain, 2015), this study seeks to investigate GP nurses’ perceptions and practices in the provision of spiritual care within the context of general practice rather than looking at how to build a nurse-patient relationship. The idea was to discern what is being carried out in practice rather than looking at implementing new theories in practice.

Parse’s Humanbecoming Theory (PHT) refers to the idea that the patient’s perspective of the quality of their life is the main focus in nursing. Coined by Rosemary Parse in 1981, the original purpose of PHT was to confront the proposition that practices and knowledge in nursing tend to lack a theory grounded in human sciences. Parse was concerned about the ascendancy of the medical model practice of nursing, while thinking about humans as mysterious beings with personal values (Fawcett, 2001).

PHT has been used to ‘illuminate meaning, synchronize rhythms, and mobilize transcendence’, guiding nursing practice, focusing on quality of life and personal meaning as described by the patient (McCarthy and Aquino-Russell, 2009, p.36). Therefore, from its formation, PHT has interested researchers who want to explore the experiences of patients ‘focus[ing] on individuals' own life experiences of some kind’ (Fawcett, 2001, p.194). Through such research, PHT academics can determine how feelings, such as joy, hope and suffering intersect to maintain patterns and processes of universal lived experiences (Fawcett, 2001).

However, just as experiences through practice have meaning and feelings, and feelings come from experiences which have meaning (Tapp and Lavoie, 2016), spirituality also

involves experiences, meaning and feelings. Despite this, very few studies have undertaken PHT through the lens of spirituality (Como, 2007) particularly in the UK. This research seeks to investigate nursing practices, and the nurse-patient relationship is important if I am to investigate why a GP nurse avowing that they deliver spiritual care practises in the way that they do. Whilst the strength of PHT is in its focus on the quality of life uncovering lived experiences, its potential weakness is that these experiences may be seen as universal and experienced by everyone (Edwards, 2000). In addition, PHT does not consider social and cultural worldviews, and thus the world is seen through its own specific cultural lens (Edwards, 2000). Furthermore, according to Parse (2010):

> The fundamental idea of humanbecoming that humans are indivisible, unpredictable, everchanging, as specified in the ontology, precludes any use of terms such as physiological, biological, psychological, or spiritual to describe the human.

Since my study involves addressing spirituality in humans, the application of PHT, although offering theoretical opportunities, would not enable me to acknowledge independent practices of spiritual care and so I would not be able to achieve my research aims. By contrast, Watson's Theory of Human Caring does focus on individual and spiritual practices (Pajnkihar et al., 2017).

Watson's Theory of Human Caring (WTHC) refers to the idea of 'transpersonal method of healing', which aims to recognise patients' spiritual needs 'through an altered state of consciousness' (Stegmeir, 2002, p.13). It has been criticised for expressing patients' healing experiences through 'the power of love, faith, compassion, caring, community and intention, consciousness and access to a deeper/higher energy source' (Stegmeir, 2002, p.13); this propensity for a spiritual concept has been continuously questioned on the grounds that the theory relies on inner human experience. According to Watson, the inner human experience, which she defined as spirituality, is anything that is intangible or could not be tested in a laboratory (Stegmeir, 2002, p.13) (see for example, Pajnkihar et al., 2017; Fawcett, 2005). The practices and experiences of nurses and nursing students, in particular, 'may struggle with the spiritual and humanities-based background necessary to unpack WTHC in order to apply it at the bedside' (Clark, 2016, p.1). The increasing recognition by Watson that nursing care works with, and through, mind, body and spirit as elements of caring, as well as the creation and continuity of interconnected human caring, led to her to call for transpersonal skills to create deeper interconnected human caring (see Clark, 2016). However, the strength of Watson's Theory is in its conception of spirituality within the process of caring-healing; its weakness is that the application of the theory can be broad and difficult to apply (Pajnkihar et al, 2017) particularly within the limitations of this study. Furthermore, in this study, investigating

practices and contextual influences is essential if I am to comprehend why nurses deliver spiritual care the way they do in the general practice context.

Whilst nursing theories could provide a good foundation to consider spiritual care in nursing, they focus on the aspect of nursing and do not give enough scope to conceptualise spiritual care as a concept. Although the research is investigating spiritual care from a nursing perspective, concerns about spiritual care development are as much an issue for other healthcare professionals and educators.

Thus, having reviewed the three theoretical frameworks, it will be apparent that benefits could be drawn from PHT and WTHC in particular, however, my analysis would be limited by being tied explicitly to the way these theories are used in analysis: PHT uses the researcher's own words to produce an 'essence' of the phenomenon being studied (Tapp and Lavoie, 2016, p.8); and 'WTHC takes into account the individual's active role and the experiences of both persons (the nurse and the patient) being involved in the process of care' (Pajnkihar et al, 2017, p.248). This study focuses on investigating GP nurses' perceptions and practices as told by them, and so there was a desire to be able to capture this data in a way that was not limiting. Thus, I considered the broader positions offered by Roy Bhaskar's theory of critical realism (CR) to explore whether Bhaskar's concept of the *real*, *actual* and *empirical* might be of benefit to my research. Although Bhaskar has been criticised for not addressing the 'lack of methodological development' in primary research, despite having explanatory strength (Fletcher, 2016), his notion of a stratified reality has been progressively applied to studies relating to healthcare (Baumbusch, Dahlke and Phinney, 2012; Walsh and Evans, 2014; Fletcher, 2016; Mendizabal-Espinosa, 2017), and in general practice (Appleby, Wilson and Swinton, 2018), and thus appears to offer broader possibilities. According to Ackroyd and Karlsson (2014), Bhaskar commented that in reality there are only a few studies that have adopted CR as a methodology and argued that new researchers would benefit from using CR to accomplish interesting and profound research. There are several principles which support CR, which demonstrates its promise as a 'new approach' for research into nursing (Schiller, 2016, p.88). These have a bearing on the present study's design and analysis.

Bhaskar's Critical Realist Theory

Critical realism (CR) is a philosophical stance that adopts a combination of 'a realist ontology with a constructionist epistemology' (Walsh and Evans, 2014, p.e5). Ontology concerns the nature of reality and what exists (Schiller, 2016). When carrying out research, a key ontological concern is whether one's perceived reality exists,

independent of the mind, or whether reality exists only within the mind (Schiller, 2016). Epistemology is related to how knowledge can be gained about reality and how information can be generated to describe reality (Danermark et al., 2005).

Positivists propose that reality can be measured and assume there is a constant reality which is objective (Robson, 2011). Conversely, constructivists argue that there are other ways to learn about the world stating that there are multiple realities that must be interpreted by people (Cohen, Manion and Morrison, 2018), which entertains a range of attitudes to reality including those that resonate with a CR position. However, Bhaskar (2008, p.17) critiqued both positivism and constructivism and argued that both paradigms cause what he called the 'epistemic fallacy', answering an ontological question with an answer about our knowledge of it, in other words the problematic reduction of ontology to epistemology because:

> Despite the seeming opposition between the constructivist and positivist perspectives, each reduces reality to human knowledge, whether that knowledge acts as lens or container for reality. (Fletcher, 2016, p.4).

Therefore, in contrast, CR acknowledges that a natural world including the social world of humans exists that we can attempt to know (thus aligning with central aspects of the positivist tradition) 'based on simplicity, linearity and certainty' (Walsh and Evans, 2014, p.e2). However, some human knowledge is based on how it is interpreted (constructivists) (Fletcher, 2016). According to Walsh and Evans (2014), a constructionist epistemology can have fundamental explanatory powers beyond the research area because it attempts to investigate and explain underlying tendencies that provide the basis for a surface phenomenon.

A key idea of CR emphasises that ontology is not reduced by the way we perceive reality, as 'human knowledge captures only a small part of a deeper and vaster reality' (Fletcher, 2016, p.4), and therefore it points to the possibility of wider knowledge of the world (Walsh and Evans, 2014). This is important because a wider knowledge of the world means obtaining knowledge about actual events and structures that propose theories of reality is possible (Schiller, 2015). These important ontological and epistemological beliefs determine what and how phenomena can be studied.

Approaching the investigation of sociology and culture from a meta-theoretical viewpoint, and carrying out research within a critical realist framework, Bhaskar applied the concepts of *real*, *actual* and *empirical*, to describe why strong social structures and mechanisms can produce and influence events (Bhaskar, 2008). Whilst these domains

are relational and are part of the same reality, it is useful to look at each of them independently, see Figure 3.

Figure 3: The distinctive nature of Bhaskar's Stratified Reality (taken from Bhaskar (2008, p.2))

	Domain of Real	Domain of Actual	Domain of Empirical
Mechanisms	√		
Events	√	√	
Experiences	√	√	√

Real

The *real* domain, the deepest level of Bhaskar's ontological levels, is 'independent of the thought, awareness and even existence of human beings' (Schiller, 2015, p.89), where 'generative mechanisms, the way of acting of a thing' exist as causative agents that influence events in the world when triggered (Bhaskar, 2008, p.42). *Real* can perhaps be summed up best by de Souza (2014, p.142) who states that:

> The domain of the real comprises structures, powers [what an object can do] and generative mechanisms, namely whatever exists as natural or social objects in nature. 'Structures' refer to internally related physical and material objects and/or human practices. They are internally related because the relations between them are necessary.

These mechanisms or structures are experienced throughout our lives, for example, within social or family groups. Through social interaction, social structures become a natural part of us and 'determine, constrain and oppress our activities' (Houston, 2001, p.846). Thus, the *real* transcends the divide between subjectivist-objectivist, in that 'although social structures and phenomena exist as a product of the existence of human beings (e.g. class, culture, or discrimination), these entities are seen to be as independent of individual human beings as physical entities' (Clark, Lissel and Davis, 2008, p.e68). In addition, Astbury and Leeuw (2010, p.375) explain that:

> When applied to social policies and programs, mechanisms are the underlying processes or "hidden causal levers" that account for how and why a program works to bring about desired changes in the reasoning and behavior of participants.

Thus, not only does the *real* arise from social interaction, but it also operates independent of our knowledge (Bhaskar, 2008). Although the *real* does not actually control practices

— in fact, Bhaskar (2008, p.2) stated that mechanisms exist because of the activities they govern which 'enables us to empirically identify them' — the existence of mechanisms is responsible for practices or actions underlying what is seen and experienced (Bhaskar, 2008). Thus, the *real* domain, has properties found in causal structures, such as, internally related objects and/or human practices, mechanisms, and 'whatever exists as natural or social objects' (de Souza, 2014, p.142); they all 'act as causal forces to produce events which appear in the *empirical* domain' (Fletcher, 2016, p.3).

Within much of the literature on healthcare, there is an existing perspective on the progression of the *real*, relating to patient care, particularly, spiritual care, with healthcare staff situated in relation to an almost organisational, controlled inescapability of achievement or failure, such as Advanced Practice Nurses' (APNs) lack of knowledge and training. For example, in a multinational nursing study relating to how nurses integrate spiritual care in practice, DeKoninck et al. (2016) identified that the way in which spiritual care was provided varied greatly. Among the study participants, the majority of them, made up of advanced nurses and GP nurses, considered that they had never received spiritual care training during their professional development. In addition, it was stated that a barrier to providing spiritual care was a lack of training. The study found that those who expressed comfort in providing spiritual care indicated that their personal spirituality played a significant role in their lives. It appears that when nurses have an encounter with spirituality or spiritual care, whether that is through training or the identification of their own spiritual needs, they feel more confident in the provision of spiritual care. It would suggest that if organisations do not provide spiritual care training for their nurses, there is a strong possibility that the nurses will fail to deliver spiritual care. The *real* in palliative care, in contrast, is believed to develop staff to have a regard for quality and a genuine regard for holistic care, which includes the ability to provide spiritual care (Faull and Blankley, 2015).

Therefore, the *real*, is not simply how individuals perceive the world but is an integrated phenomenon:

> The ideas and meanings held by individuals – their concepts, beliefs, feelings, intentions, and so on – as equally real to physical objects and processes (Maxwell, 2012, p.viii).

However, as human agents are predisposed to behave in a way that is based on knowledge they obtain about the world, this constrains the horizon of their agency and their practice and, in turn, they are not fully conscious of the motives for their actions and

practices. The *real* domain, therefore, causes social actors to view the real world as natural and normal (Bhaskar, 2008) created by social activity that is objective and internalised. Thus, the *real* domain is made up of thoughts and actions of social actors guided by mental schemes of internalised social structures. Consequently, a GP nurse's real world, for example, internalised during social interactions, leads them to believe and behave in certain ways (Clark, Lissel and Davis, 2008), for example, when they acknowledge and seek to incorporate a spiritual dimension to their care. Their actions reaffirm the underlying tensions that exist between spirituality and science, as previously mentioned, because of how the *real* is defined, and thus, may be the reason studies of this area of nursing have been lacking.

Whilst Bhaskar acknowledged the generative capacities of mechanisms in the *real* domain, he maintained that people activate the 'causal tendencies of mechanisms' acting on environmental cues that enable them to 'make things happen' (Astbury and Leeuw, 2010, p.370; Fletcher, 2016). Since the mechanisms in the *real* domain are 'countervailing' in nature:

> In Context A, mechanism (M1) is not activated. That is, M1 is dormant; still possessing causal ''tendencies'' or ''capacities'' but not the conditions that ''enable'' it to be triggered. In Contexts B and C, the conditions are conducive to triggering M1. However, in Context C, no effect or different effects are observed. This could be due to a countervailing mechanism (M2) that is present in Context C but not in Context B. (Astbury and Leeuw, 2010, p.369).

The implications are that it is possible for mechanisms to intercept anticipated effects or create effects that are in direct contrast to those expected. The *real* can, however, only operate in relation to the *actual*, a domain wherein every event exists.

Actual

For Bhaskar (2008), the *actual* is the middle domain within a stratum of reality, which enables individuals to observe phenomena arising from events within it. Forms of events include structure (contextual factors), for example work environment and command over other structural factors such as culture and rules; agency, such as events based on personal beliefs and attitudes; and social objects, such as professional competency requirements necessary to access controlling structures and systems (McEvoy and Richards, 2003; Clark, Lissel and Davis, 2008). In addition, Bhaskar (2008) proposed that whether or not they are experienced or perceived by individuals, events take place and events occur in the *actual* domain.

Bhaskar (2008) originally regarded the philosophy of science principally as starting with an ontological question such as, 'What possessions do people and societies own which could make them potential knowledgeable objects?' rather than with a question that more commonly starts with epistemology on how knowledge is attainable (Danermark et al., 2005). For both questions, the various types of causal mechanisms are the fundamental elements describing the possibilities and positions of phenomena in the world, which is:

> Reality here is assumed to consist of several domains; one of these is that of mechanisms. These mechanisms sometimes generate an event. When they are experienced, they become an empirical fact. If we are to attain knowledge about underlying causal mechanisms we must focus on these mechanisms, not only on the empirically observable events (Bhaskar, 2008, p.5).

Consequently, critical realism (Bhaskar, 2008), can be applied to describe the world's social structures and how agency is able to produce events influenced by the family, work environment and society making it possible to get a better understanding of the complex layers that exist below to develop a clear understanding of the 'mechanisms of action' which can be observed above that explain the actions of human agents (McEvoy & Richards, 2003, p.414). For example, in a study investigating dystocia (a complication of labour) by Walsh and Evans (2014), it was shown that the use of multiple research questions that used multiple research methods, was able to interpret the experiences of women by adopting a holistic exploration of the problem. In contrast to Bourdieu's theory of capital, which seeks to explain why powerful and influential social systems and structures exist and are able to reproduce (Bourdieu, 1986), Bhaskar's theory focuses on the effects of those structures and creation of phenomena in the real world. For Bhaskar, therefore, the object of scientific investigation is:

> To produce knowledge about those generative mechanisms and structures that combine to produce phenomena. Such mechanisms and structures are labelled as intransitive objects of enquiry, meaning that they exist and act independently of human minds but are still knowable through investigation (Schiller, 2016).

Thus, rather than focusing mainly on method and design in healthcare research, it is important to reflect on underlying assumptions about reality (Clark, Lissel and Davis., 2008), particularly in the field of nursing research and practice as Walsh and Evan (2014, p.e5) suggest:

> The more frequent utilisation of the theoretical perspective of critical realism in midwifery research, though it does pose some challenges for the novice researcher. These are related to its relative complexity, combining different ontological and epistemological positions and to its embracing of other disciplines as it seeks to explore deeper causes for surface phenomena.

Although each field, discipline or sector has its own distinctive properties, mechanisms, events and experiences are characteristic of all fields:

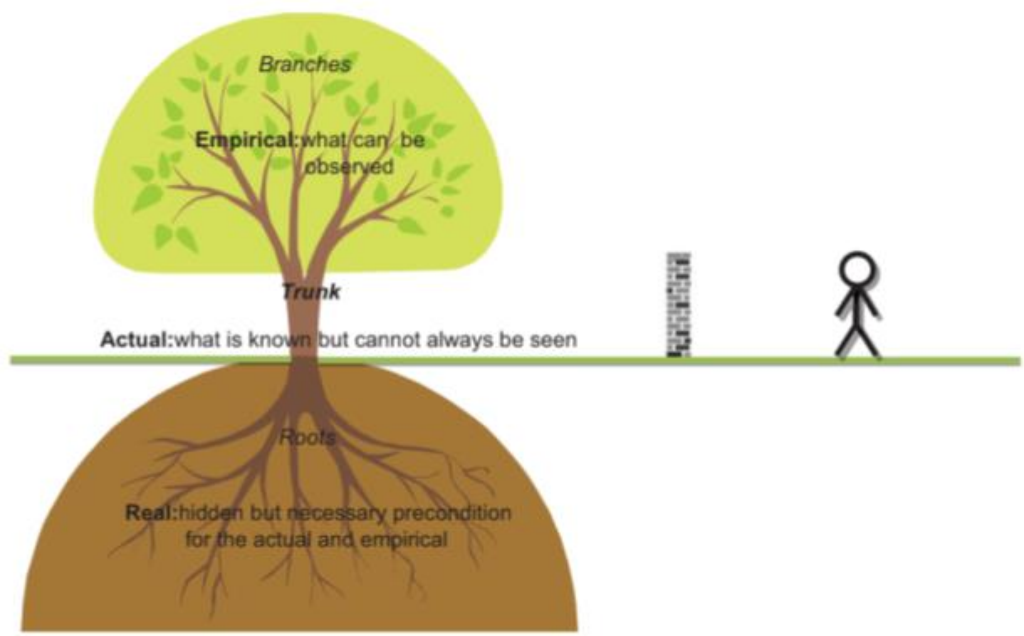
> Structures and mechanisms then are real and distinct from the patterns of events that they generate; just as events are real and distinct from the experiences in which they are apprehended (Bhaskar, 2008, p.46).

In particular, fields are areas in society where agency exists as well as social structures, but 'they are two completely separate phenomena with qualitatively different characteristics' (Danermark et al., 2005, p.12). 'Here structures are viewed as laying down conditions for people's lives, while agency provides the effective causes for what happens in society — only human beings can act' (Danermark et al., 2005, p.12).

The *real* and *actual* domains interact to produce actions or practices by individual actors shaped by the interaction of multiple forces. The position of the GP nurses and GP practices is made up of the interplay of, for example, events within the working environment and/or stemming from personal beliefs, and causative mechanisms that influence the events.

Walsh and Evans (2014, p.e2) offer the analogy of a tree (see Figure 4) to explain the concept of domains. The domains can be considered as individual levels of ontology, each with its own formation of reality. Unlike several different paradigms that solely recognise, for example, the *actual* or the *empirical* domains, critical realism considers the *real* domain, 'an independent reality' (Schiller, 2016, p.91) where interpretations of and behaviour within the world are influenced by individual and socially created meaning (Clark, Lissel and Davis., 2008).

Figure 4: Tree diagram of three ontological levels: Empirical, Actual and Real (taken from Walsh and Evans (2014, p.e2))



For Bhaskar, the *real* and *actual* are mutually constitutive of one another since together they give reality extra 'ontological depth' (Scott, 2010, p.13). As a result, the *actual* shapes and directs the *real,* whilst the *real* gives the *actual* value and meaning through the social actor's agency, constraining how the individual actor acts in relation to their character and their professional requirements (Archer, 2000). However, the amount of change an individual can influence is controlled mainly by the field's structure and shape, and thus restricts human agency. Additionally, practice is embedded in the *real,* and the *real* initiates unconscious practice. As a result, the social context of the agent determines their behaviour, although, not through choice (McEvoy and Richards, 2003), which suggests that actors are limited since they are restricted by their position in the field. However, actors use their limited time by applying strategies that support or enhance their standing in the field, and thus 'make things happen' (Astbury and Leeuw, 2010, p.370).

Empirical

Bhaskar (2008) defined the *empirical* as the final layer of reality, which is composed of human (social actors) experiences, practices and perceptions only (Clark, Lissel and Davis, 2008) (see Figure 4). According to Bhaskar, the *empirical* domain does not have an effect on the *real* domain since:

> The generative mechanisms, the causal powers or tendencies 'ways of acting of things', […] are natural or social and can be activated to produce particular outcomes that may, or may not, be consciously experienced or known by human beings (Schiller, 2016, p.89).

Therefore, it is unlikely that social actors will have, other than perhaps the academic elite, the ability to develop 'reflexivity', a self-reflection of action in a social environment (Caetano, 2015) beyond these limits except during a crisis when the *real* and *actual* are not synchronised or when there is a scarcity of match between dispositions and positions (Bhaskar, 2008). Therefore, the social actor when not in crisis, lacks voluntary action and reflexivity, and when there are events (visible in the empirical level), they normally do not involve rationality and reflexivity. Instead, for Bhaskar, the world consists of 'mechanisms not events' (Danermark et al., 2005). Focusing on mechanisms instead of events means changing the focus from the events themselves to what causes them (Danermark et al., 2005). They are embodied in the *real*, and the *real* domain:

> Is the source of such mechanisms which combine to generate the flux of phenomena that constitute the actual states and happenings of the world (Bhaskar, 2008, p.37).

Hence, mechanisms are exemplars of the *real* in action, experienced in the *empirical*.

Bhaskar later refined his 'causal laws' (Bhaskar, 2008), describing mechanisms as neither unconscious nor merely a logical explanation; rather the logic of mechanisms is that they are independent of events that they generate, but they are activated through agency and can be manipulated or overturned. Thus, there is more than one way that mechanisms act (Bhaskar, 2008), and the actor has some autonomy in how to act. Nevertheless, for Bhaskar, available choices are limited by the field and so is the scope for actors to be strategic. Moreover, this limited scope omits reflexivity. Rather, actors purposely act on the basis of experiences from which they have learnt, and by either a reflexive consciousness or recent understandings since:

> Men as causal agents, capable of acting self-consciously on the world, do so in an endeavour to express to themselves in thought the diverse and deeper structures that account [...] for all the phenomena of our world (Bhaskar, 2008, p.9).

Applying Bhaskar in Spiritual Care and GP Nurse Research

Bhaskar's direct involvement in the study of spirituality is limited and is rarely a major focus in any of his works; there are exceptions such as, '(Re-)contextualizing metaReality' (Bhaskar and Hartwig, 2012) and 'Reflections on MetaReality' (Bhaskar, 2012). Nonetheless, Hartwig in an introduction to Bhaskar's (2012, p.xii) book, argues

that Bhaskar's work from the mid–1990s 'attempts to synthesise West and East, science and religion, materialism and idealism, atheism and theism', since Bhaskar argued that all socially real entities (such as employment, organisations or socioeconomic structures such as gender and class) in effect are intangible and that they cannot exist independently of all people and their beliefs and personal meanings. This suggests that GP nurses' experiences, the context of their work and any other social entity that has become a part of their existence, will coalesce with their beliefs and personal meanings which in turn will have an impact on how they offer spiritual care. In fact, much of Bhaskar's writing can be likened to the methods he used to analyse the existence of reality which is 'stratified, emergent and transformed by agents' (Fleetwood, 2014).

In addition, Hartwig avers that for Bhaskar, spiritual affiliation is governed by the world and less by free choice, the deepest level of our being, the continuous engagement in it (Bhaskar 2012), and is part of the larger, social practice of maintenance and development in the *real* domain (Danermark et al., 2005); so for Bhaskar (2012), spiritual decisions can be considered as being placed within a field. However, he perceived transcendence as a system of meaning which is ubiquitous in life, although it is hidden and largely unnoticed (Bhaskar, 2012).

It is surprising then, that Bhaskar's theory has seldom been applied to healthcare, particularly spiritual care. However, his concepts of *real*, *actual* and *empirical* have been used in academic investigations relating to midwifery, nursing students and GPs. For example, Walsh and Evans (2014) have recognised ways in which midwifery researchers, seeking to apply a critical lens to maternity care, use events and practices to explore causative mechanisms, making judgements about the state of care that women receive. Likewise, Baumbusch, Dahlke and Phinney's (2012) research has shown how a nursing school used beliefs and knowledge, information about nursing care of older people, in educating nursing students. Researchers also make use of the improvements in care once the students have completed the course. Appleby, Wilson and Swinton (2018) have established ways in which general practice impacts how GPs connect with their patients, in particular, the more personalised aspects of practice namely, embracing, pragmatic, guarded and rejecting, which characterised the GPs' attitudes to spiritual care provision. Knowledge and beliefs about care can also enable further acquisition of care. Mendizabal-Espinosa's British study (2017) has shown how Mexican hospitals employ particular forms of knowledge, beliefs and practices to promote babies' wellbeing and care, and through education 'empower' the parents' current, usually restricted, position.

Within healthcare, Bhaskar's theory has also been used to validate how, for example, nursing and healthcare lack the required [care] knowledge to allow staff to understand complex social situations (Clark, Lissel and Davis, 2008; Baumbusch, Dahlke and Phinney, 2012; Walsh and Evans, 2014; Williams, Rycroft-Malone and Burton, 2017), to enable them to be successful in healthcare (Parlour and McCormack, 2012), and/or perhaps enable them to remain in healthcare.

Applying Bhaskar's Stratified Nature of Reality

As indicated by some researchers who have used CR, Bhaskar's notion of a stratified reality (Bhaskar, 2008) appears to be useful in helping understand the practices of staff in healthcare. Indeed, as Williams, Rycroft-Malone and Burton (2017, p.9) state, Bhaskar's 'work is of great importance to advance nursing and healthcare knowledge of understanding complex social situations', and as a philosophical framework applied as a theoretical framework, CR is helping to link theory and practice.

However, I had four reasons for selecting Bhaskar's notion of a stratified reality as arguably the most apposite frame of reference for investigating the perceptions and practices of GP nurses in the UK. First, although Bhaskar never used the *real* domain as an instrument for assessing spirituality or transcendence, the *real* as a concept for identifying the power of particular structures in general practice and influence of generative mechanisms, according to Parlour and McCormack (2012, p.319) 'has demonstrated the efficacy of this approach in explicating underlying mechanisms within the practice context and how these impact upon practice' and, thus, is also likely to have applicability to the concept of spirituality. Furthermore, as Walsh and Evan (2014, p.e5) argue, applying the concept of real would enable me:

> To combine different ontological and epistemological positions and to its embracing of other disciplines as it seeks to explore deeper causes for surface phenomena. This is also a strength, particularly in researching complexity in care.

According to Bhaskar (2008) reality exists independent of people's understanding of it. Essentially, the *real* domain is where mechanisms exist so 'how we interpret it influences our actions which in turn can influence reality' (Williams, Rycroft-Malone and Burton, 2017, p.4). Thus, I determined that drawing on the *real* domain would permit me to look beyond mere descriptions of spiritual care to help me explore deeper, underlying reasons for their actions.

Second, since the *real* is a combining of internalised social mechanisms and structures that influence the actions of actors (Bhaskar, 2008), using the *real* domain would assist

me to postulate what GP nurses' perceptions of spiritual care are and why, including their ensuing practices. Furthermore, since the mechanisms in the *real* domain 'remain generative' and 'rather definitive' (Walsh and Evans, 2014, p.e4) drawing on the *real* should equally afford the opportunity of establishing how these practices facilitate the further progression of the *real*.

Third, Bhaskar's (2008) description of the empirical domain as the layer of reality that is made up of perceptions, practices and experience, I believed that applying the concept of the *empirical* domain would enable me to obtain 'information that becomes known to human beings through the direct and indirect practices or experiences associated with the *actual* domain, which in turn are a result of the interaction of generative mechanisms in the *real* domain' (Schiller, 2016, p.90). It would then be possible to identify opportunities for investigating what influences their perceptions and practices.

And finally, applying Bhaskar's (2008) concepts of *real, actual* and *empirical* would present me with the opportunity of interpreting the degree of complexity that GP nurses experience in their role, as well as the strategies they adopt, if any, to enable them in the provision of spiritual care. According to Bhaskar (2008), applying the three concepts would enable me to be attentive to the interaction between agency and structure, and encourage a search for the generative mechanisms that transform our understanding of the social world. A deep analysis of the data would be possible with the use of the critical realist concepts to consider events at individual, organisational and social levels. Thus, it appears that Bhaskar's *real, actual* and *empirical* reality would be beneficial to me.

Part 2: The Research Questions

As stated previously, the purpose of my research is to investigate GP nurses' perceptions of spiritual care; to identify how the general practice context impacts on their provision of spiritual care; to explore patterns or commonalities in their practices; and, to determine the implications of these practices for GP settings within the UK. To achieve these aims, and by drawing upon Bhaskar's concepts of real, actual and empirical, I identified my research questions as:

- What are GP nurses' perceptions of spiritual care?
- What is the impact of the general practice context on GP nurses' provision of spiritual care?
- What patterns or commonalities can be found in GP nurses' provision of spiritual care?
- What are the implications of GP nurses' spiritual care practices for GP settings?

The findings and analysis of the data produced by the responses to these questions might help to identify implications for professional development to support GP nurses to develop this dimension of their practice.

Conceptual Framework

The main concepts that underpin this research are spirituality and spiritual care. Both concepts are explained individually and then linked within a conceptual framework.

Spirituality

As previously mentioned, the concept of spirituality is defined in different ways, particularly across different cultures and countries (Puchalski et al., 2014). At an international conference on improving care (see Puchalski et al., 2014). Participants (various healthcare professional) proposed a definition of spirituality:

> Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices (Puchalski et al., 2014, p.646).

This definition, as do others, suggest that the concept of spirituality has many defining characteristics or layers of meaning. This is evident in the definition proffered by Weathers, McCarthy and Coffey (2015) who provide three key layers that offer a litany of possible variables. This definition is applied in this study, because it takes into account the key characteristics proposed in Puchalski et al. (2014), but categories them into three defined layers:

1) 'Connectedness'—'a sense of connectedness to oneself, to others, to nature or the world or, and to a Higher Power, God or Supreme Being.'
2) 'Transcendence'—'a dimension of spirituality', 'and self-transcendence has been defined as the ability to see beyond the boundaries of the self, the environment, and present limitations.'
3) 'Meaning in life'—an appreciation of one's positive elements over other concerns (Weathers, McCarthy and Coffey, 2015, p.93).

This definition accepts the premise that spirituality is located in everyone whether they have a faith or not highlighting that spirituality is profoundly subjective and legitimises its importance in healthcare. However, Pesut et al.(2008) argue that spirituality is connected to religion, which means this would exclude people who do not have a faith. It is essential to recognise the distinction between 'spirituality' and 'religion' (Koenig, 2012). If religion was accepted as a prerequisite for spirituality then Weathers, McCarthy and Coffey's

(2015) definition above, would not be appropriate. Definitions of religion can be confined to belief systems that express a connection with a higher power, demonstrated by the frequency of attending rituals, ceremonies and the offering of prayers (Hodge, 2000).

There are a variety of ways of thinking about spirituality in the healthcare system, encouraging alternative ways to articulate the concept of spirituality in healthcare (Swinton and Pattison, 2010). For example, spirituality can be conceived as prioritising the importance of being human and listening, and of rekindling and holding onto the vocational elements and existential dimension (McSherry et. al, 2020), and has also been applied to various aspects of healthcare acknowledging its religious, political, cultural, social, and humanistic affiliations (McSherry and Cash, 2004). In this research, cultural and social aspects presented the most beneficial line of investigation to gain a clearer understanding of GP nurses' working contexts and directives that might have an impact on their role. Understanding cultural aspects, such as GPs' views (for example, Vermandere et al., 2011) was important to investigate claims that GP practices function as values-based businesses; additionally, investigating the social aspects, such as the working attitudes of GPs, presented added validity. Similarly, Appleby, Wilson and Swinton (2018) proposed four approaches to understanding spirituality, the study excluded political and humanistic aspects. The reason for this was to concentrate on the two ways that would offer the most straight–forward reasons for comparing organisational intent (cultural aspects) and GPs' perceptions (social aspects).

Spiritual Care

Accompanying the broadened recognition of spirituality as an emphasis in modern healthcare, the term *spiritual care* is also increasingly gaining currency in the sector. While for some, the term might imply a process akin to 'religious healing', the term should again be understood more broadly to imply care that is cognisant and respectful of the spiritual considerations defined above (Koenig, 2012). Accordingly, in this study, the term 'spiritual care' is used inclusively, in line with this broader conception of the term.

The notion of spiritual care is not synonymous with 'pastoral care'. 'Pastoral care', in chaplaincy assessments such as the *NHS Chaplaincy Guidelines 2015—Promoting Excellence in Pastoral, Spiritual & Religious Care* (NHS England, 2015), is defined as the change that people report experiencing due to chaplaincy intervention, whereas spiritual care, represents the meaning of the changes encountered. This is because spiritual care incorporates two key components: the need to look objectively at human needs, while being subjectively aware of individual needs (Cook, 2013). Research has

highlighted ‘the importance of spiritual care in nursing to improve the quality of life of many patients’ (Narayanasamy and Owens, 2001, p.446), while definitions of spiritual care have referred to the need to recognise a person’s wants and needs (Delgado, 2005). It is for this reason that spirituality has been characterised as having the same meaning as ‘chaplaincy care’ or ‘existential dimension’ (for example, Hvidt et al., 2016), both of which relate to improving patient care through direct involvement by staff of understanding patients’ wants and needs.

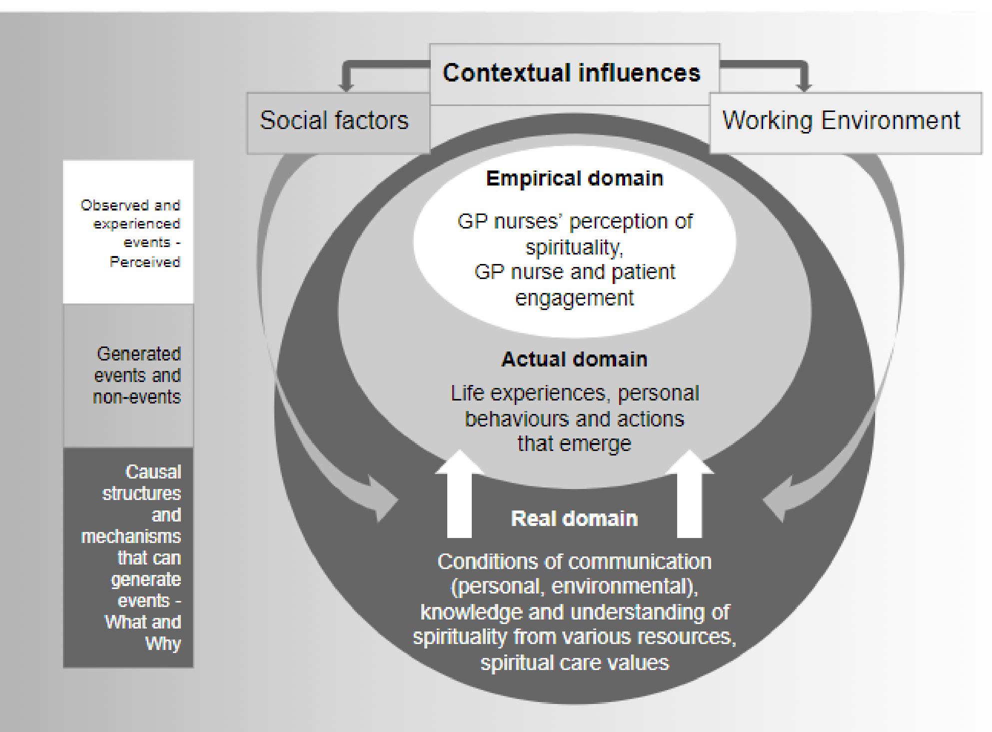
The aim of this research is to generate not only new data from the results of GP nurses’ perceptions of spiritual care, but also a degree of practical insight on their provision of spiritual care. Addressing this aim requires the collection of data on what GP nurses believe to be the meaning of spirituality (thus focusing on a diverse group of people within general practice) and data pertaining to the choices made by them regarding the provision of spiritual care, influenced by the specific context of general practice; when combined this data should enable me to provide an understanding of GP nurses’ perceptions and practices in this developing arena of healthcare which could help identify implications for professional development.

Explanation of the Conceptual Framework

Figure 5 presents the conceptual framework created from the concepts outlined above. The figure is a model of how I would hope to map the perceptions of GP nurses towards spiritual care as well as the factors impacting the provision of spiritual care. There are three distinct sections:

- The actions involved in developing GP nurses’ perceptions and provision of spiritual care (experienced in the *empirical*) are represented in Bhaskar’s domains of *actual* and *real.*
- The annotations within the circles provide key situations when activities understood as being ‘real’, are only apparent via the perspectives of GP nurses.
- The panel at the side provides a description of each domain in developing GP nurses’ perceptions and the provision of spiritual care, and its relationship with the domain directly above it.

Figure 5: Proposed conceptual framework



The diagram identifies structures or systems that are in, and are influenced by, society and work environments. The descriptions of these influential external structures or systems were based upon the work of Mingers (2002). In his paper on information systems, Mingers (2002) points out that within these systems, there is a range of philosophical positions and difficulties within the underlying philosophies of science, in particular interpretivism and positivism. Mingers (2002) proposes critical realism as philosophy that could potentially overcome the difficulties in both philosophies for information systems and could 'discover underlying structures that generate particular patterns of events (or non-events)' and shape the practice of IS research (Mingers, 2002, p.301). In the same way, the issues identified from the literature review suggests an essential requirement to investigate the provision of spiritual care by GP nurses.

In the conceptual framework, there are three key areas relating to the way GP nurses perceive and provide spiritual care, and these are placed within specific domains.

1) Beliefs are subjective and thus have a different meaning for individuals which may have been derived from or influenced by religious, cultural or social factors. These beliefs are formed as mechanisms, developed within the family setting, other influential relationships, and from various resources open to nurses in a

clinical setting (Puchalski, 2013). Societal and cultural differences can together explain ways in which spiritual care is interpreted and delivered in general practice and can also explain personal beliefs and practices (Puchalski, 2013; Appleby, Wilson and Swinton, 2018). The possibility of these contexts to enable or hinder specific practices or mechanisms is identified in the diagram since this is the study's main focus. The purpose of the study is to focus on the identified gap relating to GP nurses' provision of spiritual care which includes the impact of the general practice environment (*real*).

2) The causal nature of these mechanisms generates life experiences, personal behaviours and actions, including organisational directives (Fletcher, 2016). Thus, GP nurses' perceptions differ because they may have inadvertently constructed a definition of spirituality based on professional discourse (Rumbold, 2002). The diagram suggests that the provision of spiritual care (events and non-events) are generated through the interaction between GP nurses and patients during clinical practice, influenced by communication and relationships explained above; this happens within the *actual* domain. This conceptualisation of spiritual care is guided by various sources, for example Bhaskar's (2008) notion of a stratified reality which encouraged the exploration of many drivers of spirituality, and Mingers and Willcocks (2004) statement that inactive resources are unable to generate events, such as spiritual care. Growing awareness of the need for healthcare staff to work together to deliver quality healthcare (NHS England, 2016a) and the current goal to move more care into GP practice (Appleby, Wilson and Swinton, 2018) suggests that developing relationships is the key to understanding how to effectively provide spiritual care (NMC, 2018) (*actual*).
3) Beliefs about spiritual care are conceptualised in the framework as communicative and relational with patients', in line with the perception of connectedness as provided by Weathers, McCarthy and Coffey (2015) The outcomes arising from relationships outlined on the diagram are generated by events in the actual domain directly below, which in turn, are caused by structures and mechanisms activated in the *real* domain, under the right conditions. This is a significant difference that incorporates the 'generative mechanisms' required for investigating complex phenomena in healthcare (Walsh and Evans, 2014), and seriously considers the compelling arguments within the work of Fletcher (2016) and Mendizabal-Espinosa, (2017) on the subjective nature of understanding spiritual care in healthcare (*empirical*).

Embedded in the diagram is the two-dimensional concept of providing spiritual care by acknowledging that it is necessary to both identify objective practices and have

subjective knowledge of their qualities in order for this care to be realised. By providing a coherent set of concepts and the descriptions of the underlying factors that might impact on perceptions and practices, this conceptual framework underpins the research aims and questions pursued in this study to develop more accurate ways of thinking about the provision of spiritual care.

Part 3: Investigating Research Methodologies

In selecting an appropriate research methodology, I had two considerations: first, the need to be able to understand perceptions as well as explain events; and second, the need to ensure that my chosen methodology was consistent with Bhaskar's notion of a stratified reality (2008). Critical realism enables researchers to address complex concepts and research questions with the use of different types of methods and tools (Leech, Dellinger and Brannagan, 2009), and provides mixed methods researchers with strategies to better interpret the context of their study (Doyle, Brady and Byrne, 2016; Schiller, 2016); thus a mixed methods approach is well-suited to studies applying critical realism (Walsh and Evans, 2014).

I assessed three possible and commonly applied approaches used in research on spiritual care in nursing, all of which could help me to identify, explain and theorise: grounded theory (GT), phenomenology, and mixed methods (Martins, Romeiro and Caldeira, 2017). They were not compared like for like but rather on an individual basis to determine whether they would be suitable for use in this study considering that CR forms the theoretical framework. Each methodology has similar factors: they incorporate qualitative approaches; they are concerned with an individual's whole experience instead of elements of it; they search for meaning rather than focusing on the measurements; they use first-person accounts to generate descriptions of practice; and they acknowledge the necessity of experience in understanding human actions (Creswell et al., 2007). However, although philosophically each method is acceptable, they differ in their approach and emphasis, which could give rise to ethical and methodological challenges. Of the three methods, I excluded an ethnography approach since the researcher is required to observe participants (Holloway and Galvin, 2017) and this would not be practically possible due to the nature and privacy of the GP nurse's role. Despite that, in a study investigating 'focused ethnography', Cruz and Higginbottom (2013, p.37) reported that with shorter field times and specific data collection strategies, this branch of ethnography could be applied in nursing research. However, in order to be able to apply focus ethnography, the research would need to be undertaken by a nurse. Although I became interested in spirituality in nursing, my own professional background is not in nursing and so I would not be able to conduct this type of research.

Grounded Theory

Research using grounded theory (GT) involves generating interpretations of phenomena or discovering theories. Findings from GT research provide a social description, the observation of phenomena, and the recording of it without preconceptions (Charmaz, 2014). Evidently, this approach seems methodologically inappropriate for my research. Examining social interactions and relationships is a crucial aspect of GT research, where researchers actively engage and immerse themselves in the lives of participants over an extended period. By attentively observing and listening to the words and actions of individuals, the aim is to uncover the underlying motivations and explanations for their behaviour (Glaser, 1978). This is a critique of GT and as such, this means that there is no possibility of a position without preconceptions in research. As this study would involve checking the scope of prior research, this would be difficult without developing assumptions (Hussein et al., 2014; Fletcher, 2016). Additionally, there were ethical concerns pertaining to the amount of time GP nurses could give to the study, as well as particular issues around their availability since any research is likely to involve disrupting their work, which is highly pressured and time restricted. Furthermore, not only can research involving GT studies prove ‘a time-consuming, tiring and laborious process’ which can be difficult for novice researchers (Hussein et al., 2014, p.5), but contrary to, for example hospitals, general practice is an extremely divided setting with GP nurses, in general, working different shifts, frequently working on their own in GP settings, and they spend most of their time with patients. Although, there are some GT studies investigating how spiritual care is taught in nursing, such as Lewinson, McSherry and Kevern’s (2018) research about a group of 13 British pre-registration adult nursing students, it is perhaps unsurprising that research using GT in general practice is comparatively rare. These practical issues combined with the ethical challenges influenced me to look at the other methodologies frequently used by other researchers theorising spiritual care in healthcare; I next explored the use of phenomenology.

Phenomenology

A phenomenological study typically uses in-depth interviews and observations in an attempt to gain knowledge of participants’ worlds (Walsh and Evans, 2014). It offers a methodological approach that is consistent with many of the intentions outlined above:

> The discipline of phenomenology may be defined initially as the study of structures of experience, or consciousness. Literally, phenomenology is the study of “phenomena”: appearances of things, or things as they appear in our experience, or the ways we experience things, thus the meanings things have in our experience (Smith, 2018, p.2).

The use of phenomenology means the researcher analyses data by searching for important statements and themes within them that have significant meaning for participants. An attempt is then made to create a statement of the experience from which readers can benefit.

There are many phenomenological studies of staff in healthcare. I am interested in a particular genre, namely:

> [That] all person-centred care must be holistic in nature, that is caring for the bio-psycho-social-spiritual aspects of the person. To neglect any of these dimensions will undoubtedly lead to a violation of the person's dignity. (McSherry, Suckling and Boughey, 2016, p.91)

With this in mind, phenomenology plays an important part in nursing; it appreciates not just a person's experience but also, in relation to holistic nursing, the needs, approaches and awareness that the role spiritual care plays (McSherry et al., 2016). According to Budd, Hill and Shannon (2010, p.274), 'Phenomenology places ontological reality front and centre and, in keeping with Bhaskar, the ontological reality is not bound or constrained by positivistic conceptions.' However, Bhaskar argues that phenomenology is limited because it focuses on participants rather than any other important issue in the context. By researching in the *real*, researchers are able to study social context, which is ever present and continually reproduces outcomes of intentional human agency (Bhaskar, 2008). Thus, having dismissed two possible approaches, I considered mixed methods.

Mixed Methods Design

Historically, the use of mixed methods (MM) was to answer research questions using various appropriate forms of data (Burke Johnson, Onwuegbuzie and Turner, 2007). Collected data includes both quantitative and qualitative data such as interviews, surveys, and observations, and can be applied to increase knowledge and understanding of events, communities, people, culture to enable a convergence of the truth (Burke Johnson, Onwuegbuzie and Turner, 2007). However, until the 1980s, there were concerns about how the subjective nature of qualitative research could be made more widely or generally applicable and valid, since the findings could be influenced by the researchers; bias can be reduced but is never eliminated (Watkins and Gioia, 2015). By contrast, quantitative research seeks a broad understanding of phenomena, but does not account for the depth that is occasionally required in research (Watkins and Gioia, 2015).

The utilisation of MM research has increased during the past 30 years, which has led to a large number of studies adopting this approach in the early twenty-first century (Cohen, Manion and Morrison, 2018). This change may be attributed to four different triangulation techniques: data — in a study, the application of different sources; researcher — the use of different investigators; theory — findings are interpreted with the use of numerous theories and perspectives; methodological — the application of multiple methods to investigate a research problem (Denzin, 1989). Examples of the use of MM can now readily be seen in social science research, drawing on data from sources such as narratives and questionnaires amongst others.

However, for MM researchers, there is a clear distinction between a single method of triangulation, which uses only one paradigm such as quantitative, and multiple methods of triangulation which uses quantitative and qualitative paradigms, but it is only in the application of the between–methods that bias will be reduced (Denzin, 1989). In other words, single methods and multiple methods are analytically different: single methods have limited value, but multiple methods come from the analysis of combining different sources, methods or researchers (Denzin, 1989). To preserve this distinction, Burke Johnson, Onwuegbuzie and Turner (2007, p.114) call the single approach triangulation in a study '*within–methods*', and the multiple approach '*between–methods'.*

During the process of analysis, 'MM involves unpacking (or "unmixing") the quantitative and qualitative aspects to acquire a deeper understanding of what each paradigm contributes to solving problems' (Watkins and Gioia, 2015, p.11) so that data collection is not only analysed, but also concerned with:

> The process philosophical bases of research, paradigms which guide research and assumptions which inform the design and conduct of research (Cohen, Manion and Morrison, 2018, p.31).

Thus, MM is a process of gathering information through triangulation that will, according to Denzin (1989), result in one of three outcomes: convergence, inconsistency, or contradiction, which is then reconstructed by the researcher 'into superior explanations of the social phenomena' (Burke Johnson, Onwuegbuzie and Turner, 2007, p.115). Consequently, MM elicits not only the events but how people make sense of them. Therefore, MM is an important vantage point for exploring the 'multiple empirical appearances of [social phenomena]' (Gorard and Taylor, 2004, p.7). However, MM is more than simply the analysis of research data, rather it:

> Can be applied to all the stages and areas of research, for example, philosophical foundations and paradigms, methodology, research questions and design (Cohen, Manion and Morrison, 2018 p.33).

Whilst MM uses a variety of tools to collect data, such as questionnaires, surveys, which gather general understandings, and interviews which draw on practices and/or experiences of individuals to obtain a deeper understanding of their life within its social context (Watkins and Gioia, 2015). Not only does MM gain understandings by the methodical collection, rigorous (predetermined and verified system) analysis, and epistemologically sound (how we come to know what we know) analysis of both qualitative and quantitative data, but their integration, 'underscores the advantages of using both research approaches to illuminate and advance our understanding of the phenomenon of interest' (Gorard and Taylor, 2004, p.9). Through this process, MM focuses on the general findings of the population and on the individual meanings and interpretations of events in their lives.

Rationale for Mixed Methods

Much research on spiritual care, both nationally and internationally, has been criticised for pursuing research using a single paradigm. According to Martins, Romeiro and Caldeira (2017, p.9), 'quasi-experimental and experimental studies, mixed methods, and correlational designs appear to be an urgent need for the development and consolidation of knowledge'. This suggests that the constructivist or positivist perspective of reality, perhaps on their own, oversimplifies perspectives which could lead to partial or biased knowledge, particularly as research has identified that spirituality is complex and subjective (Withers, Zuniga and van Sell, 2017). Therefore, using only one data source may limit the possibility of deepening the understanding of the human dimension. According to Cohen, Manion and Morrison (2018, p.6), the ontology of a MM paradigm:

> Recognizes that phenomena are complex to the extent that single methods approaches might result in partial, selective and incomplete understanding, and in an epistemology that requires pragmatic combinations of methods – in sequence, in parallel, or in synthesis – in order to fully embrace and comprehend the phenomenon and to do justice to its several facets.

In addition, Onwuegbuzie and Leech (2003, p.2) state that researchers stay polarised when they limit themselves to either the quantitative or qualitative 'mono-method' research methods threatening the advancement of research in the social sciences. However, according to Doyle, Brady and Byrne (2016), there are challenges to the idea that MM research is inherently better than research that uses one method due to incompatibility. In addition, it is critically important that researchers are explicit about the

benefits of using mixed methods and that the research question is suitable for the MM design (Doyle, Brady and Byrne, 2016). Essentially, Shannon-Baker (2016, p.331) argues that critical realism is a paradigm which can address the limitations found in either the quantitative or qualitative approach to research when they are used together 'in the belief that theories on reality are partial thus emphasising the importance of diverse viewpoints' and thus benefiting from the MM design.

In relation to my study aims, MM can enable me to understand GP nurses' perceptions of spiritual care via the questionnaire (quantitative), and why they deliver spiritual care the way they do, and not just describe their practices by holding interviews (qualitative). The practices and experiences told by GP nurses should also provide me with an important way of 'understanding how factors in the individual and the workplace setting interact to causally influence key behaviours' (Clark, Lissel and Davis, 2008, p.e74). Thus, MM could help me understand reality from individuals' perspectives and identify the link between this and local practices (Zachariadis, Scott and Barrett, 2010). Essentially, the quantitative and the qualitative elements of this study would be gathering different sets of data and as such will not be subject to issues of compatibility. Furthermore, MM should enable me to understand GP nurses' reasons for their practices and why they react the way they do, since MM is well suited to conveying the complexities of human life (Doyle, Brady and Byrne, 2016). It involves 'a deep understanding of the phenomena under study' (Zachariadis, Scott and Barrett, 2010, p.1): through experiences people can understand their practices, enabling me to highlight previous practices within social contexts.

Bhaskar's (2008) notion of a stratified reality also fits well with MM since, in MM, the individual, context and events in the study are seen as being linked, influencing one another rather than working independently. MM researchers are concerned with 'data that emerges from both quantitative findings and qualitative findings' (Creswell and Plano Clark 2017), and that 'these findings mutually inform one another highlighting relationships between local practices and changes that are occurring at another level of analysis' (Zachariadis, Scott and Barrett, 2010, p.12). Therefore, using MM to explore reality is appropriate since reality is a complex interaction between structure and agency (Bhaskar, 2008), which 'acknowledges the possibility of science, but recognises the social dimensions of humans' (Clark, Lissel and Davis, 2008, p.e68) and as such, MM would enable these diverse viewpoints to be addressed and brought together within a study. Indeed, Bhaskar (2008) argued that appropriate types of research can identify the presence of causative or generative mechanisms within the social world because the presence of human agents is influenced by mechanisms.

In addition, considering the application of MM enables a more 'comprehensive and complete understanding of phenomena' (Cohen, Manion and Morrison, 2018, p.33), MM research is pertinent to Bhaskar's theory within the actual domain which foregrounds social actors and their struggles in the world (Bhaskar, 2008). MM is also concerned with addressing challenging research questions by:

> Combining particularity with generality, 'patterned regularity' with 'contextual complexity', insider and outsider perspectives (emic and etic research), focusing on the whole and its constituent parts, and the causes of effects (Cohen, Manion and Morrison, 2018, p.33).

Thus, MM can help to draw attention to different aspects of phenomena. Indeed, as Creswell and Plano Clark (2017, p.61) argue:

> Mixed method research can yield insights into, and explanations of, the processes at work in a phenomenon and the multiple views of the phenomenon.

Furthermore, accounts from narratives about experiences are created through interaction with other people within the workplace and so, as Cohen, Manion and Morrison (2018, p.33) points out, 'MM increases the usefulness and credibility of the results found, indeed affording the opportunity for unexpected results to be found.' Therefore, it was clear to me that MM offered my study the best approach to achieving the research aims and addressing the research questions, along with my chosen conceptual tools.

Data Collection

Data collection involved conducting a feasibility test, choosing a research location, developing appropriate data collection tools, recruiting and selecting research participants, sending out the questionnaire, and conducting interviews.

I started by identifying both quantitative and qualitative methods which would help me to understand GP nurses' perceptions of spiritual care and describe their practices in the provision of spiritual care. Although numerical data generated from using quantitative methods can be collected by observing and interviewing participants, as previously mentioned, this would not be practically possible, hence, a questionnaire was thought to be the most appropriate means of collecting any quantitative data. I decided to use a pre-validated questionnaire, which was specifically created to identify nurses' perception

of spiritual care and which had previously been used by the RCN (2011b). This questionnaire included the 17-item Spirituality and Spiritual Care Rating Scale, which is discussed further in this chapter. In relation to qualitative methods, narratives from interviews or focus groups seemed most applicable for ease of communicating with the participants and collating qualitative data.

Feasibility Study

I carried out a feasibility study to ensure that the data collection tools (the questionnaire and interview questions) chosen and developed for my research, 'work as intended' (Oppenheim, 2000, p.47). I started with obtaining permission from the creator of the Spirituality and Spiritual Care Rating Scale (SSCRS), Professor Wilf McSherry (see Appendix 2), to use the scale as the main part of the questionnaire in my research. A group of ten education and professional doctoral students and lecturers (one nursing) completed the questionnaire. It was the same questionnaire that the RCN (2011b) had used to survey their members, however, it had been designed for all nursing staff to complete and included demographic sections; this meant that some questions referred to practices relating to hospitals and other environments. Considering the questionnaire did not relate to clinical procedures, I felt that asking the group to complete the form was appropriate for the feasibility study. However, when I tested the interview questions, I chose the nursing lecturer as I felt that she was best suited to answer the questions.

After completing the questionnaire, it became clear that it needed to be modified for use in this specific context. The initial feedback was that its focus was geared towards all nursing and midwifery staff which meant that the overall focus was not directed toward general practice. Since my study was, from the outset, designed to investigate GP nurses' perceptions and the provision of spiritual care in general practice I edited some of the questions to focus specifically on this area of healthcare, for example, references to chaplains (who work in hospitals) were changed to read 'local spiritual or religious leaders'. The main part of the questionnaire (the SSCRS), which focuses on perceptions of spiritual care, was found to be coherent and appropriate and thus was not adapted. This meant that the data generated by this section would enable me to identify participants' perception of spiritual care. All of the demographic section was omitted to protect confidentiality. Once the questionnaire was updated, it was sent to a different nursing lecturer and a nurse manager who completed it in order to verify the appropriateness of the design of the questionnaire for my research.

Although during the feasibility study the interview with the nursing lecturer was thought to be effective and appropriate for my research, the data collection process of holding focus groups proved unsuitable for the study. Respondents to the questionnaire had the option to express an interest in taking part in a focus group. However, once data collection had commenced, two weeks into gathering data, only four GP nurses' out of a pool of 25 respondents agreed to take part in a focus group. As there were not many responses, and as a result of a supervisory meeting discussion, it was decided that I would carry out individual interviews instead of focus groups. At the supervisory meeting, there was an opportunity to discuss whether altering the data collection method had any broader implications in terms of methodology; it was agreed that it did not. In addition, the necessary ethical approval was gained before proceeding with the amended strategy.

I originally decided to hold focus groups because the group dynamics of people that focus and discuss the same topic can inspire ideas (Bowling 2004). However, according to Cohen, Manion and Morrison (2018, p.527), a problem with focus groups is that when the topic for discussion is personal (such as the complex and subjective nature of spirituality), some people may be reserved around other people, especially if other group members are known, and ''public line' information is given as participants collude in withholding information.'

Whilst all focus group discussions would have been kept private and confidential, there might have been some GP nurses who would have felt that they would be judged by their peers about the way they deliver [or not] spiritual care, and they may have felt the need to exaggerate or give false information so that they would not be judged. The benefit of having individual interviews is that it might be easier to organise individual attendance than co-ordinate a single meeting with six busy professionals. Many GP nurses work on their own and/or part-time so getting them together was proving to be a challenge; furthermore, I would have required at least two groups to verify whether the results uniquely relate to the group's behaviour (Cohen, Manion and Morrison, 2018). Therefore, the use of interviews meant that dominant viewpoints often found in groups discussion will not exist, issues of confidentiality will not arise (Robson and McCartan, 2016), and according to Cohen, Manion and Morrison (2018), interviews generate more data with the same number of individuals than a focus group. This interview process is discussed further in this chapter.

Selecting the Research Location

Initially I planned to carry out my research across two research locations. The intention was to collate and analyse data from each location separately, and then make comparisons between them. The idea was to maximise opportunities by obtaining a sufficient amount of data and to discern whether there might be similarities in perceptions and practices among the participants. However, I decided to change this plan for two key reasons: first, I felt that since GP practices are situated in different towns and cities within an NHS region, there would be some opportunities to make comparison within one location; second, I felt that using one location would enable me to have greater manageability and coherence as I conducted this small-scale, time-restricted study.

I decided to locate my research within a culturally and socially diverse region where it could be assumed that the spiritual needs of that population are correspondingly diverse, and it would be interesting to discern how GP nurses manage care for a diverse group of people. I had also chosen this particular region for my research because it promoted itself as having a strong commitment to meeting national healthcare standards and a record in maintaining a high standard of primary care. In addition, the region's website promotes how the region means to improve and 'transform care': employees are urged to continue providing on-going care for patients; supporting patients with specific needs ensuring care is closer to home; and ensure patients have access to high quality services in general practice (uncited to maintain anonymity).

However, like many NHS organisations, those operating in this area make limited explicit reference to spiritual care. Spiritual care is not perceived as a specific service in either the NHS's *CQC Agreement* (CQC, 2013) (a mandatory agreement for any care provider including GP practices that wish to provide care) or its *NHS England Standard Personal Medical Services Contract 2018/19* (NHS England, 2018) (the statement submitted by NHS England to all regions and contractors outlining their commitment to reduce health inequalities). In addition, whilst the *NHS' Chaplaincy Guidelines* (NHS England, 2015) acknowledges that local NHS organisations are responsible for providing their patients with the spiritual care they require, but many of these organisations do not mention the needs of such care.

Data Collection Tools

This section discusses the process of choosing and developing the most appropriate tools to collect the research data.

Survey

Numerous research instruments can be employed in MM research to generate quantitative data (for example, surveys, evaluations) and thus can be used to elicit perceptions of spiritual care. I decided to use a questionnaire to create the survey for three reasons. First, as Watkins and Gioia (2015, p.5) indicate, the quantitative research 'can generate a broad understanding of a phenomenon from many people' which should help me reach a lot of GP nurses across the region to assist me in addressing my research aims and predominantly, the first question; second, GP nurses are very busy so I thought it would be, in terms of practicability, an easier and quicker method for them to complete as the questionnaire would be available online no matter their work pattern; and third because, the questionnaire is online, GP nurses may feel more comfortable responding to questions of a 'sensitive subject matter' (Leavy, 2017, p.19). I believed this to be relevant since studies have shown that spirituality is an important but confusing concept for many healthcare professionals (McSherry and Jamieson, 2011); complexity at an individual and practical level may also be mirrored at the organisational level. The use of a questionnaire would enable perceptions to be gathered online and give respondents the option to register for the second phase of the research. Moreover, the questionnaire presents possibilities to add further textual data in which respondents can explain or elaborate on the responses they have given. I have found that in small studies that I have previously carried out, for example when I created a questionnaire to investigate lecturers' use of IT in their lectures, some respondents took the opportunity to articulate their thoughts about why they responded the way they did.

Therefore, I elected to use an online questionnaire; I created a Google form which allowed me to investigate my chosen subjects but included text boxes for respondents to add further information or comments. I was particularly interested in using the Spirituality and Spiritual Care Rating Scale (SSCRS) for the main content rather than other questionnaires widely used in research into spiritual care, namely *Spiritual Care Competence Scale*, which measures respondents perception of their ability in providing spiritual care, and *Spiritual Attitude and Involvement List*, which evaluates respondents' personal spirituality (van Leeuwen and Schep-Akkerman, 2015; Ross et al., 2016). The SSCRS is a 17-item scale that elicits descriptions of respondents' perceptions of spiritual care, and allows the investigator to obtain an understanding into their spiritual care practices, and how respondents become aware of their practices and their environment (Ross et al., 2016). Thus:

> The reason for using a pre-validated instrument (SSCRS) was to increase the reliability and validity of the survey. The SSCRS has been used in over 42 studies in eleven different countries. (RCN, 2011b, p.7).

Having received permission to use the SSCRS, the questionnaire was developed into an online form, incorporating and structured around the SSCRS key questions (see Appendix 3). There was an optional section added to the end of the questionnaire asking whether respondents (a potential number of 183 GP nurses) would be interested in being interviewed as a follow up to the questionnaire. I did not, however, maintain a list of those who agreed to be interviewed alongside their responses to the questionnaire. Instead, I set out to promote the opportunity, to respondents, of participating in the next phase of the study; however, I separated their questionnaire responses from the list of contact details of those who wanted to be interviewed so their responses remained anonymous.

Semi-structured Interviews

Whilst MM research can use various forms of data (for example, observations, diaries), to elicit information on the provision of spiritual care, I had two key reasons why I chose to use interviews. First, as Holloway and Galvin (2017, p.88) indicate, the qualitative research interview is 'an interview which can identify feelings, perceptions and thoughts elicited from information produced' which should enable me to address the research aims and questions. Second, the idea of interviews is conceptually 'a way for researchers to prompt or ask for examples and descriptions; the purpose of which is to search for elaboration, meaning or reasons' (Holloway and Galvin, 2017, p.93). However, interviews enable the researcher and interviewee to jointly develop the practice, with the interview not only carried out to produce data but also the possibility to investigate what the research means to the interviewee. In addition, interviews present opportunities to have one-to-one conversations, enabling interviewees to become more open about the events experienced, and how they interpreted them. Therefore, individual interviews offer a significant opportunity for investigating the relationship between participants' beliefs and social structures particularly on complex and personal topics (Holloway and Galvin, 2017).

I was particularly drawn to 'semi-structured' instead of 'structured' or 'unstructured' interviews (Bryman, 2012). Semi-structured interviews can and do, use the stories of the interviewee to understand the way they live in the context of society, enabling the researcher to 'modify [questions] based on the flow of the interview, and additional unplanned questions are asked to follow up' (Robson, 2011, p.280). While structured interviews ensure that the discourse is focused and appropriate to the topic explored, they can be inflexible which may prevent new data from emerging, whereas unstructured

interviews allow interviewees the flexibility to speak freely, but can cause participants to discuss unrelated topics (Bryman, 2012).

Many researchers (for example, McSherry and Jamieson, 2011; Rogers and Wattis, 2015) have identified the difficulty and complexity of the concepts of spirituality and spiritual care. In an attempt to overcome this, I collated, modified and sent a collection of six definitions, each one with a different emphasis and published in the last twenty years, to respondents prior to the interview. It is likely that if the interviewees were unsure of the concepts, they may have searched on the internet and it is probable that they would have found varying definitions, some of which identify the concept largely with religion. Six definitions were provided in order to offer some clarity without influencing their perceptions of the concepts. The definitions of spiritual care which were sent are presented in Appendix 4; however, Table 1 provides the modified definitions together with my comments about the key characteristics of each one pertinent to the healthcare focus of this investigation. Along with the definitions, I sent six questions that make up the semi-structured element of the interviews also presented in Appendix 4. By providing this information in advance, I wanted to give the interviewees some time to think about the complex concept of spiritual care, to enable them to see the structure of the interview (Gillham, 2005), and thus, help focus the interview (Bryman, 2012). I was also able to follow up with or pose challenging questions according to practices or themes which emerged from responses during the interviews.

Table 1: Modified definitions of spiritual care

Author	Definitions	Comments
1. Rogers and Wattis, 2015 (p.53)	Spiritual care engages a person as a unique spiritual being, in ways that will provide them with a sense of meaning and purpose, connecting or reconnecting with a community where they experience a sense of wellbeing, addressing suffering and developing coping strategies to improve their quality of life.	Spiritual care is dynamic and recognises the differences in people. Both religious and non-religious beliefs are covered by the pluralistic idea.

2. RCN, 2011b	Spiritual care will help a patient find confidence, faith, hope, love, meaning, values, belief, forgiveness, strength, trust, self-expression and creativity.	The needs of the patient are highlighted in this definition, and is inclusive of people who are religious or non-religious. This is particularly useful in a multi-cultural society.
3. Puchalski, 2001	Spiritual care is a loving approach that attends to an individual's emotional, social, psychological and physical needs.	This definition presents a holistic concept of spiritual care that is a component of the biological make-up of human beings.
4. NHS Education for Scotland, 2009	Spiritual care is an essential element in healing and growth, and is essential to holistic care and person-centred care.	A general perspective of spiritual care which is included within different types of care.
5. Anandarajah and Hight, 2001	Spiritual care involves presence, compassion and encouragement of hope to patients.	This definition is not specifically related to religion. The reference to hope gives people the desire for the best achievement without being demanding.
6. General suggestion	Spiritual care is asking questions to patients to discover their needs.	One element of giving spiritual care, which is often used in conjunction with other elements, with no indication of what those questions may be. A vague definition added to give variety.

Recruiting Participants

The NHS Health Research Authority granted approval for the research's ethics (see Appendix 5), in addition to the approval granted by the research region's main office (see

Appendix 6) and Oxford Brookes University (see Appendix 7) in advance of recruiting participants for my research; ethical approval was for both the initial proposal of focus groups and then for the amended strategy of individual interviews. Having chosen to focus on GP nurses (typically, hospital based nurses are not only researched more frequently, but they have quite different support needs and practices, in addition, GP nurses are under-represented in NHS general practice development literature), I contacted them, via a gatekeeper. The gatekeeper sent out the recruitment email to all GP nurses in the research region. Once it was agreed to conduct interviews rather than focus groups, a second email was issued. This second email explained the change and proposed that those who had already completed the questionnaire and who had not left their details because they did not want to participate in a focus group but would be willing to be interviewed, should email the researcher directly. The research was open to all GP nurses, however, they had to be currently employed in at least one of the GP practices in the region; participation from agency nurses that were working in the region at the time, was also welcome.

For the reasons summarised in Chapter Two, the GP nurse role requires experience and confidence. The role is complex and challenging with significant levels of autonomy and pressures relating to time (While and Webley-Brown, 2017). Thus, an online questionnaire was considered a convenient and effective way to encourage GP nurses to participate in my research (Robson and McCartan, 2016).

Sending the Questionnaire

The recruitment email, sent by the gatekeeper, included a link to the participant information sheet (PIS) which outlined important aspects of the study to potential participants about the people involved in the research and the motivation and procedures of the study. On the PIS was a link to the web-based questionnaire and consent was captured on it before a participant was asked to complete it. The questionnaire was anonymous and available for completion for one month.

Although the questionnaire was anonymous and did not collect any personal information, in an attempt to register participants for the study's second phase, individual interviews, respondents had the option to give their name and email address at the end of the questionnaire to express their interest in this qualitative part of the research. There were 39 respondents to the questionnaire, but for the reasons outlined in the feasibility test, there was a change from focus groups to interviews. Due to the fact that using the questionnaire was the only way to express interest, some respondents who had completed the questionnaire but did not wish to participate in a focus group may have

signed up to be interviewed but would have lost the chance to do so. Thus, after gaining ethical approval to amend my questionnaire (see Appendix 8) and focus groups to interviews, an additional email was sent, via the gatekeeper, explaining the change and asking those who had already completed the questionnaire to contact me directly.

Selecting and Preparing Participants for Interviews

Fourteen GP nurses submitted their contact details via the questionnaire or directly to me via email (if they had already completed the questionnaire prior to the change from focus groups to interviews); ten respondents were selected. The four GP nurses who were not interviewed all met the research criteria, but either changed their mind due to time constraints or I was unable to contact them; they might have left the organisation, and therefore no longer had access to their email account. Due to the number of available respondents and the size and limitations of this research, I decided to interview the remaining ten GP nurses rather than advertise for more participants.

I contacted all ten respondents via email, and I outlined the study, explained the reason for choosing spiritual care and GP nurses, and I clarified how the data would be used. I explained that the aim of the interviews is to learn more about their perceptions and to identify their provision of spiritual care. I also explained how I would be subsequently using my findings for other purposes, such as academic journal papers and presentations. I explained the need to digitally record interviews and this would be with the use of my personal, password protected iPad; the audio files would then be uploaded to my personal Google Drive and then deleted from the device before leaving the research site. It was also made clear that all collated information would stay anonymous and be treated confidentially. Furthermore, the GP nurses were sent a copy of the Participant Information Sheet (Appendix 9), privacy statement (GDPR) (Appendix 10) to read and keep, and a consent form (Appendix 11) to sign and return before or on the day of the interview.

Conducting the Interviews

The GP nurses chose the venue in which the interviews would take place as well as the day and time. All the GP nurses chose to have their interviews at their place of work, either during a break or outside their normal working hours, in order to mitigate any disruption to the GP practice. Prior to commencing the interview, GP nurses were given the opportunity to seek clarification on the research or interview procedures. Following this, they provided their consent by signing and returning a consent form.

The interview began by asking each participant to explain their decision for their chosen definition; this process allowed them to reflect on their interpretation of spiritual care as well as start the interview process. In order to immerse myself in the data, I transcribed the data ensuring I had reviewed each recording a number of times in the process.

Ethical and Methodological Considerations

Throughout my research, I adhered to the required principles pertaining to ethics of avoiding harm, securing privacy, and establishing autonomy, as required by the research site's codes of practice and the Research Ethics Committee (UREC) at Oxford Brookes University. In doing so, I made certain that the research was thoroughly explained to the GP nurses including the fact that I am not a nurse. I felt that disclosing this fact was important because I believe that the interviewees would see me as an objective person and potentially provide more sensitive data because of my detachment from the profession (Bonner and Tolhurst, 2002); while, my limited knowledge of nursing may have required me to understand the basics of what the GP nurses were saying (Bonner and Tolhurst, 2002). However, since the research was non-clinical, this was not a concern.

I was conscious of the fact that GP nurses work in different practices; they have varying working hours and days, and have different contextual difficulties for example, staff shortage, lone-working, limited patient contact time in comparison to other nurses in different environments. Thus, I spent a considerable amount of time organising interviews that would not negatively impact on their working day. I also tried to avoid any psychological harm during interviews by providing details of internal and external, local support groups/organisations such as MIND, to help interviewees manage any negative experiences that may arise. However, I realised from the outset, that the interviews as a research method, can give rise to its own ethical concerns.

Whilst May (2011, p.148) argues that 'the experiential [aspects of the interviewing process] need not be bracketed in seeking scientific rigour, the 'postmodern' critique of the interview process is concerned with three issues: interaction, 'refusal' and research aim' all of which I was required to address throughout my research.

In relation to interaction, for many reviewers of the interview process the most troublesome aspect is the potential exploitation between the interviewer and the interviewee. However, during this process, interaction is presumed and required, because the interviewer must develop a close relationship with the interviewee to establish the necessary level of rapport and trust to encourage the telling of experiences.

At the same time, I remained mindful of the potential influence of my own values, experiences, and beliefs on the interpretation of the narratives collected throughout the various stages of the research process.

Another issue of the interview process is centred on the problem of 'refusal' and the authenticity of the investigation (Denzin, 1997). More specifically, interviewees can avoid or refuse to answer questions, because so much is chosen not to be told or has been forgotten, and thus they provide 'incomplete' stories (Alvermann, 2002). As a consequence, these concerns have led to critics arguing that investigations that use narratives are inherently inaccurate except when they can be validated by, for example, triangulation (Lincoln and Guba, 1985). Arguably, people choose to talk about their experiences, and this should be taken in good faith rather than attempting to cross-check them. In fact, the process of verification in narrative research, might actually change or distort the experiences, including the possibility of the researcher imposing their own narrative. Even though the mixed methods approach in my study applied a methodological type of triangulation (Denzin, 1997), rather than verifying the validity of the experiences told during the interview process, the data from the survey (combined data from the questionnaires) helped to identify GP nurses' perceptions of spiritual care, and offered little in the way of how they practise spiritual care; more specifically, the interview questions generated data relating to the provision of spiritual care by GP nurses. Applying both methods enabled me to explore the multiple aspects (Gorard and Taylor, 2004) of spiritual care in healthcare rather than for inconsistencies or contradictions.

The final issue of the interview process centres on the aim of the research, that is whose practices and information is the research trying to capture, and if it is possible for the researcher to directly reproduce and portray lived experiences. Writers on the interview process argue that narratives, stories, anecdotes are the most effective way to identify shared experiences. However, some researchers give two key reasons why they believe that it is impossible to obtain a precise account of what was said or meant; first, investigators are unable to access the experiences and practices of others, and second, they create descriptions of experiences in the social text; namely:

> Language and speech do not mirror experience: They create experience and in the process of creation constantly transform and defer that which is being described. The meanings of a subject's statements are, therefore, always in motion (Denzin 1997, p.5).

Mindful of this, I regularly consulted the transcripts when interpreting stories and allocating themes, searching for times when I may not have adequately represented the

GP nurses. For example, I describe experiences involving GP nurses' provision of spiritual care in Chapter Four. However, in spite of these best attempts, I appreciate the fact that I played a significant role in the research process, in choosing the questions that were asked and the choosing of the experiences and the themes to be analysed. Additionally, whilst the themes from the experiences in this study have been told by GP nurses, they have been chosen and presented by me.

Analysing the Data

It is recognised that the main feature of critical realism (CR), and the one that differentiates it from other types of theories, is the need to apply a methodology that will be able to distinguish between the posited *real* and *empirical* (observable) worlds. Applying CR with the use of mixed methods meant that data collection and analysis needed to be capable of identifying underlying mechanisms and structures throughout. The questionnaire was analysed first and started after all the data from the questionnaire and interviews had ended. The reason for this was because the questionnaire was the only way that respondents could express an interest in being interviewed. The entire process lasted approximately four months.

Following the approach adopted by other researchers utilising mixed methods, the analysis of the data was conducted in two distinct phases: descriptive analysis as outlined by May (2011) and thematic analysis, following the six-phase framework proposed by Braun and Clarke (2006). This sequential approach allowed for a comprehensive examination of the data, ensuring both the descriptive aspects and underlying themes were captured and analysed. I applied the six phases of thematic analysis (Appendix 12):

- Phase 1 — (familiarising) assisted in re-reading and reorganising data.
- Phase 2 — (generating codes) – this phase was about relating to the concepts of the *real, actual* and *empirical* when identifying codes.
- Phase 3 — (searching) used to identify themes from the codes.
- Phase 4 — (reviewing) was the opportunity to check if the themes were representative of the coded data.
- Phase 5 — (defining) was a continual refinement of the themes and general picture of the analysis, generating names and definitions of the themes.
- Phase 6 — (producing) used to determine final analysis and select extracted quotes that are relevant to the literature and the research question.

When analysing the quantitative data, I used descriptive statistics as it is useful for describing or summarising data enabling a visual interpretation of the important aspects within it (May, 2011). I had considered carrying out inferential statistics to identify associations between the statements (SSCRS) and to potentially gain a deeper analysis of the data (Watkins and Gioia, 2015). However, the survey generated a low number of responses, demographic data was not collected from which inferences could be made, and the SSCRS had been shown to have consistent validity and reliability in measuring spirituality and spiritual care with a good 'Cronbach's alpha score ranging from 0.64 to 0.84' (Ross et al., 2016, p.447). Since, according to Sullivan and Artino (2013, p.542) 'using the Cronbach alpha provides evidence that the components of the scale are sufficiently intercorrelated and that the grouped items measure the underlying variable', it was not deemed necessary or appropriate to carry out inferential statistics. The data from the SSCRS part of the questionnaire enabled me to make conclusions about GP nurses' perceptions of spiritual care. This information was entered into Statistical Package for Social Sciences (SPSS) software (version 25) allowing me to organise and summarise the sample population (Thomas, 2013), and then identify and analyse patterns within the data. Data produced in the free text boxes provided, gave respondents the opportunity to add comments to their responses; the text was transcribed verbatim, and analysed using thematic analysis. This qualitative element of the questionnaire was used to interpret common patterns found in the quantitative component of the survey data (Thomas, 2013).

In advance of analysing the transcripts (qualitative data), I searched for experiences and practices throughout all the narratives of each GP nurse who participated and searched for common patterns in the data in relation to the concepts of *real, actual* and *empirical*. A focus on these concepts meant that when carrying out thematic analysis, I was attentive to themes which emerged that appeared to describe possible underlying reasons for these GP nurses' perceptions and practices. In addition to investigating GP nurses' reported practices, which included the reasons for the way they practise, the application of the concepts enabled me to look beyond experiences and events observed in the *empirical* and *actual*, to identify structures and mechanisms that have influenced their practices such as the beliefs they have acquired during their upbringing. I then coded the text using NVivo (version 12). I was able to apply line-by-line coding to help me develop initial codes that detailed the processes involved (Best, Butow and Olver, 2016) in the provision of spiritual care by GP nurses. I decided to focus on the patterns and commonalities where GP nurses converge in their practices although from the data set, I could have just as equally analysed the data from the point of divergence, but decided on the former for two reasons: first, this thesis is an educational doctorate, I am

interested in professional education and I hoped to identify implications for professional development; and second, I am interested in supporting this constituency to practise to the best of their ability. Subsequently, I applied thematic analysis and then used these themes to place the participants' practices into Bhaskar's notion of a stratified reality by emphasising the GP nurses' subjective positions and contextual situations, including the causal links of these events (Creswell, 2003).

In a similar way to other mixed methods studies, I had individually analysed the quantitative and qualitative data before combining the findings in the interpretation phase (Creswell and Plano Clark, 2017) to gain greater insight of GP nurses' perceptions and practices (Charmaz, 2014). In doing so, I have been able to draw on findings from both methods to provide a better understanding of these links and thus investigate and address my research aims and questions.

Personal Account/Reflexivity

Validity and reliability were used to assess the research's rigour and quality, ensuring the trustworthiness of the data and the consistency of the findings (Woods, 2003). I was able to locate myself within the study, with the aid of reflexivity, and thus examine my own beliefs and experiences which may have biased the investigation. Thus, reflexivity is important, particularly within qualitative research, as it is recognised that it is impossible to separate a researcher from their own socially constructed world which may have been formed by professional and personal experiences. Fundamentally, reflexivity acts like a way of ensuring the general quality of the study, and this was achieved by understanding my motivation for carrying out the research, and thus enabling the reader to have an awareness of any potential bias that may have unintentionally pervaded this study.

Based on my educational experiences and practices, I have recognised the significance of incorporating the spiritual aspect of care to promote the overall wellbeing of patients; although, the spiritual aspect of care is often understated or not recognised within healthcare. An example of this is through my work at the Oxford Centre for Spirituality and Wellbeing. The centre was created to help healthcare professionals develop understanding and competence in this element of patient-centred care. An important lesson I learned while working at the centre was how many healthcare professionals have difficulty in the practical application or structured assessment of spiritual care. Healthcare professionals (nurses, doctors, chaplains, management) who felt the need to participate in the development opportunities that were delivered by the centre demonstrated that the physical aspect of care is prioritised over the other aspects of

care, such as social, psychological and spiritual, in their day-to-day work. This important problem led me to want to look more closely at how the spiritual aspect of care is practised in healthcare. Reflexivity enabled me to declare my personal motivation for this research in addition to: identify the study's ontological and epistemological underpinnings; explain the theoretical and methodological approaches undertaken, including the combination of data (questionnaire and interviews) used; and ensured that research ethics were observed in such a way that any bias that could pervade the study was acknowledged.

Presenting the Data

Numerous techniques can be used in mixed methods research (Denzin, 1989). Initially, I had considered presenting my data as one overall finding that combined the quantitative and qualitative data identified from the two methods employed in the research. However, having considered this type of presentation, I realised that I could not support it because the information lacked the nuances of findings and analysis that each method brought to the final interpretation. Therefore, I reverted to presenting each method independently; in this study I started with the quantitative method to generalise findings from the population, followed by an in-depth exploration of GP nurses' practices using the qualitative method; the findings were then combined to represent the social context (Creswell, 2003). In presenting the data from the SSCRS, I used percentages, frequencies and charts. This was important, as Robson (2011) argues that these methods of displaying data can be an effective way of analysing and presenting data.

In identifying the narratives from the interview data, I applied the GP nurses' own words as much as possible. This was important to me since, as May (2011, p.155) argues, 'the analysis of interviews focuses not only on motivations and reasons, but also on social identities and how these are constructed within the social setting in which people live and work'. In addition, actual references from interviewees have been used to enable them to allow their voice to be heard, and thus express themselves.

However, I understand that there may be a lack of consistency between the meaning of each GP nurse's reported practice and the narratives I introduce in the following chapter, because of:

> The limits of language to capture the complexity and depth of experienced meaning [...] the resistance of people to reveal fully felt meanings of which they are aware, and the complexity caused by the fact that texts are often a co-creation of the interviewer and participant (Polkinghorne, 2007, p.481).

My goal was to report practices that GP nurses would be familiar with, although I would emphasise that any interpretations of GP nurses' practices are mine and not theirs.

My analysis from both methods provided me with the opportunity to present data in different ways. I decided to present it in Chapter Four; individual sections address the quantitative and qualitative aspects of my research. I analysed both methods in this way for two reasons. First, as I have previously mentioned, this is one of the traditional ways in which mixed methods research has been carried out, thus making it somewhat easy to make a comparison between my findings and those of other studies on spiritual care, particularly those that have used the SSCRS; and, second, as current research has identified, there is a paucity of research that seeks to investigate 'the effect of the long-term practitioner-patient relationship [...] and the quality of care in general practice' (The Academy of Medical Sciences, 2009, p.9) which relates to the data collected from the interviews.

Summary

The methodological structure of the present research was established in this chapter as well as the practical steps of collecting the data and the rationale for adopting Bhaskar's (2008) notion of a stratified reality applying its posited concepts of *real*, *actual* and *empirical* to explain and understand the practices of GP nurses. The chapter has sought to justify my decisions to use a survey and interviews that were semi-structured, enabling me to address the research questions and reach the study's aims. It has also provided a summary of some methodological and ethical issues I addressed in carrying out this study. Furthermore, I explained the reasons for choosing to analyse and present GP nurse's perception of spiritual care, and practices in the way I did. With this context established, attention turns in the following chapter to presenting and analysing the resulting primary data gathered in this study on how GP nurses perceive and practise spiritual care.

Chapter Four: Findings and Analysis

Introduction

This chapter provides information on the data collection process that was undertaken, which involved administering questionnaires and conducting interviews with a sample of GP nurses to research their perceptions and the provision of spiritual care. Common themes emerging from the data will be reported and analysed. Several limitations were identified in this present study, and one of these limitations pertained to the sample consisting solely of GP nurses, this is discussed further in the conclusion chapter.

The chapter starts by outlining the findings from the online questionnaire, concentrating primarily on GP nurses' perceptions of the concept of spiritual care, and provides an insight into the impact of the general practice context on their provision of spiritual care. Next, the chapter highlights the findings from the semi-structured interviews to explore how GP nurses care for patients' differences while delivering spiritual care with their own spiritual and/or religious beliefs, before concentrating on the strategies they apply, namely 'sincerity', 'inherent kindness', 'respecting the individual', 'encouraging relationships' and 'valuing the wider context'. In conclusion, this chapter brings together the findings obtained from both quantitative and qualitative methods, allowing for a comprehensive interpretation of the data.

By doing this, three important areas are highlighted: first, the subjective and relational aspects of spiritual care and methods for achieving this with patients and in an organisational context within a GP setting; second, the rationale behind why some GP nurses choose to focus attention on the spiritual dimension of their care; third, which causal powers from structures are activated by an internal dialogue (Caetano, 2015) or 'reflexive *real'*, coming from endeavours, restrictions and exclusion, which continues to be shaped by GP nurses' practices and experiences in general practice, and how this informs the decisions GP nurses make as to whether to deliver spiritual care or not. The chapter concludes by setting out all the findings in a concise model of how the key dimensions that GP nurses seem to have that influences their perceptions and practices in the provision of spiritual care for patients in GP settings.

Online Questionnaire — Quantitative Data

The initial step towards understanding how GP nurses' perceptions and practices are influenced by the general practice context was by investigating whether it was possible to obtain meaningful accounts of their perceptions. To assess the influence of the general practice context on the provision of spiritual care, it was necessary to establish various

levels of similarity. The first two research questions therefore asked: What are GP nurses' perceptions of spiritual care? What is the impact of the general practice context on GP nurses' provision of spiritual care?

The online questionnaire was the first phase of this study; it has four parts which help to address these questions. The first part represents the collective data on GP nurses' perceptions (the SSCRS) addressing the first research question. The second part investigates possible variations in how GP nurses, religious leaders, patients, and/or their families perceive their roles in providing spiritual care. The third part distinguishes differences between recognising patients' spiritual needs and perceived capacity for being able to meet those needs. The final part addresses whether there are differences between the respondents in terms of their training in the provision of spiritual care. Therefore, the examination of various practical constraints experienced by GP nurses allowed for an assessment of their influence on meeting the spiritual needs of patients. Thus, the last three parts help to partly address the second research question.

The results are outlined, but the general argument proposed here is quite simple; there are similarities between these GP nurses on their perceptions of spiritual care that govern their interactions with patients. Although not all GP nurses indicated that they were governed by these beliefs, it was apparent that there was some consistency amongst them in the interview phase.

Common Perceptions of Spiritual Care

At the beginning of the questionnaire is the SSCRS. GP nurses were asked to complete this 17-item scale by choosing responses from a list of statements, ranked from 'Strongly Disagree' to 'Strongly Agree', that they considered best reflected their perceptions of spiritual care. Descriptive analysis was employed to present a comprehensive summary of the collected data, allowing for the depiction of the population through the use of graphs and tables and to identify relationships between variables (Robson, 2011).

Out of a possible sample size of 183 (the total of GP nurses working in the region), a total of 39 GP nurses completed the questionnaire equating to 21% of the sample population. This population is spread across a large region so it was decided that sending out a questionnaire would be the most effective method to employ. However, since GP nurses work in general practice, an area of healthcare which is under increasing pressure (Baird et al., 2016), they might not have wanted to participate in the study. Nonetheless, sending an online questionnaire, which is easily accessible at any time, appeared to be the most beneficial method with which to reach them. Since the number of respondents

is small, the findings from the survey (combined and evaluated data for the questionnaires) are unlikely to adequately represent the population of GP nurses in the UK but will nevertheless furnish valuable preliminary data on a neglected research population. The GP nurses were given the task of ranking their perceptions about spiritual care in the first part of the questionnaire.

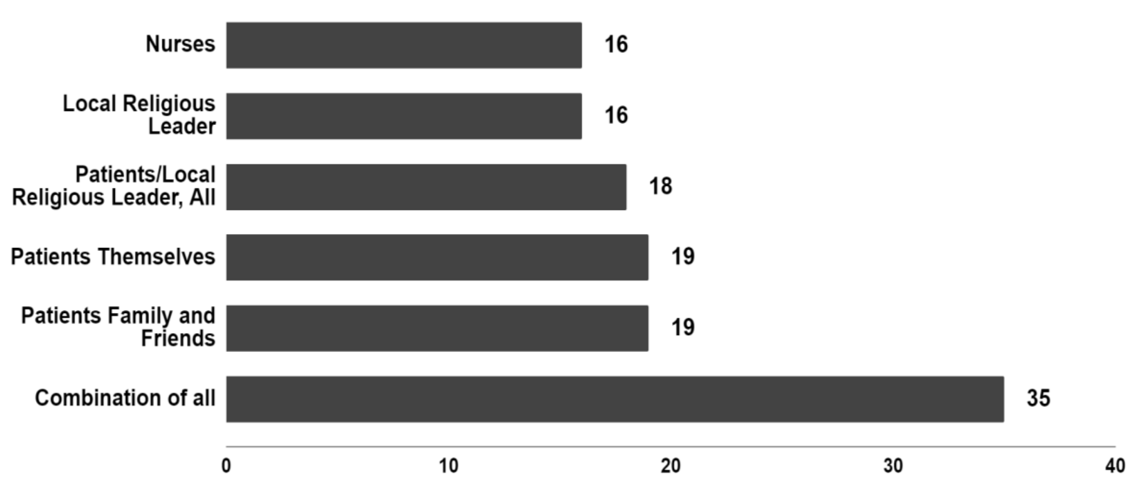
Although several researchers (for example, Oxhandler, 2017; Withers, Zuniga and van Sell, 2017) state that the spiritual care can prove challenging because of the ambiguous nature of its meaning for healthcare staff, one reason being the existence of many definitions (Timmins and Caldeira, 2017) which can confuse healthcare staff about its practical application (McSherry, 2007) so spiritual care remains very vaguely defined, over 92% of respondents to the SSCRS reported the belief that nurses can provide spiritual care by showing kindness, concern and cheerfulness. Furthermore, nearly all the GP nurses (except one respondent who was not sure) *Agree* or *Strongly Agree* that nurses could provide spiritual care by spending time with a patient, supporting and reassuring them; most GP nurses (except for two respondents who were not sure) *Agree* or *Strongly Agree* that nurses can provide spiritual care by listening to and allowing patients time to discuss and explore their fears, anxieties and troubles. A possible explanation for these results may be because they were drawing from a limited number of definitions, which means if asked, they may have offered others in this context. These responses highlight the subjective and relational importance connected to the provision of spiritual care.

In addition, all the respondents reported the belief that nurses can provide spiritual care by having respect for privacy, dignity and the religious and cultural beliefs of a patient, with over three quarters (77%) of respondents believing nurses can provide spiritual care by arranging a visit by a religious leader or the patient's own religious leader if requested. However, the respondents were divided when it came to the statement referring to spirituality as being concerned with a belief or faith in God; there were just as many GP nurses who were *Uncertain* or *Disagree* with the statement as those who did: in other words some GP nurses believe that it is not necessary to have a belief in God or a Supreme Being in order to provide spiritual care. This is interesting since research shows that among healthcare staff, spirituality can be confused with religion (McSherry, 2007) and so this could have meant that some GP nurses may not have felt comfortable or capable of providing spiritual care because they did not have a faith.

Differences in Perceptions Spiritual Care

Figure 6 identifies respondents' views as to whom they deem responsible for providing patients with spiritual care; these consist of the patient having some responsibility for meeting their own spiritual needs as well as nurses, religious leaders, the patient's family, or a combination of all these groups working together. It is no surprise that religious leaders would be considered as the group of people to deliver spiritual care since spirituality has been, and still is widely linked with religion in the minds of many people (Koenig, 2012). Other parties such as family members would also be expected to provide spiritual care, although it is unlikely that they will have, unlike religious leaders, training in this area; nevertheless, they are best placed to identify the patient's wants and desires, may actually be a part of the patient's spiritual needs, and/or could provide invaluable help to healthcare staff so they can provide spiritual care that the patient requires.

Figure 6: Parties deemed responsible for providing spiritual care



What is surprising about the data in this part of the questionnaire is that although 82% of GP nurses had encountered a patient who identified that they had a spiritual need, mainly recognised by the patient identifying their needs or the GP nurse listening to and/or observing the patient, a third of respondents (35.9%) believed they were generally unable to adequately address the spiritual needs of their patients. Further still, 69.2% could not recall receiving any educational or professional development on spiritual care during their pre-registration nurse education, and since qualifying as a nurse, nearly 90% of respondents reported that they have never had any training on spiritual care. Although the suggestion of developing healthcare staff's spiritual care skills is welcomed [by respondents], many feel that they have not had development in this area, however amongst those who did (n=9), only a few could recall specific sessions focused on spiritual care provision (during a palliative care course and two lectures, one of which

was by a hospital chaplain), which could have included any session that addressed, for example, empathy and listening (see Appendix 13).

Finally, all 39 respondents were invited to explain, in a free text box, whether they feel that nurses are adequately trained in spiritual care-related topics. A third of them stated that there is no training available on spiritual care; one respondent stating that:

> There is no emphasis on this during nurse training and no further study days are offered once in a place of work.
>
> GP Nurse 23

Another third said that there is no time to attend a course [if there was one] or that training is not a priority:

> I think nurses are so focused on care plans/booked appointment times etc. that the time for talking to patients is lost and that nurse-patient bond is not formulated.
>
> GP Nurse 10

> We are too busy with the physical needs and time restraints are so bad now, we are all under so much pressure overworked and lack of staff.
>
> GP Nurse 17

Many of the other respondents suggested that in practice nurses will develop their skills and gain confidence in the provision of spiritual care or have inherent skills. There are two examples below:

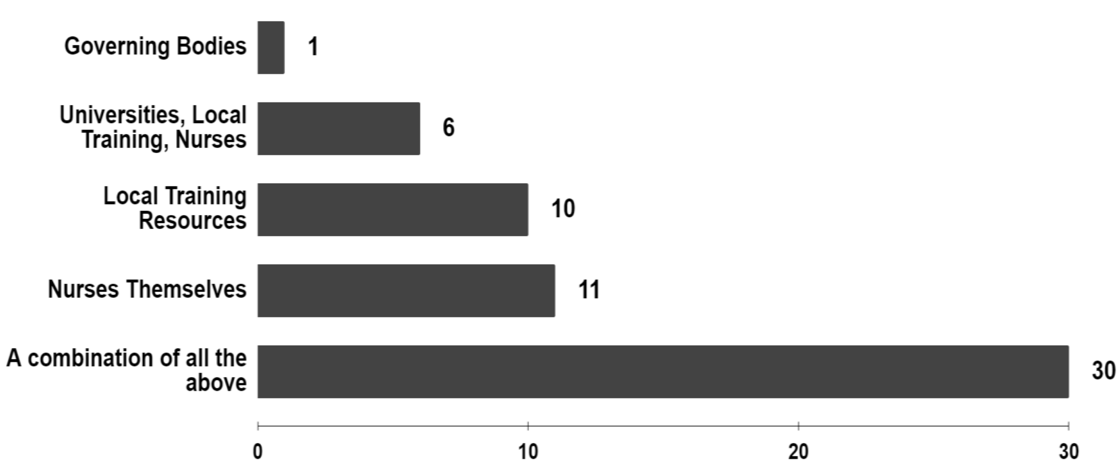
> Being in the profession for long gives one experience to deal with situations as we don't get a lot of training.
>
> GP Nurse 34

> If you are a good nurse you are able, to the best of your ability, to ensure you give holistic care.
>
> GP Nurse 30

These reasons indicate that GP nurses are very mindful of the need to expand their knowledge of spiritual care and suggest the need for training as well as the acknowledgment of the value of spiritual care in healthcare. Moreover, some people could argue that some GP nurses might use their lack of understanding about spirituality as a reason for not engaging with patients and thus not deliver spiritual care. Nevertheless, the final question on the questionnaire asked respondents who they feel

is responsible for providing nurses with instructions concerning spiritual care. Over three quarters (76.9%) of respondents reported that they considered it the responsibility of governing bodies, training institutions, local training resources as well as nurses all working together (see Figure 7).

Figure 7: Responsible for providing instruction on spiritual care



As mentioned in Chapter Three, demographic data was not collated, to protect participants' confidentiality, so it was not possible to make comparisons between different groups such as male versus females, or nurses with five years' experience versus those with less than one year's experience. Instead a comparison was made to identify the similarities and differences among the participants regarding their perceptions.

Appendix 14 provides an outline of the comparative perceptions of spiritual care established among the GP nurses. It displays the frequencies and percentages pertaining to each of the statements, but the responses are in order of the highest ranking agreement first, rather than in alphabetical order, thus, identifying the greatest consensus by responses about spiritual care. Throughout the research, a shortened version that describes a statement was used along with a reference letter for simplicity and clarity.

Within the questionnaire, m) *having respect for the patient*, c) *it is not necessary to go to Church/Place of Worship,* f) *spending time with a patient*, j) *listening to and allowing patients time,* and a) *showing kindness,* emerged as the highest comparable statements. These top five statements were ranked similarly either *Agree* or *Strongly Agree,* or in the case of statement c) *Strongly Disagree or Disagree,* by large numbers of GP nurses (m) 100%, c) 97.5%, f) 97.5%, j) 94.9%, and a) 92.3) respectively. These results could, perhaps, be considered as common perceptions of spiritual care by these GP nurses.

The analysis from the interviews, which follows after this section, will investigate the implications of this argument.

Individually, these statements represent similar underlying orientation towards spiritual care. Therefore, discovering that all of the statements were considered essential to nearly all the GP nurses as a whole group, suggests that GP nurses have a degree of commonality in their perceptions of spiritual care. The last column in Appendix 14 presents the percentage of GP nurses who agree with the questionnaire statements.

Perhaps, since there was not a high representation among respondents, these statements could not be considered as possible typical perceptions of spiritual care by GP nurses (in the region), but identifies the perceptions of some of them. Whether or not b) *concerned with a need to forgive and be forgiven* (53.9%), and d) *not concerned with a belief or faith* (48.8%) should be considered as typical is not so clear due to their lower percentage rates.

The similarities and differences identified begin to address the first research question: What are GP nurses' perceptions of spiritual care? The results from the quantitative part of the study suggest a number of common perceptions.

Comparing Attributed and Adopted Perceptions of Spiritual Care

The results (see Appendix 14) show that GP nurses' perceptions of spiritual care mostly agree with all the statements provided in the SSCRS, but the top five statements (m) *having respect for privacy, dignity and religious and cultural beliefs of a patient*, c) *it is not necessary to go to Church/Place of Worship,* f) *spending time with a patient*, j) *listening to and allowing patients time, and* (a) *by showing kindness, concern and cheerfulness when giving care,* were identified as key elements in the provision of spiritual care and were considered of utmost importance by all GP nurses. These statements had the highest percentage of agreement by GP nurses, respectively. However, statements f), j) and a) had slight variances due to some respondents declaring themselves to be uncertain about them. Again, the variance in GP nurses' perceptions of spiritual care agrees with the findings in the literature that identifies the challenges healthcare staff encounter because of the ambiguous nature of its meaning and application (McSherry, 2007) and therefore, spiritual care remains a very vaguely defined aspect of practice for nurses.

It is possible that the GP nurses may have responded in accordance with beliefs specific to their role, instead of their perceptions of spiritual care in general. The differences in perceptions may be due to a lack of training and so GP nurses may be unclear about the

concept of spiritual care. According to Delgado (2005) the differences are dependent on circumstances. The circumstances that can greatly influence GP nurses' knowledge and provision of spiritual care, such as the appointment based system employed in GP practices, may be restricting how they deliver spiritual care (While and Webley-Brown, 2017; Walsh, 2017) as well as the frequency of spiritual care. This system differs from the visit-based practice of community nurses and the ward-based approach used in hospitals.

The remaining rankings within the survey are similar and offer an initial suggestion that these GP nurses' share common perceptions of spiritual care. Despite a few differences between the lower ranking statements, such as b) *concerned with a need for forgiveness,* and d) *not concerned with a belief or faith,* essentially, the rankings identified GP nurses as being guided by similar meaningful perceptions of spiritual care.

Discerning GP Nurses' Agreement

The findings (left in a free text box) from the fourteen GP nurse respondents, who believed they could not meet their patients' spiritual needs, provides a basic indication of shared reasons. Thirteen out of the fourteen respondents completed the text box (although two respondents gave two reasons). This group only represents a third of the total sample population, therefore, it is not considered representative of GP nurses in this group. However, the analysis of this data was to identify additional findings pertaining to these GP nurses' perceptions which is further investigated along with the qualitative interview data.

Interestingly, the data suggests that the respondents who commented that they were unable to deliver spiritual care, highlighted the potential difficulty of working in general practice. Lack of understanding on the provision of spiritual care as well as time constraints were two of the problems mentioned. Both these issues suggest that GP nurses could benefit from having development on spiritual care that is designed specifically around their work within general practice. This reason prompts the question whether spiritual care could be delivered in a timely manner. This question is addressed in the interview data analysis.

Even though the amount of statements and questions in the questionnaire restricts the quantitative data (combined as a survey), these findings appear to present a clear understanding of these GP nurses' perception of spiritual care. Applying critical realism helped to identify, in the posited *empirical* domain, the perceptions of spiritual care by the GP nurses through the measurement of responses to the questionnaire. It was

possible to establish commonalities among the GP nurses because their choices identified common responses; these responses are associated with their perceptions derived from beliefs and experiences and as such, represent the posited *actual* domain. As the researcher, it was possible to understand this domain through the analysis of the statements. In the deepest *real* domain, generative mechanisms operated to encourage their response. There were many factors that contributed to this: upbringing - the family environment that may have influenced their beliefs about the world (Appleby, Wilson and Swinton, 2018); relational/interpersonal – such as personal experiences and empathic thoughts that may have been triggered by the statements (Vermandere et al. 2012); and profession experiences – like experiences with delivering spiritual care to patients which may have shaped their knowledge of the concept (Puchalski, 2001). Over the years, these factors have contributed to our understanding of spiritual care in healthcare. As a consequence, there are many generating mechanisms at work in the *real* domain that have a bearing on how people perceive spiritual care in the *empirical* domain. In addition, the perceptions of these GP nurses' give an indication as to how they believe the provision of spiritual care should be delivered. In order to better understand the impact of general practice on GP nurses' practices and to explore the importance of GP nurses' role in the provision of spiritual care, the next section focuses on the qualitative data from the interviews.

Semi-structured Interviews — Qualitative Data

This second phase was aimed at addressing the second and third research questions: What is the impact of the general practice context on GP nurses' provision of spiritual care? What patterns or commonalities can be found in GP nurses practices? The data for analysis was taken from the semi-structured interviews held with GP nurses. There were ten interviews that generated over four hours of data, averaging around 25 minutes per interview; this data is divided into two sections. The initial section provides information about frequent problems and difficult choices encountered by the GP nurses' taken from their feedback about the provision of spiritual care, which also highlighted the tensions incurred in these problems. The second section establishes and reviews common ideas about GP nurses' spiritual care practices: that there is a degree of GP nurse homogeneity and that a lot of the activities that GP nurses do are evidently good.

Overall, this phase asserts that GP nurses' provision of spiritual care predominately emanates from their beliefs in spiritual care. These tacit understandings inform similar care practices to address various spiritual care needs. While the findings from the questionnaire as well as the interview data and the interpretations made from both methods, which follow this qualitative data section, give an understanding about the

differences between the respondents, this section deliberately outlines the typical decision-making problems reported by GP nurses, serve as a roadmap for the advancement of the concept of spiritual care. The qualitative data assists in explaining the important part spiritual care plays when GP nurses have to make decisions, supporting ideas (in the discussion chapter) and the part that spiritual care plays in the provision of high-quality care. The reported beliefs differed among GP nurses and sometimes from their practices. At the end of the section, the ramifications of these differences are interpreted.

Similarities and Differences in the Provision of Spiritual Care

A qualitative inductive analysis of the provision of spiritual care was conducted to present the perspective of GP nurses. Although the quantitative analysis came earlier and in a different fashion than the qualitative analysis, the findings complemented each other. Table 2 outlines the themes, codes and descriptions of the responses established during the qualitative analysis.

From the data, eleven codes were generated. This was sufficient to code all the responses pertaining to the provision of spiritual care given by the GP nurses. Whilst some of the codes were dominant in the analysis than other codes among the GP nurses interviewed, together these codes could arguably be seen as producing a basic outline of the practices used by GP nurses to provide spiritual care. These codes have been applied throughout the remainder of this study, to give nuanced understandings of the provision of spiritual care in general practice by GP nurses.

Table 2: Codes from the analysis of the provision of spiritual care

Codes	**Description of the codes** In the interest of their role, GP nurses' discussed...
GP nurse spiritual care priorities	
'Sincerity'	...genuineness in the way they care for their patients in a focused and affectionate way
'Inherent kindness'	… carrying out the role of a GP nurse in a friendly and supportive way while meeting organisational needs
Patient spiritual care priorities	

'Respecting the individual'	...appreciating individual differences and needs and working to meet patient needs
'Encouraging relationships'	...human connections and developing closeness with patients; this can range from a brief contact to the formation of longer relationships
'Valuing the wider context'	...having an appreciation for nature or the wider society
Organisation outcome priorities	
'Viability of GP practices'	...the sustainability of GP practices as an important factor
'Effect on society'	...significance to society (positive change at societal level is more than just the total of GP practices' work at patient level)
Patients spiritual care outcome priorities	
'Approach'	...patients having the (equitable) opportunity to approach appointments that are discerned as inherently 'caring'
'Independence'	...patients making 'healthy' self-organised choices for the future (occasionally quoted in association with the notion of patients becoming less reliant on GP practices and other healthcare organisations)
'Development'	...patients starting on a process of positive change
'Caretaking'	...vulnerable patients currently being cared for

Provision of Spiritual Care

Ongoing efforts to define spiritual care have led to a generation of numerous definitions based on studies by researchers on the concept (for example, Carr, 2001; Johnston and Mayers, 2005; Pesut et al., 2008; Koenig, 2012; Withers, Zuniga and van Sell, 2017). These definitions have facilitated the identification of important factors and fundamental criteria which increase our understanding of such a complex concept in relation to other types of care. In deciding on the codes shown in table 2, and to avoid being too descriptive when analysing the data, I felt it was necessary to have knowledge of the

different definitions that surround the concept of spiritual care. By developing this knowledge, I was able to make careful choices guided by these definitions.

Overall, the statements made by the GP nurses about the provision of spiritual care in general practice had a propensity to be conceived as a process rather than the results of their actions. The majority of these were the view of having ‘sincerity’, which most of the GP nurses seem to identify as the essential rationale for their provision of spiritual care.

‘Sincerity’, in this study, referred to GP nurse statements about spiritual care that emphasises the importance of listening and valuing the patient. Being sincere meant forging relationships as a staff member of the GP practice while being considerate and mindful of the patient's needs. The term sometimes used by GP nurses for this approach was ‘value’, not in an instrumental sense of ‘monetary worth’, rather to signify awareness, attention and emotional commitment to engage with patients. The quote below from GP Nurse 8, encapsulates this perspective:

> I give care to my patients to make them feel listened to and valued; I would listen to anything that concerns the patient.
>
> Interviewee, GP Nurse 8

‘Sincerity’ also involved the importance of recognition. Although the emphasis for delivering quality care seemed, at first, like an independent requirement to ‘value’, closer inspection of the comments indicated that the importance of recognition was completely tied to the notion of genuine attention and awareness that GP nurses believe the provision of spiritual care gives:

> In the GP surgery, there are back-to-back appointments and [...] you're conscious you can't go on too long. I have had people that have burst into tears, or sometimes, people just want to talk about their family, if someone has just lost their husband or wife, then you would probably give more spiritual care.
>
> Interviewee, GP Nurse 3

Around a third of the interviewees emphasised the significance of ‘respecting the individual’ and all the interviewees stressed the value of ‘encouraging relationships’. ‘Respecting the individual’ required appreciating people’s differences and adapting services to meet the needs of each patient. Essentially it suggests approaching each patient as a ‘whole’ person instead of simply by their condition or illness. The following

quote from GP Nurse 1, illustrates this when discussing the GP nurse's practices in the provision of spiritual care:

> Now it's important I think to engage with people in fact, all the time. The one they perceive as their spirituality and where that comes from is very important to them. So, you have to, to my mind, be open to that and accept it moving forward and involve them in the consultation around it. If you don't involve them then what are you doing? You just say, 'Right, you are here for your diabetes review, your blood sugars are this, you need to improve that, you need to change this, need to change that, bye.'
>
> Interviewee, GP Nurse 1

'Encouraging relationships' provides a rather different focus, one that is subjective and relational, as it was aimed at building strong personal connections. It required engaging in conversation to develop a GP nurse-patient relationship and a sense of connectedness, whether that involved a brief encounter, a relationship that questioned social norms, or conventional support for the importance of working together. Where 'respecting the individual' was possibly directed towards the individualistic view of personal growth, 'encouraging relationships' related more to wellbeing through mutual support. However, in the interviews with the GP nurses, these slight differences did not conflict. Instead, both ideas were found to be present alongside each other, whether the GP nurse and the patient expressed their beliefs or not, as shown in the following quotes:

> Because I had explored the other side of her life, what was going on and I showed some understanding or I sort of explored that with her, and maybe just asked some important questions about how she was, that's what led to her deciding to change and that to me is some kind of spirituality in nursing, I guess.
>
> Interviewee, GP Nurse 4

> I have a patient who has got this problem; she is able to function although her carer is elderly, and the patient is able to engage with others. I try to provide support to them and help them become engaged with others again, because the patient used to be involved with the community, but since the family member's death and mental health, she's lost those connections, so I try and help them reconnect together and locally.
>
> Interviewee, GP Nurse 2

Other practices referred to were 'inherent kindness' and 'valuing the wider context'. 'Valuing the wider context' means times when an appreciation was shown towards members of the wider society or nature as indicated by this quote from respondent 9:

> The cancer patient says, 'Why me?' How do you explain that to the patient? Trying to say to them that it is not their fault. It's just nature's way of doing

> things. I mean our bodies are not in our control. We can say no matter how many medical things we know and everything, but at the end of the day…
>
> Interviewee, GP Nurse 9

Interestingly, 'valuing the wider context' was only coded once in the practices from the interviews. However, 'inherent kindness' was mentioned by nearly all the GP nurses. 'Inherent kindness' distinguished GP nurse actions from more bureaucratic behaviour often linked with GP practices, such as time restricted appointments. Being inspired by a belief in 'inherent kindness' meant trying to overcome the problems of managing a lot of patients, so that the procedure did not produce a system of procedures and regulations that became important by itself.

Although there are specific procedures within general practice such as time restrictions, GP nurses often remarked how they would have to exceed them during some patient consultations and attempt to protect the patient from the formalities. Trusting in 'inherent kindness' meant trusting that GP nurses would treat patients like people, rather than acting as an employee of a GP practice towards its beneficiaries.

This viewpoint did not negate the importance of procedures which must be adhered to in order to prevent risk, meet patient expectations and to ensure practices remain viable. Instead, GP nurses felt that the requirements of GP practices were not the main consideration to communicate to patients. This viewpoint is presented in the quotes below:

> So if the person gives me an indication that they need a bit of extra something in addition to what they are medically there for, then I do, but not in a trained way, just in a human to human way, I would probably delve into what you could call spiritual care, but not in a set format. I'm not professing to know what that should cover. Just as if that person wasn't my patient and was my friend.
>
> Interviewee, GP Nurse 6

> You ask, how have you been this year? That's the first thing I asked them. They will say, I'll be fine, you know, but then you ask, 'Do you get any shortness of breath?', and then they go well, and they go on to something so totally random. Someone said I lost my wife last year and you know, you can't just go right, okay, I've got to get on here. So, you just continue [the discussion].
>
> Interviewee, GP Nurse 7

The deliberate impression of informality, despite the formality behind the action, was joined with a focus upon sincere compassion to initiate 'inherent kindness'.

Naturally, the motivation to behave in this manner corresponds with the notion of genuineness because of the relational aspect of the concept of 'care'. In addition, there is a clear relationship with the idea of 'respecting the individual'. However, in order to maintain the information about how it applies in GP practices, it has been differentiated in the current analysis as an independent code. By providing distinctions, a clear contrast can be established. In paraphrasing the participants, the opposite to being genuine is being hypocritical and thus disingenuous. The opposite of understanding and 'respecting the individual' is typecasting people. In contrast, the opposite of 'inherent kindness' is delivering a service which clearly says to patients that their needs are less important than the need for GP nurses to work efficiently.

Combining this group of practices as one ('sincerity', 'respecting the individual', 'encouraging relationships', 'valuing the wider context' and 'inherent kindness'), it could be argued that these practices are common among GP nurses in this sample population while providing spiritual care even though the needs of their patients and their work aims are potentially very different. However, this would be with the exception of 'valuing the wider context', since the others were constantly mentioned.

Spiritual Care Outcomes

In Table 2, the interviewed GP nurses made references to the different outcomes of spiritual care for their patient namely, 'approach', 'independence', 'development', 'caretaking'. In fact, all ten interviewees made reference to at least two of these outcomes. Simply put, these outcomes seem a plausible way of identifying the spiritual care outcomes the GP nurses perceive that their patients need. Giving patients the freedom to 'approach' important topics with GP nurses such as faith, family and friends, was the central objective of all the GP nurses. 'Independence' was fascinating, and possibly not of instinctive importance for some GP nurses, but promoting independence was certainly the main objective for five out of the ten GP nurses interviewed. Eight out of ten GP nurses were keen on aiding patients to be better prepared and/or connected with others, with the aim of guiding them to greater 'caretaking'. Finally, in relation to general practice, nearly all the GP nurses (n=7) seemed to be concerned about staff 'development', to improve their skills and thus being in a greater position to help the patient develop their wellbeing with the aid of supportive services. These plausible explanations of GP nurses' reasons for the provision of spiritual care appeared encouraging, and they presented a straightforward way of appreciating the significance of the provision of spiritual care.

Nuances Produced by Spiritual Care Outcomes Statements

The summary Table 3 was created detailing the coded outcomes from the provision of spiritual care given by each interviewed GP nurse. The table reflects what was previously mentioned, that different outcomes were used by the same GP nurse. As such, the table did not offer definite evidence of only one common practice by GP nurses but instead multiple practices. This data emphasises the fact that it is unrealistic to find complete consensus on the outcomes that can be provided from the provision of spiritual care in GP practices. Rather, the question is whether there is consensus to form an understanding of the outcomes delivered by GP nurses.

The table was created by using coded data from the interviews, but also relied on the researcher's discernment and comprehension of the discussions. This discernment came from the experience of having carried out all the interviews, recorded all the data (which could be replayed), and carried out the analysis process. In order to be counted as a code, the outcomes had to occur in the data of at least two GP nurses (Bryman, 2012).

Table 3: Discernment of spiritual care outcomes

Spiritual care outcomes	GP nurse									
	1	2	3	4	5	6	7	8	9	10
Approach	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Independence	✓	✓	✓	✓					✓	
Caretaking	✓	✓	✓	✓	✓	✓		✓		✓
Development	✓	✓	✓	✓	✓	✓	✓			

As a result of a critique of the data, it was possible to identify the underlying direction of GP nurses' practices more effectively than a critique of the survey data since it did not provide this data. The reason for a more nuanced analysis was to discern different common tendencies, including the commitment by GP nurses to follow organisational directives and the influence of these directives on GP nurses' provision of spiritual care.

The richness of the interview data also resulted in being able to look beyond the differences in preferred outcomes. More importantly, the codes included an

understanding of the multiple drivers to provide essential outcomes and the quality of those outcomes. Based on these initial understandings, a deeper analysis of the data begins to uncover how the perceptions of spiritual care have an impact on how spiritual care is provided.

GP Nurses' Concerns

GP nurses' provision of spiritual care was presented in the conceptual framework (Chapter Three) as practices and experiences for decision-making. During the interviews, narrative descriptions of managing barriers and difficult choices were established. Although, of course, the emphasis and instances of problems were different among the GP nurses, the analysis identified four important concerns and four obvious choices that were notable among the GP nurses; these are discussed below in Table 4 along with the important concerns that relate to practices in tension in the provision of spiritual care.

Table 4: Four important decision-making concerns

	Description of Concerns	Practices in tension
1	How to manage choices as a GP nurse (in relation to attitude, activity and objectives) with the restriction of organisational conditions relating to the needs of customers and the GP practice (for example time restrictions and development opportunities)? (number of GP nurses who were concerned =10)	Sincerity versus Fulfilling the GP nurse role as the important factor (pressures from external demands)
2	How to manage active personal relationships and sensitivity for GP nurses, with the formality and professionalism that may be necessary to minimise risk, abide by procedures or be more effective? (number of GP nurses who were concerned =8)	Inherent kindness versus Formality and professionalism
3	How to manage equitable person-centred care giving, and the ongoing unity of patients as a whole group? (number of GP nurses who were concerned =3)	Respecting the individuals' needs versus Unity of people

4	How to describe the scope of involvement that GP practices take on pertaining to the appropriate amount of support or safety? (number of GP nurses who were concerned =6)	Providing versus Supporting

The codes from the analysis of the provision of spiritual care identified in Table 4 appear to be key in decision-making in relation to at least three out of the four important concerns.

Sincerity and GP Nurse Role

One concern, prioritising 'sincerity', was most notably drawn up in decision-making regarding how to respond to organisational demands. Many difficulties related to worry over how to be sincere when caring for patients' needs amidst restrictions presented in an organisational environment that is often associated with resources or finance. The prioritisation of 'sincerity' occasionally meant making difficult choices (for example, about the lack of time), but also provided GP nurses with reasons to justify their choices:

> We would want to give holistic care, but very often when a patient comes in for sutures, to just do all the sutures. [...] I think sometimes you know whether a patient offers you an opportunity to go deeper.
>
> Interviewee, GP Nurse 10

Although the prioritisation of 'sincerity' was frequently quoted as the reason GP nurses might have limited time, this was not necessarily always the reason. In addition to this, 'sincerity' was named as the drive for creating new knowledge about patients' beliefs about their condition which were seen as conforming to the GP practice's objectives, as explained below:

> In an ideal world we'll get to a point where we will try and unpick that for people without waiting for them [...] Because I saw a woman the other day, an only child, dealing with everything on her own and it was at the stage where her mum needed to go into a home, but she didn't want her to go into a home, but she was physically exhausted and it all got too much.
>
> Interviewee, GP Nurse 6

However, creating a mutual situation was not always possible and 'sincerity's greatest counterbalance was the belief of an important factor that GP practices must continue to be viable organisations. The sustainability of GP practices as businesses reappeared during all the interviews as the fundamental opposite to patient-prioritising decisions. However, a preoccupation with the operational aspects of GP practices was

acknowledged as not regularly distributed equally across all GP staff. Certain problems seemed to emerge in GP practices where the ‘job’ and ‘social’ aspects of working in GP setting concerned two distinct sets of GP staff instead of one set accountable for both sides:

> One of the dangers of this particular job, is you could end up working on your own, so you become very fortress, defensive, about what you are doing. [Doctors say] you're not my doctor, they just close ranks and so protecting each other, nurses don't do that. If something’s gone wrong they’ll scratch each other’s eyes out or something. And you watch it, that someday when they think something's wrong if it's not getting done right, they'll go for it a little bit. Whether they do it directly to the person or not; it's quite hierarchical.
>
> Interviewee, GP Nurse 1

Generally, running appointments late was deemed acceptable, but compromising the GP practice’s operations was not due to the important belief in the essential work of GP practices. Although many GP nurses identified mutually beneficial situations, those who had encountered strong organisational opposition essentially considered that a shortened or reduced GP nurse appointment time would be more useful than no appointment if it was still beneficial for patients. The difficulty was to manage the situation in such a way that still represented ‘sincerity’:

> You can kind of go through the motions and not particularly engage sometimes because people are in out in out and there's a limit to your thinking; you know, do I want to say or do something. I don’t want to ask them something because it might open a can of worms and then I've got others waiting, and you know.
>
> Interviewee, GP Nurse 3

‘Inherent Kindness’ and Professionalism

The next concern related to the formality and professionalism required for general practice operational duties, especially for GP nurses as they work directly with patients. Some GP nurses also discussed with evident relish the easy-going and friendly nature of GP practices, some of which use signposting or social prescribing with the aim of helping to support patients once they have left the practice.

> A lot of it I think for me now is signposting services. We have a lot of mental health patients here. A lot of our appointments are people suffering from anxiety depression obviously they have a lot of needs in various ways for that.
>
> Interviewee, GP Nurse 2

In addition, there were justifications for formality. Generally, precise procedures were established for how private and operational actions should be applied. Even beyond administrative structures, regulated approaches and regular implementation of procedures were usually the only means to guarantee that activities relating to safeguarding were conducted and complicated processes were effectively managed. The concerns of GP nurses related to the degree to which efficiency standards may be utilised in their work before their efforts would be weakened.

The 'inherent kindness' value, in the provision of spiritual care, was connected to this concern. An attempt by GP nurses to manage the difficulty of coping with a lot of patients within the structure of GP practices' directives was motivated by their belief in 'inherent kindness'. This belief meant that patients would be treated respectfully even though GP nurses had the additional pressure of following restrictive, organisation procedures, such as adhering to short, allocated patient contact times. The 'aim' was introducing an informal presence to patients, while accomplishing formal aspects needed to lessen risk and be more efficient 'in the background'. To counterbalance the possible detaching effects of formal processes, it was deemed necessary to hide real kindness and caring communication:

> We had some Jehovah's Witnesses, they didn't want blood transfusions, even though it was going to save their lives so it's a really difficult one. Like how do you manage that? And that's not something that I got taught when I was in training and how to manage that situation so that's quite tricky. That's quite tricky knowing that you could potentially save someone's life, but their beliefs say no you can't do that. You want to save lives, but if they're saying absolutely no to a transfusion. What can you do? I don't think they really associate this type of thing with GP practices.
>
> Interviewee, GP Nurse 5

Respecting the Individual and Group

The third concern was managing the giving and openness of person-centred care to each patient while being fair to a group of patients as a whole. Here the practice in the provision of spiritual care and 'respecting the individual' differed with examining the wellbeing of patients and staff. In particular, this concern relates to the degree to which GP nurses could provide for individual patient needs without the possibility of providing a disruptive service for other patients. This concern was one of the most important aspects of decision-making discussed, along with the motivation for 'sincerity' while facing organisational demands.

As part of person-centred care, the choice of which patient GP nurses could deliver spiritual care to was a continual balance and agreement. Identifying appropriate patients was the main task in opening and building the discussion to be successful. GP nurses needed to choose patients who looked as though they would like to engage in 'deeper' conversation within their allotted appointment time. This study supported the belief that while the objective was to work openly with patients, there was always a dilemma between patients who could be thought of as wanting to engage in conversation and those who do not. The following quote demonstrates this:

> I think sometimes with a lot of spiritual care, it takes a while to build that rapport for the patient to be able to open up because a lot of people find it difficult to talk sometimes. They feel like you're overstepping so you have to gauge the person, you know, which patients you can talk to about things like that, but you've only got ten minutes at a time with the patient. So, the ones that I know well, are the ones I generally can talk to because some of them are very much, 'I don't, I just want to come here for the physical care'; that's it done. Whereas some are more open to discuss the mental side of things or the spiritual, you know, if they're not coping, more of a holistic approach. Whereas some patients don't want that.
>
> Interviewee, GP Nurse 2

This problem of treating all patients fairly was also mentioned in the interviews in relation to time within a GP practice, which limits appointment times.

> But you know, sometimes it's just a moment, a therapeutic touch. [...] It doesn't take much, but I think we sometimes feel like it does and then it's another burden on all the things that we have to do. [...] I think it's something that is as natural to us as nurses because we go into our job to be caring anyway, so I think, probably for a lot of people, they do it really naturally without even thinking about it. It's not a task to them, but I think some people might find it is a job, an extra job, an extra job like a blood test or something, to be asking about how you feel in 10 – 15 minutes, but it's not, it should just be within us.
>
> Interviewee, GP Nurse 4

Providing and Supporting

The last important concern was about how to describe the boundaries of the role of involvement faced by GP nurses. To what extent should GP nurses be responsible for patients, and how much should patients be counted on to manage their health and wellbeing for themselves?

> Some people say ‘I have no faith, but I have spirituality’ so that's a fundamental belief in themselves or something like that, you know. It's about my job, I see as using that, whatever way that transforms them and to be able to use that in such a way to achieve the care outcomes that we both need.
>
> Interviewee, GP Nurse 1

One way this problem could be understood was in perceiving GP practices as providing or supporting the health and wellbeing of patients. Acting like a provider, a GP nurse’s duty required them to offer ‘caring’ to patients (see quote below), whereas in the role of the supporter, the GP nurse’s duty was concerned with supporting the patient, as a result of their own understanding of the ‘caring’, which might include helping to prevent health barriers from occurring (see previous quote).

> When you get a patient that will come in for something fairly routine and then you’ll have a conversation and more things will come out in that and then you feel like you can’t just send them on the way. I had a lady not long ago; she was worried about a lump in her breast. Obviously, I’m not a doctor so I said that we will book her in to see a doctor. Then it came out that she was struggling to care for her husband who had end-of-life cancer and that she had no other family; it was all just sort of in that moment. She just released quite a lot of things, so it was just really unpicking those things with her and trying to come up with a bit of a plan and to not throw her out the room until we did what we needed to do.
>
> Interviewee, GP Nurse 6

This problem did not seem to be directly linked to any of the practices in the provision of spiritual care, but rather a conceptual divide between the way they could be explained. ‘Approach’ and ‘caretaking’ outcomes for the provision of spiritual care seemed to imply supplying, yet ‘independence’ and ‘development’ outcomes for the provision of spiritual care seemed to imply supporting. These created purposeful contrasting views on the duty of the patient’s own action in co-developing the care proposed by GP nurses.

Both aspects of supporting, development and promoting independence, centred respectively on positive and negative opportunities for the patient (more information in the discussion). By contrast, both aspects of provision, ‘approach’ and ‘caretaking’, are connected to the actual generation of opportunities (‘approach’) and removal of barriers to better health and safe living (‘caretaking’). These contrasts, in preference for specific outcome practices, are outlined below in Table 5 and reviewed later.

Table 5: Differentiating spiritual care outcomes by preferred outcomes style

	GP nurse role: Provision	GP nurse role: Supporter
Fostering opportunities	Approach	Development
Removing barriers	Caretaking	Independence

Organisational Decision-making by GP Nurses

In the conceptual framework, the provision of spiritual care was modelled as a common sense approach for decision-making about potential options for action by GP nurses in GP practices. The possible options for action could be defined as 'leadership', 'work schemes' and 'relationships', relating roughly to the operational actions that GP nurses might be able to perform. The qualitative analysis highlights some instances where these spiritual care outcomes influenced GP nurses' choices at each of these levels, except leadership.

A limitation of the semi-structured interviews was that GP nurses were not expressly asked to explore leadership. It may have been helpful to understand whether GP nurses can contribute to organisational changes regarding matters concerning spiritual care and its provision since many of them work autonomously. There is some evidence that leaders use their spirituality to make positive changes with an organisation (Strack et al., 2002), and so having an awareness of GP nurses' position may have offered further insight into their practices and whether this has had any effect on the organisation. Consequently, there was little discussion about leadership during the interviews. Although leadership was rarely mentioned, it was interesting to record the sort of GP nurse operations that were discussed without prompting. Key practices in the provision of spiritual care seem to pervade across GP nurses' practices, not just the direct patient relationships and time restrictions as previously described. There was an example of how an approach influenced problematic operational choices. For example, one GP nurse reported being led by their values when dealing with a patient, a GP pivotal to the patient's care had decided to leave the patient:

> But I'm sure a big portion of the unhappiness of things would be related to how patients' needs aren't being met. A doctor told me to 'just take this' and went off and did not actually care about them. There are a billion variables aren't there, time etc, but it would be nice to be equipped to not make a situation worse.
>
> Interviewee, GP Nurse 6

Spiritual care outcomes appear to direct the actions of GP nurses. In the first three concerns, spiritual care aligned them with the 'aim' (sincere, personalised, friendly and caring action) in tension with practical and organisational influences encountered by GP nurses. Spiritual care outcomes seem to function differently, with pressures being experienced between the outcome choices (providing or supporting), instead of between an 'expected' aim and a varied reality. They supply GP nurses with arguably contradictory attitudes to resolve.

Spiritual care outcomes were evident in decisions between different voiced choices. An additional conclusion identified from the analysis was that there were numerous unvoiced beliefs refining GP nurses' options, where general agreement seemed to be that the necessary behaviours were 'expected'.

Delivering 'Expected Care'

Assumptions

The initial part of identifying GP nurses' decision-making process necessitated recognising narratives on decision-making from interview transcripts. One way of identifying these narratives was when GP nurses appeared to be considering different decision options before deciding on the best course of action. Taking into consideration different decision options and identifying the outcome of what would be seen as a 'benefit' to the patient became crucial.

However, while examining the transcripts, there appeared to be other insights into decision-making. GP nurses seemed to be led by fundamental beliefs which were seldom mentioned as alternative decision-making possibilities. The notions of 'expectedness' (certainty) and 'caring practice' pervaded their choices. This meant that the provision of spiritual care appeared to be conducted at an unspoken and intuitive or spiritual awareness level, even when situations seemed challenging or stressful. Thus, there was a dilemma in how to concentrate on facts, rather than emotions or ideals in relating to the preconceived values of 'sincerity', 'respecting the individual', and 'inherent kindness'.

Hence, the idea that values serve as a means of filtering for GP nurses' decision-making, which is set out in the conceptual framework, seemed to be justified. Beyond the emphasising of the provision of spiritual care, a number of important beliefs which emerged from the data were that:

1) GP practices must continue to exist.
2) GP nurse and patient interactions should be carried out in a conducive environment for the provision of spiritual care, rather than be impacted by socially or organisationally-related influences.
3) People should always be placed first before animals or the environment.
4) There should always be a drive for open communication within GP practices.

The existence of GP practices is considered important, but it is once again mentioned here because it is an important concern that could have an impact on the standard of care the NHS provides its patients. Bearing in mind the societal context in which this study was carried out, it was anticipated that GP practices would become busier and thus GP nurses' patient contact time would be more strictly adhered to than before.

Many GP nurses reported the belief that open communication within GP practices among staff would be ideal. Unrestricted and non-hierarchical sharing of views and perspectives refers to the term open communication, and involves the inclusion of GP nurses in their creation and preparation. According to GP nurses, open communication seems to vary across GP practices in terms of extent and value, but is generally considered an important ideal practice even when it is not accomplished. Although contextually interesting, the second of the assumptions was the most controversial.

Confidence in Practice

During the interviews, the importance of spiritual care was explicit. However, the organisational practices underpinning most of the debate around decision-making was surprising. GP nurses' practical decisions were essentially seen as an optimising organisational task instead of being viewed as being actively aware of patients' differing needs and delivering the 'benefit'.

GP nurses' main practices in the provision of spiritual care, along with their unvoiced beliefs, can be discerned as acknowledged expectations from the way GP practices operate. This partially explains how certain choices could be seen as managerial because they were made with the intention of being of 'benefit' (sincere, personalised, kind) decided earlier and the significance of those decisions has already been accepted

within the organisation. However, the contrasting significance pertaining to the variety of practices could have been inadvertently concealed from GP nurses if they accept that providing the ‘expected’ benefit is an equitable duty to be competently (to a certain extent) performed, but not necessarily any less or more in a virtuous manner.

Recognising that a lack of confidence occurs among GP nurses provides a reason for an apparently perplexing part of GP nurse discussion. Although GP nurses would gladly affirm that spiritual care is important and that they seek to deliver it, there was a certain recognition, by all the GP nurses interviewed, for the need to develop this knowledge. This recognition seems contradictory since there were several assertions made by all the GP nurses that they were, in some way, able to deliver spiritual care. This contradiction seemed all the more conflicting considering the number of times that the GP nurses stated that they were in some way involved in providing for or supporting patients. The most that any of the GP nurses would acknowledge involves a humanitarian way, considering organisational directives as being in conflict and their role as being more mutual. All of them considered that the ways they engage with patients was the ‘beneficial’ way. A sample of the discourse is provided in the following quotes:

> I think sometimes we’re frightened of what we have, and need to get rid of that first before we can approach these things with our patients. Also, our personal experiences, our history is what happened to us. If we've had relatives or friends or family with the same conditions that can really affect you. We should actually use that as an experience, to help someone else.
>
> Interviewee, GP Nurse 4

> I think a lot of my spirituality comes from life's hardships, life incidents, life's catastrophes, life's positives along the way. And just like the patient, you know, I've just as many disasters and ups and downs as anybody else so those life experiences have probably informed my spirituality.
>
> Interviewee, GP Nurse 1

> I would probably talk to my colleague about it, then probably base it on what we've discussed between ourselves and probably say to the patient come back another time, then we will find the facts or get a bit more into it. The way you're brought up and the family, environment and community; that makes a lot of difference.
>
> Interviewee, GP Nurse 9

Training and Organisational Knowledge

In order to determine when valid courses of action appeared ‘expected’, GP nurse practices had to be organised in certain ways. This meant that new or inexperienced GP

nurses had to learn how to provide spiritual care from competent staff. During the interviews, it was apparent that experienced GP nurses played an integral part in developing other GP nurses. Planned tasks were created where they could mentor others and develop the knowledge of GP nurses whom they thought they could help, and whom they considered expressed their values. The following quotes expressed this point, but the first quote particularly emphasised this last point:

> If I think about the biggest influences in my spiritual care are older nurses that I've worked with after I left university in community care. I remember one sister who was, do as I do, do as I say. She was deeply religious but again she had a way of handling and doing things and saying things that didn't offend so you pick things up. I don't quite agree in that way; that's what I mean about the clinical supervision in some ways, I think a lot of spirituality develops when you get groups of nurses together and you have this chance to ask, how do I handle this?, or patients were really angry with me because, you know, I didn't either [...] or they just walked in and I just do things and they walk out, you know.
>
> Interviewee, GP Nurse 1

> I don't think it's a sort of textbook learning subject. I think maybe talking it through, maybe scenarios, and you know picking it out of just conversations about, how you would do this or how you would cope with that, is probably best because you then reflect on it.
>
> Interviewee, GP Nurse 6

> I just say just be yourself. [...] I think it's just all about observation and just make sure that they watch and learn from experience.
>
> Interviewee, GP Nurse 7

Other identified ways of obtaining training and gaining knowledge included, a) applying person-centred care principles in the GP nurse role (respecting and incorporating the patient in their care plan), and b) GP practices adopting a spiritual care attitude, exemplifying the principles they want to see. Through methods of mentoring, shadowing and confidence building, and the application of principles, GP nurses provided important frameworks in which organisational decisions on the provision of spiritual care were simplified. Many of the recognised difficulties were between good intentions and practicalities affected by organisational influential sources, instead of the type of the GP nurse’s intended aim. The next chapter presents how it may be possible to address the difficulty of developing knowledge about the provision of spiritual care in an explicit way.

Uniting around the different practices in the provision of spiritual care seemed to allow GP nurses to collaborate as a mutually supportive team. Whereas previous studies emphasised the stresses and anomalies that exist in GP settings (Roland and Everington, 2016), the discovery that GP nurses coalesce around having different practices in the provision of spiritual care might be an indicator as to how conflicts that have been voiced are mitigated or avoided to permit GP nurses to practise.

In the example of resolving a conflict of intentions below, the nurse recounts needing to reaffirm to her colleagues, her genuine dedication to the aims of the GP practice (her dedication to the shared practice directives). She did this when she discovered that colleagues interpreted her decision in the provision of spiritual care as time-consuming and not cost-effective when managing patient contact time. She explained that the provision of spiritual care enabled the patient to potentially identify underlying issues that they might have, and therefore, raise greater awareness of the patient's health. In return, this may help the patient to make positive choices to improve their health which could result in less GP nurse contact and thus the GP practice could benefit from more available resources (GP nurses), or the patient may have additional needs which could provide further monetary benefits.

> It's about my job I see as using that whatever way that transforms himself [the patient] to be able to use that in such a way to achieve the care outcomes that we both need, and some would argue, well a cynic would say well, that's what you want. I want something out of it. So, if you say, take diabetes, I need certain things to be achieved, to achieve what? It will be a cynical sort of person who thinks it is obviously a monetary value for a practice. Do you see what I mean? There's a whole load of stuff around how and what you are trying to do and how you're trying to achieve that?
>
> Interviewee, GP Nurse 1

These results do not refute the existence of tensions such as adhering to allocated patient times and carrying out organisational requirements, or that there is a need to determine alternative practices when making important choices. However, mitigating ambiguity by acknowledging the main practices within the provision of spiritual care with the core unvoiced expectations of GP nurses thus seems to produce a strong relationship that describes an 'appropriate method' for GP nurses. This appears to restrict the amount of conflict within a GP practice that can arise during decision-making, simplifying and making more discernible options for action.

In addition, within GP practices, organisational conditions (for example, time restrictions and lack of staff) are generally recognised as sources of discord. Identifying these sources of tension as organisational and that the actualisation of these choices is

provided from a managerial position instead of an ethical one, functions as a safeguard to disperse possible harm to collaborative relationships within the GP practice from existing pressures. The function of the provision of spiritual care therefore appears to be crucial to mitigating pressures stemming from the many priorities in general practice. The managerial and administrative side of GP practices seem to act as a pressure-reducing operation for GP nurses, since they are included in validating the 'expectedness' associated with GP nurses' specific practice while preventing friction regarding possible variations in outcome choices among GP managers, GP professionals and patients.

The findings start to convey how Bhaskar's (2008) comprehension of the world, with the use of the concept of a stratified reality, acts as a useful way to identify underlying mechanisms that are experienced and observed. Applying Bhaskar's ontological domains (*empirical, actual* and *real*) to GP nurses' provision of spiritual care would be as follows in each domain: e*mpirical* – spiritual care may or may not be delivered; a*ctual* - the GP nurse might not always be aware that they have delivered spiritual care, this may be due to the ambiguous nature of its meaning and application in healthcare; r*eal* – the GP nurses take certain approaches in the provision of spiritual care and aim to achieve specific outcomes, which is based on their personal beliefs, the general practice environment, and/or by the experiences in delivering spiritual care. These approaches are specific for each of their patients and therefore subjective, and in doing so they are relational if the GP nurse is to be successful in delivering spiritual care. The benefit of the stratified ontology is that a variety of sources can be utilised to explain changes in the empirical domain (Bhaskar, 2008). Various approaches that investigate the provision of spiritual care have primarily focused on the *empirical* and *actual* domains in the quest for greater understanding of nurses' spiritual care practices. Hence, beliefs and experiences contribute to observable changes in these domains without examining the mechanisms in the *real* domain. This begins to explain why the provision of spiritual care by nurses is unclear. It is probable that the causes in the *real* are not being addressed. Thus, 'critical realism holds that individuals and social practices cannot be studied in isolation' (Walsh and Evan, 2014, p.e3).

Interpreting the Analysis from the SSCRS and Interview Data

This section interprets the combined analysed data from the survey and interview sections outlined earlier. The interpretations relate to each of the study's research questions, with an emphasis on the final question: What are the implications of GP nurses' spiritual care practices for GP settings?

What are GP Nurses' Perceptions of Spiritual Care?

The results obtained from the survey data (quantitative) and interview data (qualitative) data seem to support one another. During the qualitative data analysis, the code 'sincerity', consisted of joined components: the notion of listening and valuing the patient, with the aim of carrying out the GP nurse role the best way possible. The three top ranked patient-focused statements namely, m) *having respect for the patient*, f) *spending time with a patient*, and j) *listening to and allowing patients time,* confirmed the code 'sincerity' because they seemed to reinforce elements of the common spiritual care outcomes intention.

Other statements that were strongly agreed upon among the respondents were, a) *showing kindness* and *e) finding meaning* which were also considered fairly important by the GP nurses' quantitative responses. Statement a) *showing kindness* mapped quite well onto the qualitative code: 'caretaking'. Yet, e) *finding meaning* did not map onto 'approach'. Prioritising 'approach' indicated that patients should have the opportunity to be involved in activity deemed of 'benefit' *in and of itself*, whilst focusing on the statement 'finding meaning' prioritised searching for purpose in life. In view of the fact that the other references and codes corresponded well, the components of the coding strategy from the qualitative data were reviewed to examine other possible ways which might have enabled additional relationships within data sets.

An established practice to the provision of spiritual care 'valuing the wider context' corresponded quite closely (as regard to underlying motivations) with the quantitative statement 'finding meaning'. Initially, the idea of simply swapping 'valuing the wider context' with 'approach' appeared promising. The selected label 'valuing the wider context' implied a focus with a chosen outcome. However, it is essential to understand that this refers to a spiritual care *process intention* (qualitative code) pertaining to the way GP nurses should work, according to the interview data. Similarly, the code 'approach' resulted from narratives of GP nurses' accounts of *what should* occur for patients. Therefore, the option of labelling between work processes and spiritual care outcomes was not decided arbitrarily but emerged from the presented data.

After careful consideration, it was determined that the qualitative codes should not be altered to align with the quantitative data. The quantitative data had been faithfully generated through the clearly articulated methods employed in the inductive analysis of the qualitative data. This decision was made to maintain the integrity and independence of both types of data, allowing for a comprehensive and unbiased analysis of the research findings. 'Approach', the qualitative code labelled as representing patients'

opportunity, will be further discussed with added context, to explain the reason why ‘approach’ needs to be kept as a worthwhile spiritual care outcome intention.

Taking into account that the analyses of quantitative and qualitative findings were produced by using different sorts of data, which were generated in various ways, the similarities in the results were important. The findings indicate that the provision of spiritual care is common to many GP nurses and emphasised overlapping ways of discerning the most important spiritual care outcome intentions. Later in the study, establishing these provided the possibility of distinguishing between GP nurses according to which outcome they prioritised.

Overall, there seemed to be striking parallels in the focus and content of spiritual care perceptions agreed upon by GP nurse respondents to the questionnaire and those interviewed. ‘Sincerity’, ‘respecting the individual’, and ‘encouraging relationships’ were recorded with comparable regularity. However, making a distinction among outcomes from the provision of spiritual care was not achieved in such a clear way. Within individual narratives, practices were coded guided by definitions of spiritual care from different sources to many different outcomes although specific importance was generally evident.

What is the Impact of the General Practice Context on GP Nurses’ Provision of Spiritual Care?

Although evidence shows that the decisions GP nurses make about spiritual care involves discussions around the provision of spiritual care, the data also highlighted the fact that certain attitudes were thought to be clearly ‘caring’ and ‘expected’. Even though concerns existed in GP practices, they were not usually identified as concerns about funding conditions or were politically charged. They were concerned about to what degree a specific established aim could be accomplished in the context of established organisational challenges such as the health of the patient, and providing a high standard of person-centred care in a specific timeframe. Thus, it was considered that these concerns could be overcome managerially and were mostly rising from external control, instead of internal differences such as exceeding patient contact time.

Even though internal conflict exists, the two approaches described earlier (training via staff mentoring and shadowing and organisational knowledge as the source of confidence building) were means of minimising concerns and refraining from interpersonal disagreement about those concerns. The underlying aims of training and knowledge connected quite feasibly onto the qualitative codes: ‘development’ and ‘independence’, even though the term ‘development‘ used in the qualitative data was possibly a simpler and broader interpretation of development than is perhaps indicated

by the straightforward term ‘training’. Thus, the training and knowledge relates to GP nurses’ needs rather than those of the patients, the benefits (a greater understanding in how to deliver spiritual care) gained by the GP nurses should support greater development in the care of the patient.

However, a sample of data presented earlier helps clarify the notion that agreeing on certain approaches does not inhibit holding opposing views/practices in some cases. ‘Being able to feel confident and supported by colleagues’ (interviewee, GP Nurse 1) was the most important asset reported by the interviewed GP nurses. This is not surprising, given the fact that common practices in the provision of spiritual care are all geared towards subjective, respectful and perceptive relationships. Nevertheless, in addressing the question about the impact of the general practice context on GP nurses’ provision of spiritual care, it was evident that having the opportunity to develop confidence as an essential aspect was important without the need for agreeing on how or why GP nurses could feel greater confidence. Below is a list of the different ways GP nurses develop confidence. GP nurses reported that they:

- Spoke to colleagues or signposted patients to other groups. Collaboration developed confidence;
- Had several interactions with patients building rapport, and that developed confidence;
- Self-efficacy was improved from experience of training and opportunities in a supported environment and that developed confidence;
- Became braver with asking patients about their circumstances and that developed confidence;
- Learnt to listen rather than carrying out practical work which helped them connect with patients and that developed confidence;
- Would be completely directed by a patient rather than initiating spiritual care conversations, and that shift in the role developed confidence.

Key differences in these responses included accepting that:

- Respect should be discerned as something that is unconditional (GP nurses’ respect for the patient), or earned (the patient’s respect for the GP nurse);
- Confidence results from increased autonomy, but can include working in collaboration; and
- Confidence results from increased capacity to help others and this may include helping oneself.

These contrasting quotes clearly echo various influences as to whether or not GP nurses delivered spiritual care or not. In addition, they should be recognised as important topics pertinent to continual discussions. However, these different influences had all been quoted as funnelling into spiritual care practices created to establish the same outcome (confidence). The agreement related to a specific preferred spiritual care outcome, with no guarantee of an agreement as to what developed that practice in the provision of spiritual care and what additional practices could arise from it.

In relation to the question concerning how the context of general practice impacts GP nurses' in the provision of spiritual care, their practices seem to govern the desired outcomes. Unlike their practices in the provision of spiritual care, there were tensions between the various outcome intentions. The GP nurse role, whether it is providing or supporting patients, was identified as a specific pressure (although this was potentially an additional benefit for patients, if the GP nurse attempted to perform them simultaneously). The contrast between the purpose of providing spiritual care and the decision-making outcomes, as well as differences across outcomes centred around providing or supporting, produce extra dimensions to spiritual care; the discussion Chapter Five will present these findings.

What Patterns or Commonalities can be found in GP Nurses' Provision of Spiritual Care?

There was little apparent difference in attitudes regarding the importance of spiritual care among the surveyed population of GP nurses, but each practice emphasised different constituent aspects. Although all the interviewees had experience providing spiritual care in general practice, it is worth noting that the majority of them (70%) gained their main working knowledge and experience from previous work in other settings, such as hospices or hospitals.. This prior experience perhaps identifies a need for specific consideration for the feasibility and practicability of the provision of spiritual care in general practice, particularly as spiritual care can prove challenging because of the ambiguous nature of its meaning and application and remains a very misunderstood aspect of practice for most nurses (McSherry, 2007). This notion is particularly relevant as there is an effort by the government to encourage more qualified trained nurses to work in general practice, which means they will not have developed experience of the provision of spiritual care in other healthcare environments. The next chapter expands on the training requirements of GP nurses in the provision of spiritual care.

Nearly two thirds of those who completed the questionnaire and all those interviewed reported that it was possible for them to meet their patients spiritual needs and perceived this opportunity as a key ‘benefit’ to derive from their work. In Table 2, the four outcome priorities were stated in fairly similar proportions based on the themes from the qualitative analysis. While concentrating on the provision of spiritual care, GP nurses did not disregard the likelihood of additional outcomes. This led GP nurses to discern specific patient requirements (for example, needing to refer to a faith, the opportunity for deep discussions, not judging, confidentiality) as particularly useful. There was no need for the GP nurse to understand the eventual effect of these requirements to justify their importance. The following quote is an extreme example which demonstrates this:

> I tend to tune into someone's spirituality. I don’t try to influence it, but I tend to tune into it and use it. And if anything, I probably use it to influence the decision-making that patients may want to achieve care [...] be open to that and then accept it and move forward and involve the consultation around it if it’s important to do that.
>
> Interviewee, GP Nurse 1

Significantly, this emphasis on approaching patients, in this way, showed the GP nurses to be more focused on their role in general practice as a provider of ‘apparent’ needs, rather than only as a provider of identified and assessed needs. The significance of ‘apparent’ in the provision of spiritual care is approached and discussed later on in this chapter. Additionally, understanding various significances on the outcomes of different practices in the provision of spiritual care, especially on ‘approach’ and ‘independence’, enables further discussions (to follow) on the reasons why GP nurses may hold contrasting ideas as to the scope of practices they are establishing for patients to those held by patients regarding the provision of spiritual care.

The data clearly shows that there are a wide variety of practices in the provision of spiritual care. Therefore, as care continues so does the potential for practices to be developed and proliferated by GP nurses. The benefit factor, if the provision of spiritual care has any chance of being recognised as well as being understood, is when people acknowledge a valuable end requirement has been achieved, instead of a midpoint towards the end condition they regard as essential. It is crucial to understand and clarify why the provision of spiritual care goes beyond mere adherence to practices and involves recognising the significance of spiritual care outcomes.

In summary, to address the third research question about the patterns and commonalities in GP nurses provision of spiritual care, they appeared to be similar and direct decisions about how they practise in two ways: they expressed thoughts of

uncertainty about the provision of spiritual care, taking into account the overall context of general practice; and b) the achievement of the provision of spiritual care (practices and outcomes), which is not problematised, organised into activities and organisational managerial plans, and preferences.

What are the Implications of GP Nurses' Spiritual Care Practices for GP Settings?

The idea of the provision of spiritual care was used to describe what it means to deliver an 'accumulated' benefit. An 'accumulated' benefit was a group of practices or a state of basic health and wellbeing that was regarded as 'beneficial' by itself, rather than only an interim condition to achieve other goals. In the responses' from the interviews, outcomes such as job satisfaction and improved patient wellbeing were occasionally reported in this way. This demonstrated that it was possible for GP nurses to choose (whether unconsciously or consciously) about where in the provision of spiritual care to discern importance. Previous descriptions of practices in the provision of spiritual care outlined how each set of considered practices (approach, providing, supporting) seemed to relate to findings at progressively further intervals during delivery.

Table 6: Spiritual care value chain

Spiritual care	Approaches	Providing	Supporting
Intentional value creation in spiritual care provision	Relationships formed on respect, trust and kindness.	Greater chance of gaining from an 'accumulated' benefit — a practice or a state of being	Greater chance of independent thinking and activity by fostering opportunities and removing barriers.

The summary of findings in Table 6 identifies:

a) Quite extensive consensus about how to commence the creation of value in the provision of spiritual care (directly, by quality interactions, and building trust), but accepts that there was
b) More variance about what resolution the relationship should generate, and that
c) This variance was not only about the resolution, but also about when, in creating value, a really 'beneficial' end result could be considered to have been generated.

In addition, it includes the notion of practices in the provision of spiritual care as an imperfect process where GP nurses can only influence direct practices through relationships, then only increase the possibility of more spiritual care outcomes.

Nevertheless, for a full appreciation about the chain relating to the provision of spiritual care, this table is incomplete. While analysing the qualitative data, a further outcome was found in addition to ‘approach’, ‘caretaking’, ‘development’ and ‘independence’. It explained why GP nurses who have longer-term and wider perspectives could appear to surprisingly prioritise an approach relating to the present moment.

'Effect on society' was the supplementary outcome value; the GP nurses’ role in supporting positive differences for the individual, outside general practice, in society. Below are examples of this type of statement:

> One of the reasons I moved into the community [nursing role] because [...] there are different priorities than in the hospital setting and the care of patients doesn’t seem the same. We do a lot of social prescribing (connecting people to various groups and services for emotional and practical support) here as well which I think helps a lot.
>
> Interviewee, GP Nurse 2

> I think this as a spiritual thing is very important, no matter what we do, how we do it, self-awareness, and belonging. I think it’s really important [...] to the family, environment and community, and that makes a lot of difference.
>
> Interviewee, GP Nurse 9

During the initial analysis, the ‘effect on society’ was thought of as a predetermined ‘benefit’ approach that the GP nurse could make (for example, operating in accordance with an alternative procedure or creating a different process), instead of aims designed for creating experiences for each patient. However, it could be included at the end of Table 6 to present a more comprehensive insight of the GP nurses’ spiritual care value chain (see Table 7).

Table 7 emphasises the addition of longer-term or social effects at the final stage of the spiritual care value chain and that its understanding has no direct control by GP nurses or GP practices. In fact, it depends on so many outside forces, it becomes almost impossible to distinguish the GP nurse’s impact. Only GP nurses and GP practices who are part of a larger group, for example, GP alliances (GP practices working collaboratively) could possibly assess and differentiate these larger impacts, but even

then, they could not be completely sure whether longer-term or societal impact has occurred.

Table 7: The extended spiritual care value chain

Spiritual care	Approaches	Providing	Supporting	Effects on society
	As each interaction is further apart from the initial one, direct control over the outcomes is more difficult for GP nurses.			
Intentional value creation in spiritual care provision	Relationships formed on respect, trust and kindness	Greater chance of gaining from an 'accumulated' benefit — a practice or a state of being	Greater chance of independent thinking and activity by fostering opportunities and removing barriers	Long-term possibility of community and organisational changes in the society or the world

At the time of analysing the qualitative data when intentions for the provision of spiritual care were labelled 'approach', the discussion was the part of the activity the GP nurses knew they could manage and assert control of. They are confident in carrying out their role and the impact it has on society (doing the 'best' they could — recalling the notion of 'expectedness' mentioned earlier), but in the interview, they were more concerned with the benefits they could deliver to patients. The benefits were considered as significant and non-influential practices instead of just working towards a final aim.

This knowledge instructs us to think about the differences among GP nurses who are offering a well-established service and others who present a way for patients to choose the service they want. Clearly, this is a conceptual difference, which in practice, is less obvious. Only two out of the ten interviewees were labelled as having a tendency to use only one outcome style (in the provision category, GP Nurse 8 and GP Nurse 10), in the provision of spiritual care. Interestingly, coding the data from these two GP nurses was relatively easy because they were the shortest of all the interviews (17 and 15 mins

respectively) so if the interviews had been longer (average time of the ten interviews was 25 minutes), then these nurses may have also used more than one outcome style. The data from other GP nurses overlapped between provision and supporter which seem to be a real matter of tension.

The difference between the provision of predefined care and promoting autonomy in practice, as theorised here, generally reflects recognised differences between subjectivist or objectivist ethics. Combined with the differences between concentrating on positive or negative opportunities (for example, removing barriers or fostering favourable circumstances), these ideas may be applied to create a picture of GP nurses. The discussion chapter will continue with these possible strands of differences in order to disprove the value-neutrality regarding the provision of spiritual care of GP practices' 'social' aims. The plurality of GP nurses' outcomes evidently contributes to GP nurses' plurality of the provision of spiritual care, although sometimes not in ways GP nurses expect.

The earlier findings suggested that there were certain relationships between GP nurses' expectations for the provision of spiritual care. These included the belief that providing spiritual care is associated with feeling safe when GP nurses were directed towards promoting 'independence'/'caretaking', and the provision of spiritual care from a 'development' position in the capacity to think about positive experiences and try something different, and become more self-motivated. These investigative results were established from the analyses through both the quantitative and qualitative methods. Their findings gave a credible description of how the provision of spiritual care can influence the types of spiritual care initiated for patients.. However, from these analyses, it was evident that GP nurses' intended approaches did not always convert directly into perceptions of spiritual care in connected outcome operations. This was particularly the case when GP nurses discussed their own perceptions of spiritual care that they were establishing for patients.

An underlying objective of this study was to investigate the delivery of spiritual care by GP nurses. The accepted meaning of spiritual care implied a dependence on patients receiving the outcomes they desire in the provision of spiritual care, not only accounts from GP nurses outside the experience. Therefore, it appears necessary to continue to investigate the part perceptions and subjectivity play to better discern the described provision of spiritual care.

The main operation outlining whether GP nurses considered specific outcomes to be important seems to be the degree of agreement between their current preferred choices and the GP practices' restrictions. This conclusion highlights the GP nurse's role as an indicator that although outside demands (for example, NHS procedures) may depend on measurable outcomes, patients' lived experiences are often quite diverse. This study does not argue against the value of measured results, but for patients' lived experiences, there may be obvious reasons that account for why in general practice, outcomes relating to time restrictions or GP practice procedures, may not be achieved every time. Adequate improvement of these tangible outcomes would supposedly be based on some type of developmental involvement (for example, training, building confidence, additional skills), but if the desired result is security instead of difficulty, the development cannot regularly be associated with patients' lived experience even if planned. Expectations clearly contribute to establishing whether patients understand the value of spiritual care and therefore, by extending, they determine where along the value chain of spiritual care it is actually possible to obtain this value.

GP Nurse 1's practices clearly demonstrated the distinction between satisfying and changing expectations. They offered a safe, non-judgemental space in which the patient felt comfortable to discuss their current situation — a typical example of an 'accumulated' benefit delivered to a patient that they knew needed it. However, besides that direct delivery, they also offered coaching, collaboration and plans to support patients with life-threatening conditions. One of the plans aimed to encourage patients to recognise the importance of their medications was with a patient of faith. The GP nurse emphasised that the condition is not a disease of lack of repentance, and so they need to take the medication during non-fasting periods. The patients were supported to see alternatives to their current perspective. A positive response to this suggestion, resulted in the initial expectations being exceeded and new expectation being set:

> I think I [give spiritual care] all the time, so at certain points, I'll say, are you looking forward to Ramadan? Do you get what you are doing? How's that going to work? What's your plans? How are you going to manage this [fasting]? And then evolve [the discussion from there]. Because I know it's really important to them to fast and some of them shouldn't fast because of the kind of medications they're on, but they do fast and you're trying to balance that out, but you know how this is detrimental to their self-esteem if they don't fast. It's important, I think to engage with people so, you have to be open to that and them and accept it and move forward and involve the consultation around it, if it's important to do that.
>
> Interviewee, GP Nurse 1

From another GP nurse, there was an example where a patient acknowledged that their interaction with them had been life-changing socially:

> ‘She was a bit of a smoker but actually since her husband died what she started to do was to smoke back to back, so she was chain-smoking. She had nothing else to do with her time and she was anxious [...] We talked a bit about re-establishing social connections and thinking about what was important to her and what she missed with her husband dying, and so forth [...] She came back, the following week with one of her friends who had driven her, and she’d actually decided to stop smoking. I didn’t ask her to do that.’

Interviewee, GP Nurse 4

Reports of complete changes were less common than those of the acceptable delivery of what was expected. Yet their presences emphasises the role that encouragement plays in describing the effect of principles on spiritual care in general practice; it is necessary to include them in a complete model.

Agreement between expectations and delivery supported the beliefs about spiritual care. In situations where expectations and delivery of spiritual care were not aligned, patients did not perceive the provision of spiritual care, even if objective outcomes were being achieved. In situations where expectations and delivery of spiritual care were not alighted, patients did not perceive spiritual care, although objectively, it was occurring. Thus, the difficulty in the developmental process was changing patient expectations so that the GP nurse’s aim is to influence or challenge the patient’s expectations: to establish agreement between aim and knowledge. This seemed to occur when patients believed in the possibility of change that the GP nurse was advocating. In the next example, a GP nurse frequently spoke to patients of the significance of recognising and pursuing a health interest, as they had previously done. This encouragement helped change viewpoints:

> ‘Well it’s important. I think you have to engage on that level with patients, for example those with long-term conditions such as diabetes, because we do a lot of motivational interviewing so that we can connect with them, build up a good rapport, and help them, you know find strength, and hope, and confidence, some of those listed in the second definition [of spiritual care]. I think there are interesting values.

Interviewee, GP Nurse 10

From the interview data, checking the progress of change in patients’ beliefs seem to be related to the principles that underlie the common practices in spiritual care provision. The practices were directed towards creating relationships with patients that were

subjective, appreciative/respectful, and open. Only as a result of these relationships were the GP nurses able to assure patients of the value of their delivery in a genuine way. As illustrated in the example below, these interactions were not necessarily encouraging or promoting change, but they did appear to be supporting them. The patient felt comfortable with the GP nurse who she had come to trust and could open up to them:

> ‘I had an experience with a patient who came in for a flu jab. It was only meant to be a minute appointment and she is one of those people that just comes in and cries and she says, I don’t know what to do. She was a carer for her very sick, very physically disabled husband with no support and lost faith and confidence in herself. And again, a lot of it was having to signpost her to others. Finding that information out, showing empathy and sympathy, and then being able to try and say right and we can support you in this way, and this is another place you can go for that.’
>
> Interviewee, GP Nurse 2

Accordingly, the perception of value was thus understood through relationships, rather than just actions, as the patient’s GP practice and staff were believed to be sincere and trustworthy. The results demonstrated that there are connections relating to GP nurses' actions and perceptions of how spiritual care is practised that go beyond simply meeting expectations. These connections also include an atmospheric outcome such as being genuine, a practice such as fostering opportunities and the acceptance from patients that a practice is helpful.

In assessing the implications for practice of GP nurses' views regarding spiritual care, it is more than just delivering a service and hoping that all patients perceive spiritual care as valuable from them. Both patients and methods differ. Spiritual care is not simply conducting a formulaic set of actions based on evidence. The focus on evidence-based care meets particular challenges in the spiritual care arena. GP nurses create value in various ways: either delivering in line with patients’ expectations — based on a customer service model; or striving to change them — based on the role of an educator or motivator. The educator or motivator role may usually happen on a personal level, but it must not be forgotten that it should be involved in the creation of spiritual care by GP nurses and GP practices with the aim of making changes in society. It is only by motivating people about the discussion around change, which GP practices are based on, that more people will be aware of the value that GP practices are aiming to accomplish.

The implications illustrate that knowledge of the three domains (*empirical, actual* and *real*) of reality is revisable as it is always incomplete as a result of new knowledge. This

is not only due to the fact that generative mechanisms can never be fully explained (Walsh and Evans, 2014), but also because we filter knowledge that we receive and respond to about them with our interpretive lens (Easton, 2010). We literally construct knowledge as the complexity of phenomena is uncovered or discovered (Walsh and Evans, 2014). An interpretive lens explains why different people relate to the same event in different ways because of operating at the individual and even social levels. For example, a GP nurse would share in a patient's health concern during an appointment but will interpret the concern differently. A concern such as mental health will be understood differently across cultures (Mental Health Foundation, 2019) and the same GP nurse could make contrasting decisions with the same patient group depending on their age. This is an example of the dependent structure of knowledge emerging from closely related ontological occurrences. Combining this awareness of creating spiritual care with regard to expectation and motivation led to identifying influential dimensions in the provision of care by GP nurses. The model sets out the main points from the findings and analysis.

Model: The Main Dimensions in the GP Nurse Provision of Spiritual Care

The previous findings and analysis section set out a good deal of detail on the influence of organisational values on GP nurses' provision of spiritual care for their patients. The data yielded sufficient patterns and trends that a mapping may reasonably be attempted, without inordinate simplification, to indicate the main points from the findings. Accordingly, the below mapping (Table 8) seeks to describe the dominant orientations and dispositions towards spiritual care as evinced by the research participants. It identifies five influential dimensions: 'Congruence', 'Aim', 'Approach', 'Attitude' and 'Understanding' that may become guidelines for improving the provision of spiritual care. This approach attempts a different emphasis from that adopted by another recent model of spiritual care, the Self-exploration through Ontological, Phenomenological, and Humanistic, Ideological, and Existential expressions) (SOPHIE) model, designed to inspire health and social care students 'to identify their own existential and spiritual care needs' (Ali and Lalani, 2020, p1) during health education. While this model was designed expressly as a tool for students to reflect on what it is in their life that gives them purpose and meaning to develop a greater understanding of the spiritual care needs of patients, the model proposed in the present study, would encourage experienced nurses to reflect about why and how they deliver spiritual care based on a reflection of how they engage with patients in the general practice setting. Table 8 presents a succinct description of these points, but they are discussed further in the following discussion chapter.

Table 8: The main dimensions of the findings

Main points
Congruence ● Developing a connection between direct action and patient acknowledgement of the value of the spiritual care outcomes of that action requires congruence i.e. agreement between patient expectations and that offered by GP nurses. ● Value is recognised when GP nurses cater for patients' existing choices or influences and educate patients with new discussions around change, through delivery and transformation, respectively. ● Where patients do not understand or accept narratives of change, spiritual care outcomes might occur without the patient discerning them or judging them of value.
Aim ● Some GP nurses also attempt to develop fundamentally, wider, long-lasting impact than can be evaluated by reviewing outcomes for individuals. ● Although GP nurses refer to their GP practice's part regarding the benefits they offer them to act in a way that supports the goals of this approach, even though it lies at the end of the chain (effects on society) (see Table 7), GP practices often provide them with the opportunity to do so at the beginning. ● A result of this focus, some GP nurses are less directed towards forming extended outcomes with patients, leading to less directive appointments for patients in GP practices than with the more individually focused GP nurse.
Approach ● Tendencies of spiritual care outcomes are framed within organisational directives over the practices of GP nurses. ● Although four main spiritual care outcomes have been established during the analysis of the findings: 'approach', 'caretaking', 'development' and 'independence', they are not the sole focus within GP practices. ● There seems to be an impact of spiritual care on the kind of treatment given to patients by influencing their choice of outcomes, though not always in a straightforward manner.

Attitude

- Common spiritual care practices of ‘sincerity’, ‘respecting the individual’, ‘encouraging relationships’ and ’inherent kindness’ promote supportive and approachable relationships between GP nurses and patients.
- These connections seem to be valued by the patients for their affable and authentic qualities, which have a direct positive impact on their sense of collaboration and self-esteem.
- These types of relationships also provide the basis for influential actions required to transform the provision of spiritual care for patients.

Understanding

- GP nurses’ intentions coalesce around common practices and experiences in the provision of spiritual care, masking the possibility for disagreement among them about preferred outcomes.
- This understanding generates some pressure within GP practices (for example between concentrating on supporting and guiding patients or focusing on fostering opportunities and removing barriers).
- However, within each GP practice, nurses are also permitted to work in a variety of ways in order to facilitate patient support, providing a much broader range of experiences than if nurses were limited to just one.

Summary

This chapter emphasised the subjective and relational nature of the provision of spiritual care. The chapter identified different ways in which GP nurses care for patients’ differences, and the importance of individual and organisational needs. Through GP nurses' personal accounts, it is brought to light why certain GP nurses decide to deliver spiritual care, and the implications for GP nurses who do not want to or cannot deliver spiritual care and the impact of doing so.

In addition, the use of CR helped examine the way that GP nurses’ provision of spiritual care might cause a marked change in the world and makes suggestions based within a well-defined explanation of how reality is interpreted. The diverse perspectives of GP nurses offered the opportunity of a critical realist understanding of triangulation (using multiple research methods) to widen and deepen the investigation by recognising the importance of differing beliefs and providing opportunities to compare and contrast

various practices in the provision of spiritual care. Investigating various perspectives on value creation meant that assumptions could be avoided, and the implications of possible practices discerned.

From the findings, the quantitative and qualitative data suggested that there were common perceptions of spirituality and spiritual care in this sample. Additionally, GP nurses shared certain spiritual care practices and these could be divided into approaches to delivering spiritual care and certain demonstrable outcomes from the approaches. In contrast to the outcomes, the approaches did not align with the motivations underlying the approaches, but instead were surprisingly similar among the GP nurses. The outcomes from the approaches presented a more useful way to make a distinction between the GP nurses. Despite having independent practices directed towards slightly opposing aims and expressing various conceptions of the 'benefit', GP nurses could unite around joint approaches. Despite the fact that there was not total agreement with each GP nurse's intentions, there was sufficient alignment to generally identify the outcomes regarding the approaches used by the interviewees in the provision of spiritual care.

In addition, the qualitative data provided an understanding of the impact of general practice context on GP nurses' decisions in the provision of spiritual care. For many conscious choices, approaches to delivering spiritual care worked as guides for the ideal way GP nurses should practise with 'sincerity', 'respecting the individual', 'encouraging relationships' and 'inherent kindness' in their work. When making decisions, these principles were weighed against actual or applicable external considerations on the function of GP practices as a financially successful business and a provider of social value. GP nurses attempted to remain loyal to this decision-making approach as they deemed possible, however differences arose resulting from: a) warnings about the operational aspects of the GP practice, and b) commitment to all patients as a group over individual patients as part of that group. Many of the deliberate choices were deemed managerial and enforced by external conditions, instead of the validating of various internal ideas of the benefits.

A discrepancy was found between some GP nurses' beliefs of spiritual care created by encouraging 'independence' and other GP nurses accounts. This non agreement was interesting, beyond the emerging data from qualitative data analysis, that a development orientation was more likely to be associated with accounts of the way spiritual care is created with regards to autonomy. Qualitative descriptions also suggested that in development-oriented GP nurses, they seem more likely to recount dramatic changes in patients than by GP nurses without a development orientation.

Perceptions about the way that spiritual care is administered depended on a balance between current experiences and beliefs, but GP nurses interested in dramatic change also tried to help shape beliefs through motivating patients of the significance of that change. When goals were met, patients enthusiastically recalled improvements in developmental and social areas, where they may have not ordinarily felt valued. The experiences of patients who received spiritual care were possibly quite different from the anticipated way that spiritual care was created, particularly where GP nurses seem to concentrate on prevention and/or removing obstacles to patient wellbeing and development. Although impact was not always absent during these procedures, when it did occur, patients valued it (for example, stop smoking or less visits to the GP practice) instead of the patient themselves. Furthermore, this study advances our knowledge of how GP nurses interact with their patients, and that the provision of spiritual care does not comprise of a 'one size fits all' procedure but one that is developed around the patient's individual needs.

A connection was found that would suggest that there are five dimensions that influenced these GP nurses' provision of spiritual care. The following discussion chapter contextualises the findings in relation to these dimensions before and investigates their implications within Bhaskar's stratified reality of the *real*, *actual* and *empirical*.

Chapter Five: Discussion

The interpretation of the findings and analysis reported in the previous chapter strongly indicate five influential dimensions (‘Congruence’, ‘Aim’, ‘Approach’, ‘Attitude’ and ‘Understanding’) that have emerged from GP nurses’ perceptions and provision of spiritual care. The sections that follow expound further on the proposition that the spiritual care practices of GP nurses can helpfully be conceived in terms of five main dimensions, and explores their alignment or contrast with extant research from the literature surveyed in Chapter Two. The chapter goes on to discuss the dimensions when considered in dialogue with Bhaskarian critical realism, and presents the factors in terms of Bhaskar’s notion of a stratified reality.

Dimensions of Spiritual Care Aligned with Extant Research

Congruence

The dimension ‘Congruence’ when applied to the creation of value by GP nurses, was about more than the provision of spiritual care and expecting patients to perceive the same value from them; it was more on building patient relationships. GP nurses create value in various ways: either delivering in agreement with patients’ expectations (for example when the GP nurse respected the wishes of the Jehovah’s witnesses who did not want blood transfusions), or by completely changing the expectations to agree with what the benefits are expected to be (such as when a GP nurse spoke to a chain-smoker about reconnecting with her friends, which also resulted in her quitting smoking). In order for patients to ‘discern’ value in what the organisation does as it positively impacts their health, they need to understand how GP practices are based on change (i.e. improvement in health). When preferred experiences of patients’ are not required or valued, GP nurses’ goals may not always translate into their aims. It is possible for an outcome to be delivered in an objectively apparent way, but this does not guarantee that the patient will find value in it (e.g., stop smoking), except where the patient was either subjected to or influenced by the notion that it is valuable.

This finding broadly supports the work of Cleland et al. (2006) in this area linking particular values in practice with patients’ preferred value. Findings from their three-arm randomised controlled trial of spiritual healing (the use of complementary and alternative medicine (CAM)) indicated that the noteworthy values congruence among CAM and patients were about the merit of specific treatments in practice (for example, acupuncture or homeopathy) rather than the end results (Cleland et al., 2006). Preferences to the treatment rather than the outcome may be due to the practitioner not gathering sufficient information or completely understanding the patients’ needs.

According to van Leeuwen and Cusveller (2004) nurses need to be able to collect information about their patient's spirituality for the purpose of adequately identifying the needs of their patients; as a result, the provision of spiritual care requires professional competence. Furthermore, the findings from the study by Narayanasamy and Owens (2001) suggest that when nurses implement spiritual care not only do patients benefit from it, nurses also feel a sense of wellbeing. Therefore, professional development (whether that is educational or practice-based training) could be a major factor, if not the only one, required to develop nurses' expertise in the provision of spiritual care. Such development initiatives would enable nurses to effectively identify their patients' spiritual needs, manage any differences perceived between the nurses' aims and the patient's spiritual care outcome values and be able to make important changes that will ultimately benefit both the patient and nurse in their interaction.

Aim

The dimension 'Aim' looks at establishing the impact of spiritual care as a possible explanatory factor for the creation of value. Looking beyond general practice studies (where there seems to be little discussion on the role of impact regarding patient engagements), there are two important areas whereby concerns about the importance of communication could be addressed to clarify GP nurses' practices.

The first important area is by closing the gap between GP nurses' perception of value and their aims of value by seeking to have greater involvement by patients in discussing, establishing and developing the original value intentions of GP practices' work (i.e. meeting the needs of patients). There would have to be a higher level of acceptance of open communication in GP practices than they are currently experiencing, which is normally controlled by management and hierarchies. It would entail moving closer towards GP practices that truly put patients first. In the light of the evident change in the way healthcare services are provided, away from the hospitals and closer to home (While and Webley-Brown, 2017), it seems to be inevitable that some GP practices would as a consequence address the apparent 'self-governing deficit' and accountability issues related to this.

The second important area is by focusing on communication, influence and value; thus, it involves movements in society and identifies a change in analytical lens from organisational concerns to those of idealistic actions that would focus on patients as well as GP practices' requirements. In this study, GP nurses were found to be very successful at supporting the perceptions of patients' value (i.e., through social as well as informal

practices which permit nurses to use implicit wisdom in these relationships), however, it is also important to recognise how particular value proposals could become incompatible with how value is perceived (i.e., because very little information is being exchanged critically and because patients have insufficient influence over the kind of value to be provided by some GP practices). Yet the unspoken perceptions of GP nurses mean that their beliefs as a suitable solution for how to prevent incompatible aims and perceptions are not considered.

It is at this point, GP nurses' diverse idealistic viewpoints must be acknowledged as a separate area of discussion, particularly influential ones, that might play a part in whether aims are interpreted into perceptions of value. This study confirms that the provision of spiritual care is associated with GP nurses' own spirituality. In accordance with the present results, previous studies have demonstrated that nurses' confidence in the provision of spiritual care comes from their own spirituality (van Leeuwen and Schep-Akkerman, 2015; Ross et al., 2016).

Eight out of ten interviewed GP nurses made reference to the importance of connectivity, and occasionally attempted to demonstrate they were actively assisting patients in fostering sociability. However, this perspective may be seen more in the implicit than in the explicit value statements. This was in a context where the orientation of values 'respecting the individual' was particularly emphasised as an intention of GP nurses as they perceive it to be valuable to patients. When GP nurses emphasised the parts of their role imparting an alternative view of the world to address common interests in society, the qualitative data identified evidence of explicit efforts to impact patients' perception through informative influence.

Approach

This dimension focuses on the differences found in the findings between the notion of positive and negative practices in general practice. They were used descriptively rather than being indicators of value. Fostering opportunities were defined as positive practice, while removing barriers to action were defined as negative practice. The positive realm relates to fostering active opportunities to enable patients to gain benefits and self-realisation. This is in contrast with the negative realm which relates to non-interference, independent choice and the expectation that patients be able to live independently. Positive practices may be viewed as excessively conclusive and, thus contrary to patient independence, while negative practices may be viewed as inadequately forming the life structures people need in order to improve rather than merely exist. In addition to taking into account other life considerations, your preference for one practice or the other will

depend upon the importance you attach to independence. Table 9 (its original version is Table 5 in Chapter Four) has been updated in italics to highlight the variation in chosen outcomes found among the GP nurses.

Table 9: Differentiating spiritual care outcome by preferred outcome style, annotated to illustrate different approaches

	Meeting Defined Healthcare Needs: The Objective Benefit of the GP Nurse Role in Provision	***Empowering Self-Determination: The Subjective Benefit of the GP Nurse Role as a Supporter***
Fostering opportunities: ***The Perception of Gain through the GP Nurse Role***	Approach The GP nurse role in creating opportunities for equal access to 'accumulated' benefits.	Development The GP nurse role in fostering independence through self-actualisation.
Removing Barriers: The Perception of Avoiding Loss through the GP Nurse Role	Caretaking The GP nurse role provides protection and relief from pain and misery.	Independence The GP nurse role empowers self-reliance through freedom from obstruction.

According to both quantitative and qualitative data analysis, patients attribute value to various orientations, but notably, the outcomes associated with the orientations of 'caretaking' and 'independence' yielded strikingly similar results: patients reported feelings of protection and safety. Based on the evidence derived from this understanding of value, a single realm of 'loss prevention' could be applied to simplify the last row. With this orientation, GP nurses seem to deliver value through safeguarding, irrespective of whether they do it for the protection it provides for vulnerable patients or with the expectation that patients would experience emerging independence without requiring additional involvement.

This explanation presents three orientations for spiritual care outcomes that can potentially lead to the creation of value in patient spiritual care:

- The ‘approach’ orientation seems to refer to the importance of equal opportunity in approaching objective benefits and emphasises the role of GP nurses in addressing long-term and organisational problems.
- The ‘development’ orientation seems to establish a connection between understandings of spiritual care value in self-realisation and GP nurses in the interest of patients and their subjective well-being.
- The 'loss prevention' orientation seems to establish a connection between the perception of value in safeguarding and encompasses organisations with diverse perspectives regarding the role of objective and subjective benefits.

The theoretical intention of GP nurses operating under an overarching ethical framework is expected to make practical contributions within GP practices. While the specific outcome preferences may differ, this approach can stimulate discussions on the utilisation of decision-making and non-decision-making power, as proposed by Lukes (2013). Although the GP nurses were not asked about leadership in this study, it was evident from interview data that they have some autonomy within their role as many of them work alone and plan and manage their work schedule. It appears that leadership is there but may not always be explicit or acknowledged.

This notion about contributions within decision-making discussions aligns with what van Leeuwen and Schep-Akkerman said in 2015 that there is a need to develop leadership in nurses and then nursing leaders should facilitate the implementation of spiritual care in the workplace. However, in the analysis of discourse about spirituality and nursing leadership, Reimer-Kirkham et al. (2012) avers that nurse leaders were apprehensive about incorporating spirituality in leadership practices due to social and organisational influences. These results further support the idea of the social and organisational impact on nurses on their provision of care. However, Reimer-Kirkham et al. (2012, p1036) go on to suggest that ‘Managers have an important role in contributing to an organisational culture that facilitates the religiosity or spirituality of employees and patients in a person-focused fashion’. In general, therefore, it seems that the provision of spiritual care is dependent on social and organisational decisions and the ability and strength of leaders to be an advocate of spiritual care. Moreover, pushing forward spiritual care integration within nursing care could perhaps be related to the confidence of the leader.

Attitude

The previous chapter showed that the concept of 'sincerity' as articulated by the GP nurses, implies that organisational requirements and directives, such as adhering to timed appointments for the benefit of patients, are considered as necessary requirements which could be thought of as ethical when needed. In this respect, GP nurses appear to go further than the findings in the Baldacchino (2006) report towards the notion of equity, as GP nurses employ a social obligation as well as a professional requirement. Nonetheless, the sentiments shared by GP nurses in this study and those found in Baldacchino's (2006) nursing research are similar in that both acknowledge the necessity to provide spiritual care on a professional level..

In this study, the dimension 'Attitude' refers to GP nurses having awareness of patient expectations and the concepts of 'respecting the individual' and 'inherent kindness' suggest that GP nurses aim to follow this set of principles in their interactions with patients. First, by appreciating individual differences and needs and working to meet patient needs, they try to avoid perceiving people as the same. Then, by practising in an affable, approachable and accommodating way without turning it into a depersonalising structure of organisational procedures and directives, they endeavour to communicate to patients that their dignity will be safeguarded. Nonetheless, there was a marked trend that 35.9% of the GP nurses in this study expressed a common sentiment of feeling unable to meet their patients spiritual needs, while 64% believed that they could fulfil the spiritual needs of their patients. This finding is contrary to a previous study (RCN, 2011b) which has suggested that 92.2% of nurses felt that they occasionally met their patients' needs equating to only 7.8% that felt they meet their patients' spiritual needs. These findings could have a number of causes, including inadequate levels of understanding and development in the provision of spiritual care or even the inherent qualities of the GP nurse role. In a GP setting, patients receive their care all in one appointment (whether it is a regular appointment or not) resulting in, for the most part, an end result by one nurse. In hospitals, for example, care could be spread over several days and be carried out by many different clinicians which might account for why nurses working in that type of setting perceive their ability to deliver spiritual care differently. Conversely, GP nurses might feel that they deliver spiritual care because they manage patient appointments and thus their needs.

The qualitative findings found that 'encouraging relationships' suggests that one of the primary sources of value creation of GP practices stemmed from the GP nurses' capacity to establish meaningful relationships with patients. From the qualitative analysis, all the ten interviewed GP nurses used their own understanding of spiritual care in ways thought

to help facilitate patient connection in addition to enhancing the method of healing. The level of understanding varied between them and is based on their assumption of what they perceived to be spiritual care, their practical knowledge in the provision of spiritual care and their level of confidence in providing this care. This link regarding the provision of spiritual care and understanding, confidence and knowledge aligns with what McSherry and Jamieson said in 2011. They argued for 'the need for a more coordinated approach and a collective responsibility in providing clearer guidance, resources to nurses so that they can deal more effectively and confidently in this area' (McSherry and Jamieson, 2011, p.1765). In addition, McSherry et. al (2020) argues that knowledge about spirituality supports nurses' competence and confidence in the provision of spiritual care in certain ways: it helps in understanding practices; enhances knowledge sharing among colleagues; it assists in deciding on appropriate practices in the provision of spiritual care; and creates understanding. Research has identified that nursing staff who attend spiritual care training demonstrate increased confidence in the provision of spiritual care (for example, Frouzandeh, Aein and Noorian, 2015; Martins, Romeiro and Caldeira, 2017). By entrusting the development of spiritual care practices to educational programmes, GP nurses have less of an emotional burden in trying to determine best practice, and then suitable and effective educational resources can be created to aid them in their development (McSherry et. al, 2020).

Understanding

In this study, all ten GP nurses seem to be guided by the desire to deliver quality care that centres around their patients' needs. However, occasionally they felt that they were unable to give as much time as they would have liked to manage patient care, due to time restrictions imposed on them. Given the importance of practice-focused quality targets in GP practices (While and Webley-Brown, 2017) as locally situated NHS businesses, it is possible to suggest that a distinguishing characteristic of GP nurses (compared to some nursing roles based in larger healthcare environments such as hospices) may be that their role is more challenging and complex (While and Webley-Brown, 2017) and thus the provision of spiritual care may be more difficult. The findings found that GP nurses' intentions unite around multiple yet common strategies in practices and levels of engagement in the provision of spiritual care. These findings reflect those of other researchers in relation to GPs (Vermandere et al., 2011; Appleby, Wilson and Swinton, 2018) and support the idea that GP staff exhibit less measured and standardised ways of working than other health organisations. Hvidt et al. (2016) carried out a qualitative study to explore GPs' understanding of the existential dimension (to include spirituality) of care and looked at how and when it is incorporated in practice. Their study found GPs were drawn to unmeasured and non-standardised ways of

working. Appleby, Wilson and Swinton (2018) also found that GPs had common themes in their provision of spiritual care. The outcomes of these practices focus more on the meaning and importance of patient lived experience instead of focusing on measurable outcomes. Appleby, Wilson and Swinton's (2018) systematic review of literature directly acknowledged the practice-focused nature of GP narratives and compared them with other GPs' relatively scant discussion of concluding findings. The studies claimed that the feeling of acceptability experienced by these GPs was supported by social ethics. This evidence agrees with this study's findings that suggests that the multi-faceted aspects of patient care is of main importance over measured outcomes in GP practices, while at the same time they are managing outside pressures of practicality and directive.

These findings contribute to our understanding of the diverse practices employed by GP nurses and shed light on the reasons why some may not prioritise the direct creation of measurable outcomes in their approach. This awareness allows for a deeper comprehension of the various factors that influence GP nurses' decision-making in shaping their practices. Although this might create tension within GP practices when there is pressure from the government for GP practices to act in a more measured and standardised way (for example, via the use of performance assessment tools) (DH, 2008; Goodwin et al., 2011), GP nurses in this study focus on multi-faceted aspects of patient support and guidance while taking into consideration organisational requirements.

Summary of Dimensions

Two of the dimensions, 'Congruence' and 'Aim', focus on GP nurses' common perceptions and provision of spiritual care. The interpretation of GP nurses' intention to benefit patients seems to be influenced not only by their actions aimed at fostering positive outcomes but also by the alignment of their underlying assumptions about those benefits with those of the patient. This highlights the importance of considering the mutual understanding and agreement between the GP nurse and the patient regarding the desired benefits and outcomes of their interactions. This suggests that the outcomes of patients receiving spiritual care are only considered beneficial when the GP nurse is able to cater to patients' needs. However, these needs could be different at every appointment that the patient has which could mean identifying those needs would be challenging for GP nurses, even among their regular patients.

The other three dimensions, 'Approach', 'Attitude' and 'Understanding' highlight how GP practices' directives serve as guidelines and decision-making criteria within a GP practice setting. These dimensions have implications for the type of spiritual care value that GP nurses can deliver, as they shape the approach and mindset with which they

engage in spiritual care practices. There was a connection between GP nurses' practices in and outcomes from the provision of spiritual care; respectively, they relate to how GP nurses interact with patients and why. This shows that most of the practices that GP nurses used in the provision of spiritual care were influenced by the GP setting in which they work. This suggests that if the nurses worked in a different context, such as in a hospital, these practices might be different.

As a result of identifying these dimensions, it was found that GP nurses have similar perceptions and practice in the provision of spiritual care, lack confidence in delivering spiritual care, and have difficulty in dealing with spiritual issues as other nurses working in other healthcare contexts (Sartori, 2010; RCN, 2011b); however, until this study, we could only make assumptions based on the other nursing studies. As practices carried out on behalf of the GP practice seek to create value, shared values may help to shape their planning and priorities. The degree to which these activities are expected to be valued by the patients can also be affected by effective value communication.

These dimensions proffered a model of elicitation that could be useful as a professional development tool to support GP nurses' development in the provision of spiritual care. The proposal is that as the *GP Nurse Provision of Spiritual Care* model, it could be useful in making a bridge to a more developed notion or mental construct of spiritual care; it could help practitioners capture their practice or feel confident to recognise their practice; and, could help practitioners to capture, nominate and realise what they are already doing. As such, the model may be of value to those involved in the educational and professional development of GP nurses.

Applying Critical Realism

In view of the theoretical framework used for this study, and after discussing the significance of the data in relation to the extant literature on the provision of spiritual care, it is instructive to theorise the findings applying Bhaskar's interpretation of critical realism.

Critical realism suggests that beliefs are derived from mechanisms and contextual factors within a stratified reality (namely, *real, actual* and *empirical*) in the mind of the individual (in this study the GP nurse). Watson's Human Caring Theory (WHCT) suggests that it does not matter where beliefs integrated into practice come from, as the underlying skills and experiences of the nurses are accessible and can be used by them (McEvoy and Richards, 2003). However, nurses with a lot of experience in the provision of spiritual care may find that this facilitates their approach more readily. For example, in this study, expressed or even implied awareness of spiritual care may have played a part

in the success of the provision of spiritual care. Narayanasamy (2006, p.845) describes spiritual awareness as a 'part of the biological makeup of the human species'. In nursing, and healthcare in general, spiritual awareness is known to be positively connected to confidence in the provision of spiritual care (Vermandere et al., 2011; Appleby, Wilson and Swinton, 2018). This awareness assists staff in being prepared to meet the spiritual needs of patients (Narayanasamy, 2006). However, when staff have assumptions about the meaning of spiritual care, and they are reinforced by other factors (for example, religion, upbringing), the concepts are integrated into the individual's existing beliefs of reality for these concepts. For those with less awareness, it is possible that their beliefs are unaccepting of new ideas or concepts, and thus spiritual care is less easily delivered.

There are good reasons why a connection between spiritual awareness and the provision of spiritual care exists. If, as often claimed, connections between the provision of spiritual care and spiritual awareness are fundamental relationships, evidence of this would be anticipated in investigative research. This relationship was found through CR, and studies identified in the literature review suggest that there is justification for this claim. Data from the mixed methods approach was beneficial in supporting any claim that intended development of spiritual awareness will have an underlying impact on the provision of spiritual care. However, there might be additional reasons for the connection identified between them, perhaps an innate dimension for knowledge. CR was a useful theoretical framework to delve into GP nurses' dimensions using Bhaskar's (2008) concepts of the *real, actual* and *empirical* domains. Bhaskar defines knowledge 'as a structure rather than a surface. But the natural world becomes a construction of the human mind or, in its modern versions, of the scientific community' (2008, p.15). Elder-Vass (2004, p.5) builds on Bhaskar's definition to suggest that ''experiences' are no longer purely the outcome of the events they might appear to reflect, but rather a product of the combination of those events with our prior knowledge.' Therefore, the notion that a GP nurse's dimension for knowledge might be responsible for the connection between their development of spiritual care could be indicated by the extent of their capacity to learn. Empirical evidence (for example, Vlasblom et al., 2011) has been used to claim that the development of spiritual care has an underlying impact on the provision of spiritual care, thus, it appears that confidence in the provision of spiritual care for GP nurses can be developed not only through learning and acquiring knowledge. Positive discussions about the provision of spiritual care might as easily arise from GP nurses' personalities as underlying dimensions of their experiences through practice.

According to Westhorp et al. (2011) it can be difficult to conceptualise an underlying real world that exists separately from our comprehension of it. They offer a different

perspective that 'reality is 'interdependent with' our interpretations' (Westhorp et al., 2011, p.3). They continue by asserting that:

> Everything is embedded into other levels and all the systems interact with each other. As a result, any event has many causes, and at the same time may have many consequences. This also means that every outcome of a programme is a result of multiple causes; and that every program may have many different outcomes (Westhorp et al., 2011, p.3).

This description explains why there may be different ways of developing GP nurses' knowledge of spiritual care. Westhorp et al. (2011, p.3) is just reaffirming the basis for Bhaskar's notion of a stratified reality: that 'everything in this world is organised in systems, which in turn are embedded in larger systems and connected to other levels.' Consequently, Westhorp et al. (2011) provides a reason for concluding that a positive connection between development in spiritual care are underlying connections to each other and a third variable. The educational implications, thus, are a move from not only recognising the value of professional and educational advancement for providing spiritual care, but also the significance of providing opportunities to make use of underlying dimensions.

An important finding was that the five GP nurses' practices in the provision of spiritual care ('sincerity', 'inherent kindness', 'respecting the individual', 'encouraging relationships' and 'valuing the wider context') and four decision-making concerns ('fulfilling the GP nurse role as the important factor', 'formality and professionalism', 'unity of people', 'supporting') were importantly connected with the results of this study. The exploration of important relationships between the practices and outcomes in the provision of spiritual care has provided insights that addressed the question of how the general practice context impacts the provision of spiritual care.

The Implications of GP Nurses' Spiritual Care Practices for GP Settings

In this study, the final question aimed to determine the implications of GP nurses' provision of spiritual care practices for GP settings. It is not surprising that the view that spiritual care development is seen as a way of improving nurses' confidence in the provision of spiritual care, is strong given that there is primary research evidence that clearly identifies this need (for example, RCN, 2011b).

It should be made clear here that this belief refers to both general and continued education in spiritual care as well as in what appears to be independent or impromptu strategies in the workplace that are used to inform GP nurses on these concepts and practice. Furthermore, justification for incorporating spiritual care into informative

practices of GP nurses could help them to cope with social and cultural differences of their patients. GP nurses should be given the opportunity to develop their awareness of these concepts and have the opportunity to discuss spiritual issues when they arise. Indeed, NHS Health Education England (HEE) (2017, p.7) on the development of GP nurses states, among other things, 'Enhancing the GP nurse role […] maximise the professional development of GP nurses through accessible, fit-for-purpose training'. The HEE has consistently reported the view that GP nurses should be supported in their development in the role, on socio-cultural bases. For example, in a report reinforcing the need to develop the GP nurse workforce, HEE (2017, p.36) argued that:

> [GP nurses'] work is all about person-centred care and should be about working in partnership with carers, families and others who are important to the individual. Training in preventative health, supported care, motivational interviewing, mental health paediatrics and advanced communication skills should become the norm. Prevention is a large part of the GP nurse role and […] should play in promoting a culture where improving the population's health is a core component of the practice of all nursing.

In light of the above, the lack of spiritual care development opportunities for GP nurses is either educationally unclear (for example, little reference is made to spirituality or spiritual care whether it is associated or not to holistic or person-centred (Timmins et al., 2015), or due to the ambiguity of both concepts (Lewinson, McSherry and Kevern, 2018). The first type of exclusion is hypothetical and is unlikely to change until more studies are carried out and, therefore, there is a greater need for this change. The other type of exclusion is contested by the increased number of primary research on spiritual care. Recent studies have shown that education can increase awareness of spiritual care. If the opposite was true and education was shown not to increase awareness, then we might expect to learn about this through comparative educational studies, but no studies have been found. Of course, there might be studies, but they are yet to be discerned. Nonetheless, given that nurses must be competent to assess their patients' spiritual needs, if educational studies proved to be detrimental to nurses' comprehension of spiritual care one might expect to have encountered evidence of this.

The rationale for the provision of spiritual care is that it is an important element for creating a more supportive and inclusive community, and/or that it is a means through which patients can receive high quality, person-centred care. However, regardless of the socio-cultural justification for development of spiritual care in general practice, it remains a hypothetical claim for the impact that spiritual educational strategies have on academic and general practice nursing outcomes. As there is an absence of studies that directly

acknowledge the effects of spiritual educational strategies, I am unable to argue the case.

The final question addressed here relates to the implications of GP nurses' spiritual care practices for GP settings. The implications for GP settings based on the results of this study, it appears that, until further evidence is available, GP nurses should feel comfortable in using whichever practice they choose in the provision of spiritual care. The literature review has established that there is uncertainty among nurses as to how to deliver spiritual care, although there is an awareness of its importance in nursing. Furthermore, where nurses had associated positive outcomes from the provision of spiritual care, typically, the context was different from general practice. The mixed methods approach used in this study also identified uncertainty among GP nurses about how to deliver spiritual care.

There is a recognition of a need for training in the provision of spiritual care. However, like all training programmes, educational courses would need a market where there is a demand to ensure the viability of the training. The expense (in materials, time and effort) to GP practices of organising resources for GP nurses' education in spiritual care should be taken into account when identifying the advantages to GP nurses' development. The costs associated with designing appropriate training could be large. Training organisations, or indeed the NHS itself, could take on the task of making available spiritual resources for GP settings. On the other hand, if academic institutions are able to deliver spiritual education, there would not be a need for GP practices to provide in-house training and GP nurses could attend external training; of course attendance at external training would require absence from the workplace, which in itself is an additional cost, and might not be possible for many GP nurses because of current nurse shortages and lone working in general practice.

From the perspective of policy, healthcare organisations like the NHS should be more initiative-taking in advising GP nurses about the provision of spiritual care. This is vital for promoting spiritual awareness given the paucity of official guidance from the NHS about spiritual care in the UK, with truly little, if any information directed specifically at general practice staff. However, if we are to hope for sufficient resources and materials for GP nurses, we must also hope further evidence-based practices are carried out so that GP nurses can be confident in the provision of spiritual care.

A final point on the implications for practice, there is the potential of establishing a GP nurse-patient spiritual care programme which would be practice-based and created by

GP nurses and patients. A GP nurse-patient spiritual care programme would, of course, require a strategy that would identify how this could be achieved, but it would be deliberately developed to meet patient spiritual needs. However, in order for the programme to be viable, additional research studies would be required. Nonetheless, regular discussions among GP nurses about their practices in the provision of spiritual care is suggested in order to encourage on-the-job development and support for them, as well as to improve patient care outcomes.

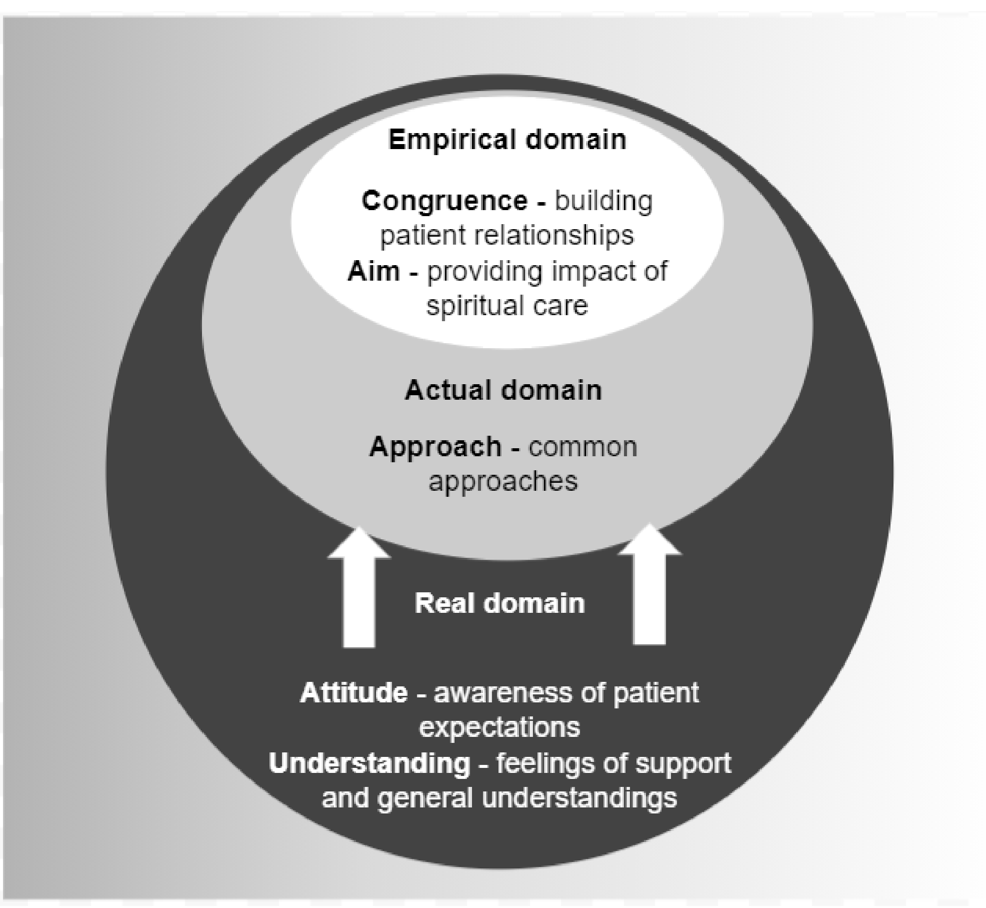
The Five Dimensions of Spiritual Care in a Stratified Reality

The identification of the *GP Nurse Provision of Spiritual Care* model supports two proposals that have implications for policy and practice. First, where GP nurses' practices in the provision of spiritual care are influential in the way they practise, the organisational implications of adopting various outcomes of spiritual care should be recognised. Second, in the provision of spiritual care, GP nurses must be mindful of their intentions and their practices must adapt to the expectations of the patient. The patients' participative and the GP nurse's influential practice both affect important organisational choices to bring about this change and use of the model.

The diagram of the proposed conceptual framework in Chapter Three presents Bhaskar's notion of a stratified reality, and the three domains of *real, actual* and *empirical,* to help make sense of the influences relating to GP nurses' perceptions of spiritual care, and the factors that impact their provision of spiritual care. The mechanisms and structures believed to influence the provision of spiritual care were placed within the *real* domain at the lower/deeper level of the circle. The information above the *real* domain illustrated how actions, thought to be *real*, were generated and experienced in the *actual* domain, but discernible through human perspectives via the *empirical* domain.

In revisiting the proposed conceptual framework set out in Chapter Three, we can now see a simplified version (Figure 8) of the framework that charts the annotated data from the *GP Nurse Provision of Spiritual Care* model presented in Chapter Four. This version of the conceptual framework highlights the added significance and validity of the model in relation to Bhaskar's concepts of the *real*, *actual* and *empirical* domains and demonstrates how GP nurses' provision of spiritual care adhere in different levels of the stratified reality. The initial creation of the model meant that the dimensions discerned as equivalent and were not ranked in any way, however, when they were theorised in this way and mapped onto the conceptual framework, a rank order is implied, and this is shown in Figure 8.

Figure 8: The conceptual framework charting the five proposed Dimensions of Spiritual Care by GP Nurses



Charting the points of the *GP Nurse Provision of Spiritual Care* model onto a conceptual framework affirms the notion that GP nurses' practices serve as a filter, that is, reducing all potential avenues for action open to them to the actions (as well as interactive relationships) finally chosen. However, charting the points also emphasises another interesting aspect within the spiritual care value chain. Patients are positioned in Bhaskar's *empirical* domain, and it is where the benefits are relevant and where GP nurses may be able to provide spiritual care. The additional conceptual framework (Figure 8) indicates that expectations serve an essential role in influencing the provision of spiritual care, as they contribute to the belief and acknowledgment of the potential for receiving spiritual care ('Congruence') and the potential of believing that there are benefits at various stages in a possible spiritual care value chain ('Aim').

These findings have important implications for the development of GP nurses as some of these concepts are more nested or more challenging than others particularly the feasibility and practicability of the provision of spiritual care within general practice. The complexities have been acknowledged in terms of their degree and richness through

the use of Bhaskar’s stratified reality helping to inform what could be professional challenges. Hence, it could conceivably be implied that for professional educators or people working with GP nurses in a reflective space, may find the professional development of spiritual care challenging. Nonetheless, these points offer important implications for development as they unite in concerns about perceptions and provision of spiritual care. It could be argued that three of them (‘Approach’, ‘Understanding’, ‘Attitude’) are more concerned with the influence of GP nurse perceptions and GP practices’ directives towards the provision of spiritual care, and that the other two (‘Congruence’, ‘Aim’) focus more on the role of actions.

Summary

The discussion in this chapter has drawn together relevant aspects that were found through the study of quantitative and qualitative data taking into account both the perceptions and provision of spiritual care. From the findings from both data, it was evident that the participants share common perceptions of spirituality and spiritual care even though many of them felt unable to always meet their patients’ spiritual needs.

The GP nurses recognised that the necessity to adhere to organisational requirements of time restrictions can be challenging. Moreover, uncertainty around the participants’ perceptions and practices, the difficulty in learning spiritual care practices and the absence of enough professional training means that many of them lack confidence in the provision of spiritual care. As a consequence, GP nurses’ provision of spiritual care tends to be based on their own spiritual beliefs and/or when the patient identifies the need for spiritual care with specific spiritual care outcomes in mind.

This investigation is the first and only study to generate data and analyse findings pertaining only to GP nurses and the concepts of spirituality and spiritual care in the UK. In doing so, this study has been able to identify five influential dimensions from both data which were brought together for the formation of the *GP Nurse Provision of Spiritual Care*, and which ultimately proffered clear connections among individual GP nurse perceptions and practices. Bhaskar’s theory of critical realism helped to make sense of participants’ practices in the provision of spiritual care in general practice and the impact of this environment on their practice. Furthermore, the application of critical realism, by accommodating this unique theory of a stratified reality and the concepts of *real, actual* and *empirical*, clearly presents how the participants’ knowledge and skills impact on practices and facilitates the spiritual needs of their patients.

Chapter Six: Conclusions and Recommendations

Conclusions

This concluding chapter will outline the three distinctive contributions to knowledge made by the present study: a systematic literature review of the extant field aiming to identify gaps in research; a structured and in-depth comparison of GP nurses' perceptions and provision of spiritual care; and, the application of Bhaskar's theory of critical realism. The chapter highlights limitations within the study, it indicates areas for further work and contextualisation of the findings, and proffers four recommendations: research into GP nurses' abilities to provide spiritual care; GP nurses' knowledge of spiritual care in general practice; further application of critical realism in research into spiritual care; and, additional use of mixed methods in research design. These recommendations could help those supporting the professional preparation and professional development of GP nurses in the provision of spiritual care.

This present study's goal was to investigate and understand GP nurses' perceptions of spiritual care, identify how the general practice context impacts on their provision of spiritual care, explore patterns or commonalities in their practices, and to determine the implications of these practices for GP settings. It was then hoped that implications for professional development could be identified to help GP nurses to develop this dimension of their practice. The complex and multifaceted nature of spirituality and spiritual care, coupled with their applicability within the general practice context, often poses challenges and generates confusion among nurses. For example, 'There is also anecdotal evidence that nurses require additional guidance and support in dealing with [...] spiritual needs of patients.' (McSherry and Jamieson, 2011, p.1758). This confusion has proven to be problematic in the provision of care. There is an inherent complexity in the topic and a degree of under-specification of how the concepts can be put into practice. In general, therefore, it seems that there is a need to maximise the potential for good practice and knowledge-sharing.

This study has shown that spiritual care can prove challenging because of the ambiguous nature of their meaning and application for healthcare staff. Frequently, references are made about a connection between existential meaning and purpose (Delgado, 2005; Koenig, 2012; van Leeuwen and Schep-Akkerman 2015), with little guidance on what these concepts look like when employed in practice. Lewinson, McSherry and Kevern (2018, p.1) report this problem succinctly, 'defining spirituality remains a conundrum, as it is subjective and means different things to different people [...] similar difficulties are encountered in efforts to define spiritual care'. The spiritual awareness of individual GP

nurses is an essential asset. GP nurses devote their professional life to accumulating and improving their competence, perceptions and practices required to develop their spiritual awareness and leverage it to make wiser decisions in their professional life. Therefore, it would be expected that a more knowledgeable and experienced GP nurse would possess a more profoundly developed spiritual awareness than an inexperienced GP nurse. This was mentioned earlier as a number of GP nurses recalled being mentored by more experienced nurses in the role as a way of developing their provision of spiritual care. In order for the understanding and provision of spiritual care to be evidence-based, it is important to move beyond solely relying on GP nurses' perceptions and practices. Depending solely on spiritual awareness may not fulfil the professional requirements necessary for providing comprehensive and evidence-based spiritual care. Furthermore, only relying on spiritual awareness without conscious reasoning puts GP nurses at risk of the suggestion that, even with good intentions, their spiritual awareness response might result in an outcome that does not meet the needs of the patient.

Moreover, the study shed light on the problematic questions of existential meaning and purpose. Where healthcare has acknowledged the need to do more than rely on professional spiritual awareness and requires the value of additional knowledge in the provision of spiritual care, it seems as though there is limited primary data relating to the significance of these concepts in general practice. At least, primary data does not look at assessing the effects on objective measures of patient satisfaction. The degree of health and happiness outcomes patients expressed or how well a patient's health improved, over time, in relation to expected outcomes, compared to previous outcomes or outcomes of other patients with similar health concerns, may vary. However, it is impossible to escape from the reality that these types of outcomes are important in healthcare and to patients. The imbalance between research carried out in general practice and that carried out in hospital settings shows an emphasis on research in hospitals with less focus on research in GP settings.

It follows from the findings that in order to get nearer to expected outcomes so that all GP nurses are able to provide spiritual care for their diverse group of patients, regardless of the GP nurses' level of spiritual awareness or experience, they require specific instruction on what the provision of spiritual care looks like in practice. Furthermore, there is a need for clear explanations on what arises when this provision is carried out with different types of patients, particularly considering that the Nursing and Midwifery Council included spirituality as a named dimension within nursing competencies. My thesis addressed this challenge from acquiring GP nurses' general perceptions of spiritual care, and their provision of spiritual care as I identified here.

Overall, the results of this research suggest directions for the educational or developmental needs of GP nurses, which take into consideration the varying context within which they operate so that training initiatives are tailored more to their needs. Moreover, holistic care includes spiritual care: that is, development in spiritual care is not afforded its own independent, formal programme. The findings of this study indicate that the development of this area would be enhanced by the inclusion of various categories of healthcare professionals and different forms of discrete professional development which is a separate module instead of being added to other modules due to the difficulty of learning spiritual care practices. Pre-registration and post-qualifying programmes could address this important and urgent need to increase professional development in spiritual care. NHS Education for Scotland (2009) identifies three strategies which may be useful in the education of spiritual care. First, the use of storytelling with the application of different media such as videos and audio to help inform aesthetic knowledge. Second, incorporating the personal perceptions and experiences of GP nurses through discussions to encourage reflective thinking thereby developing affective and cognitive skills. Third, in order to develop GP nurses' broader understanding of spirituality, because for some this will be new knowledge, education could be taught to incorporate theoretical considerations. Although it may be difficult to afford spiritual care its own model within healthcare education, an explicit consideration of spiritual care as part of holistic care could make an important contribution to foregrounding learning in this concept.

This study has shown that while findings from nursing in other healthcare environments, other than GP settings in the UK, present a fundamental basis on which to investigate the likelihood that development in spiritual care will be helpful in those environments, it however, leaves essential questions unanswered. Therefore, the first original contribution to knowledge that this thesis makes is to be the first study to have undertaken a systematic literature review of the extant field and established definitively that there is a gap in relation to only GP nurses working in the UK.

The second original contribution to knowledge is that this study is the first study to gather a body of both quantitative and qualitative data on GP nurses' perceptions of spiritual care, and to provide an exploration and identification of patterns or commonalities in GP nurses' practices in the provision of spiritual care to a diverse UK population. From the data set collected (data from an online questionnaire and narratives from interviews about their provision of spiritual care in general practice, in the UK), five influential dimensions, 'Congruence', 'Aim', 'Approach', 'Attitude' and 'Understanding' were

extrapolated to develop a spiritual care model of elicitation termed as the *Provision of Spiritual Care.*

The third original contribution to knowledge resides in the application of and findings from Bhaskar's theory of critical realism (CR). Based on recommendations to researchers of the high applicability of critical realism in healthcare studies (for example, Baumbusch, Dahlke and Phinney, 2012; Walsh and Evan, 2014) and informed by the other research that focused on the provision of spiritual care (Appleby, Wilson and Swinton, 2018), critical realism was used as the theoretical framework. Applying CR as a theoretical framework in this study enabled an investigation into underlying perceptions of spiritual care, and an exploration of the contextual influences and affective factors that impact GP nurses provision of spiritual care. The findings from the mixed method approach, applied in this study, generated evidence that even though GP nurses had common understandings of spiritual care and recognised the importance of the provision of spiritual care for patients, many of them did not feel confident to meet their patients' spiritual needs and indicated a need for development in relation to these concepts.

The strong conclusion from this investigation is that respectful and responsive interactive relationships serve as a fundamental basis for fostering professional and patient reassurance. This In turn, facilitates sincere, open, and participative dialogue, which could substantially aid in the improvement of spiritual care given to patients in the future.

Limitations of the Research

The present study had several limitations that should be acknowledged. Firstly, there were challenges in reaching the desired sample population, which may have impacted the generalizability of the findings. Secondly, there were concerns about the potential conflation of the concept of spiritual care with religious connotations, which could have influenced participants' perceptions and responses. Lastly, there might have been biases in the sample selection process, which could have influenced the representativeness of the study sample. These limitations need to be factored into account when explaining the findings of this current investigation and should be addressed if the study is reproduced.

One limitation of this study was recruiting GP nurses to participate. The understanding within the nursing community tends to be that education on spiritual care would benefit all nursing staff (RCN, 2011b). The NMC (2018) is explicit in their latest nursing standards of proficiency: 'Registered nurses prioritise the needs of people when assessing and reviewing their mental, physical, cognitive, behavioural, social and

spiritual needs'. Nonetheless, the primary research studies that were used to inform this study (Baldacchino, 2006; RCN, 2011b; Vlasblom et al., 2011) were all carried out with participants, nursing staff working in other environments such as, hospitals and hospices, but may have included some GP nurses. The studies by Baldacchino (2006) and Vlasblom et al. (2011) were carried out with nurses working in hospital environments. The RCN's (2011b) study was carried out with nurses from different environments, such as hospital, academic, general practice and hospice. Thus, research intended to investigate GP nurses' perceptions and provision of spiritual care should have nurses who only work in general practice.

Recruiting nurses who work in general practice was more challenging than if the study included nurses who work in different environments because, as previously discussed, GP nurses work in different GP settings, usually one GP practice among several in one NHS region. It was hoped that more GP nurses would have taken part in this study when they were invited to participate. As identified by the number of participants who completed the questionnaire (see Chapter Four), the sample was not large; out of a possible 183 participants 39 responded (21%). From the 39 respondents it was hoped that there would be a sufficient number of GP nurses that would be willing to participate in focus group discussions. However, only four people showed any interest in participating in a focus group, so it was decided to change to individual interviews instead, consequently, the number of respondents who were happy to be interviewed, increased to ten. Possible reasons for the lack of interest in completing the questionnaire and participating in a focus group are discussed in the following sections.

Difficult-to-reach Sample

One problem with trying to recruit GP nurse participants is that they may be difficult to reach due to their working arrangement (While and Webley-Brown, 2017). This can be due to the fact that GP nurses have tight work schedules that they often carry out on their own, they may only work part-time, and they may be the only GP nurse within a GP practice. This type of working arrangement is commonly represented among GP nurses, especially those working in small GP practices. In addition to this, the notion of participating in research which could be quite daunting for some and seen as quite time consuming; it is no surprise that many GP nurses did not want to participate.

In this study, practical ways were proactively taken to encourage participation in this study. In addition to the invitation email, the questionnaire was made easily accessible online, it was available for several weeks at any time of the day to fit in with GP nurse work patterns, and GP nurses were reminded by email to complete it. Nonetheless, this

approach was unsuccessful in attracting a greater number of participants as might have been hoped. The potential significance of this is that possibly key factors, such as the practicalities in the provision of spiritual care of those who participated did not adequately reflect the practices of GP nurses from within the region. Unfortunately, the low number of respondents means that the opportunity to identify commonality among the GP nurses was limited, although this study offers some insight into common perceptions and practices.

Religious Connotations

In addition, the difficulty in getting GP nurses to complete the online questionnaire may have been associated with an underlying belief that society has regarding spirituality and its connection with religion. As we have seen, in recent years, at the start of 2019 when this study was carried out, the NMC re-established the nursing competency to ensure that all nurses would assess patients' spiritual care needs. There appears to be no direction or stipulation from the NMC on how to carry out such an assessment. This is particularly alarming given that previous research has demonstrated that numerous healthcare staff members are perplexed by the concept of spirituality and lack clarity on how to effectively provide spiritual care. In these unclear and difficult times, it is perhaps not surprising that a large majority of GP nurses did not want to participate in a focus group that would inevitably expose how they deliver spiritual care, if at all. Thus, to encourage greater participation and open discussion among GP nurses regarding their practices in providing spiritual care, individual interviews were conducted ensuring strict anonymity to reassure the nurses about maintaining their confidentiality and identity. This problem reminds us that context is important when collating and interpreting findings. If the focus groups had been carried out, it would not have been clear whether the participants (in front of others) would have withheld or exaggerated information pertaining to their practices.

Sample Population Bias

The unsuccessful attempt to recruit more GP nurses from the population of interest was almost certainly an example of selection bias (Thomas, 2013). Selection bias is when the research participants may differ from the population being researched. This may be due to either conscious or unconscious bias in the manner that they are chosen to participate. In this study GP nurses may have decided to participate because the concepts of spirituality and spiritual care are of interest to them. An example is when one GP nurse made contact to say that they would not complete the questionnaire because they are not interested in the topic. The implication for this bias is that only GP nurses who were interested in the provision of spiritual care volunteered to participate. The

example highlights the problem of GP nurses self-selecting because of pre-existing beliefs among the study population. Nonetheless, in order to prevent or reduce bias in this study, all information disseminated to the population was clearly defined.

A way to manage this problem might be to address all, or at least, a vast majority of a study population before embarking on a study, to address underlying concerns. Researchers could more effectively emphasise the significance of the study, the meaning of each concept, and could discuss any concerns the participants might have about taking part in the study. There would be less opportunity for selection bias as described above, and higher participation rates would give any research better statistical power. These positive outcomes would be beneficial to many people, not just the researchers, but also the patients, and increase knowledge of spiritual care in the nursing community. Any future repetition of this study should attempt to recruit as many participants as possible so that more can be known about the GP nurse population in relation to spiritual care.

In response to claims that GP nurses' spiritual awareness can be used to support them in being confident to provide spiritual care, this study found evidence that seems to support that claim. When interviewed, GP nurses did discuss the usefulness of some type of development, whether that was in the form of educational or professional courses, or regular discussion with colleagues. These findings suggest that GP nurses should implement whichever educational or professional developmental approach to increase their knowledge of spiritual care in a way that is most comfortable and beneficial for them. Furthermore, theories of spiritual awareness should be revised to consider the voices of GP nurses in view of this primary research evidence.

Further work

Taken together, the implications of the results from both the primary research approaches used in this study suggest that until further research is undertaken, GP nurses should rely on their own perceptions and use whatever method they feel comfortable with in the provision of spiritual care. If GP practices are able to help GP nurses in their provision of spiritual care in practice, this may help to meet essential socio-cultural aims and could be beneficial for patients and the community. Nonetheless, claims that develop nursing and educational outcomes for GP nurses are unsupported by primary data. Therefore, the work, resources and time of these GP practices can be better focused on development strategies for which sound primary data exists.

The study has demonstrated how further research could helpfully be carried out on spiritual care in general practice, especially in culturally diverse GP settings. More specifically, research could profitably enable an analysis of the outcomes of spiritual care development strategies on different general practice staff. This would take into account an analysis of whether the fundamental findings of this study are just as appropriate across the general practice population, or if these kinds of strategies are especially useful for some groups of general practice healthcare staff (for example, healthcare assistants who carry out additional tasks which were once performed only by nurses).

Recommendations

The findings of this study underscore the ongoing necessity for continued research in the field, particularly within the context of the UK, in order to address the historical ambiguity surrounding the concepts of spirituality and spiritual care. Continued research is essential for advancing our understanding of spiritual care and its implications for healthcare practice. By deepening our knowledge in this area, we can develop more informed and effective strategies to meet the spiritual needs of patients and improve their overall wellbeing. The study's findings in respect of GP nurses are consistent with extant research evaluating how spiritual care is perceived and provided in healthcare and in general practice in the UK (Appleby, Wilson and Swinton, 2018); however, there are very few of them. There is obviously a need for research that endeavours to identify ways to eliminate the differences in competency in the provision of spiritual care between nurses working independently in diverse communities in the UK (an area that is frequently employed by GP nurses) and those working in, for example, hospices or hospitals.

Considerably more research could provide more definitive evidence. The findings of this study coincide with some broader sector-wide developments in spiritual care in nursing including the formation of an interest groups dedicated to the topic; the Enhancing Nurses' Competence in Providing Spiritual Care through Innovative Education and Compassionate Care (EPICC) group was established with this aim in mind. This project has created a network of European nursing and midwifery educators for the purpose of sharing expertise and resources about spiritual care in higher education institutions across Europe (McSherry et. al, 2020). The group's enthusiasm in addressing the disparity in spiritual care education will hopefully encourage others to research these concepts so that further primary data evidence can be created to inform policy and practice.

Further studies regarding the role of GP nurses in the UK would be valuable. This information could then be used to give a voice to GP nurses and their practices, would

make important contributions to current knowledge of spiritual care in general practice, and could enhance the design of targeted interventions aimed at supporting the development of GP nurses. In addition, further research that looks at GP nurses' dimensions in the provision of spiritual care is, therefore, an essential next step in confirming the efficacy of the *GP Nurse Provision of Spiritual Care* model, and whether they can be generalisable across this population. Once the value of the *GP Nurse Provision of Spiritual Care* model has been established, the challenge would then be to construct professional and educational development that incorporates the dimensions.

Further research applying critical realism (CR) could successfully produce interesting findings that provide greater knowledge in clinical studies. The intricate nature of spirituality and spiritual care as acknowledged by Rogers and Wattis (2015), necessitated the application of Bhaskar's concept of a stratified reality, which encompasses the *real*, *actual*, and *empirical* domains. This framework facilitated a more profound comprehension of the concepts of spirituality and spiritual care, enabling a nuanced exploration and analysis of their various dimensions. By adopting CR as the theoretical framework, this study acknowledged the importance of social structures and agency, enabling this study to incorporate different methods (Clark, Lissel and Davis, 2008) in identifying GP nurses' perceptions and practices in the provision of spiritual care. More information on the application of CR within the context of spirituality and spiritual care would contribute to a deeper understanding and increased accuracy.

Applying CR would be a productive approach in further work as there is a lack of CR research in nursing studies (Schiller, 2016); this suggests that some researchers may have difficulty in applying this approach. Therefore, the wider application of CR in clinical investigations is suggested along with greater reporting of those investigations, along with a full explanation of the methodological approach, in journal papers and other literature. These studies could then help to instil confidence in other researchers and thus, could increase the number of studies that use CR. Furthermore, an increase in studies could encourage researchers to interpret other studies to enable them to be able to synthesise findings in meta-analyses or systematic reviews.

In addition to the need for further research, it would clearly be useful to have adequate spiritual care research interventions. Studies carried out on these concepts are either quantitative or qualitative. However, this raises doubt about the robustness of using only one paradigm, particularly when researching complex topics such as spiritual care (Cohen, Manion and Morrison, 2018). Both approaches contribute in different ways and could complement each other in conveying the complexities of human life (Doyle, Brady

and Byrne, 2016). Mixed methods (MM), which incorporate the use of different paradigms, would therefore seem to be valuable as the choice of design in any new clinical research of this kind. Our comprehension of the contrasting outcomes from different approaches to developing educational programmes on spiritual care is enhanced for it. Applying a MM approach to complement the numerous quantitative and qualitative research on spiritual care would be a well-received addition to the general method (Martins, Romeiro and Caldeira, 2017).

The application of both CR and MM in this study helped to identify GP nurses' understanding and knowledge of spiritual care and offer explanations for their practices in the provision of spiritual care. Utilising a mixed methods (MM) approach, this study's data collecting process effectively combined quantitative and qualitative methods to address the questions in this research. This approach aligned well with Bhaskar's theory of critical realism, which integrates a realist ontology with a constructionist epistemology. By employing this methodological framework, the study was able to capture both the objective aspects of reality and the subjective interpretations of participants, resulting in a thorough comprehension of the phenomenon being studied. Bhaskar's concepts of a stratified reality provided the opportunity to interpret the degree of complexity that GP nurses practise in their role such as, time restricted patient appointments, as well as the practices they adopt in the provision of care. It also gave the GP nurses the opportunity to voice their concerns about their development requirements and identify the unique aspect of this study which identified a need for professional development, specific to GP nurses, in spiritual care education. Consequently, there is a clear desire among nurses in the general practice environment for future development in spiritual care education. Such educational initiatives would be highly valued by nurses and have the potential to have a greater positive impact on patients' spiritual wellbeing. The concepts of spirituality and spiritual care can indeed present challenges for GP nurses. However, acknowledging that spiritual care operates at various levels and is influenced by the context in which they work can be reassuring for the caring nature of these nurses. This recognition serves to underscore the complexity of spiritual care and the importance of providing support and resources to enable GP nurses to navigate and address the spiritual needs of their patients effectively.

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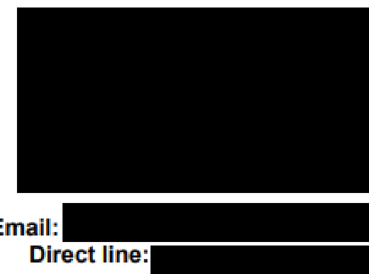
Appendix 1: Initial Search History

Keywords	BND	CINAHL	PubMed
nurs* AND (spirituality OR spiritual care) AND (general practice OR family practice OR primary care OR health centre OR health center)	Sourced 1693	Sourced 264	Sourced 1079
nurs* AND (spirituality OR spiritual care) AND (general practice OR family practice OR primary care OR health centre OR health center) NOT ("student*" OR "pre-reg*")	Sourced 761	Sourced 72	Sourced 188
Unsuitable or duplicated papers screened	Sourced 76	Sourced 68	Sourced 0
After reading the abstracts and full text – total remaining	1	2	0

Appendix 2: SSCRS Permission



Email:
Direct line:

7 February 2018

Dear Elaine,

Re: SSCRS Permission: Elaine Ulett - Professional Doctorate in Education

Thank you for the interest you have shown in my research and the Spirituality and Spiritual Care Rating Scale (SSCRS). I hereby give you authorisation and permission to reproduce or use the scale in your research. There is no fee for using the scale or the questionnaire; however I do require a copy of your research findings and report when completed (including any translated versions of the Scale). Please note that copyright on all versions of the SSCRS remains with me.

I attach a copy of the questionnaire in which the SSCRS can be found. The scale was developed as part of descriptive study. If you want to obtain a copy of my original thesis - you should be able to receive it through Inter Library Loan. The title is - A Descriptive Survey of Nurses' perceptions of Spirituality and Spiritual Care - Unpublished Master of Philosophy Thesis, The University of Hull, England.

A summary of how the SSCRS was constructed was published in the International Journal of Nursing Studies 2002:

> McSherry W., Draper P, Kendrick D (2002) Construct Validity of a Rating Scale Designed to Assess Spirituality and Spiritual Care
> *International Journal of Nursing Studies* 39 (7) 723 - 734

May I take this opportunity to wish you all the best with your research. If I can be of any assistance in the future then do not hesitate to contact me again.

Yours sincerely,

Professor Wilfred McSherry

Professor in Nursing

Appendix 3: Questionnaire Incorporating the SSCRS

Spiritual Wellbeing in Healthcare: An Investigation into General Practice Nurses' Perceptions and Practices

*Required

1. **I confirm that I have read and understand the Participant Information Sheet. I have had the opportunity to ask questions and had them answered and I agree to take part in this study.** *

Mark only one oval.

◯ Yes

Skip to question 2.

Part 1 - SPIRITUALITY AND SPIRITUAL CARE RATING SCALE

FOR EACH QUESTION PLEASE CHOOSE ONE ANSWER WHICH BEST REFLECTS THE EXTENT TO WHICH YOU AGREE OR DISAGREE WITH EACH STATEMENT.

2. **a) I believe nurses can provide spiritual care by showing kindness, concern and cheerfulness when giving care** *

Mark only one oval per row.

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
a)	◯	◯	◯	◯	◯

3. **b) I believe spirituality is concerned with a need to forgive and a need to be forgiven** *

Mark only one oval per row.

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
b)	◯	◯	◯	◯	◯

4. **c) I believe spirituality involves only going to Church/Place of Worship** *

Mark only one oval per row.

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
c)	◯	◯	◯	◯	◯

5. **d) I believe spirituality is not concerned with a belief and faith in a God or Supreme being** *

Mark only one oval per row.

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
d)	◯	◯	◯	◯	◯

6. **e) I believe spirituality is about finding meaning in the good and bad events of life** *

Mark only one oval per row.

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
e)	◯	◯	◯	◯	◯

7. **f) I believe nurses can provide spiritual care by spending time with a patient giving support and reassurance especially in time of need** *
Mark only one oval per row.

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
f)	⬭	⬭	⬭	⬭	⬭

8. **g) I believe nurses can provide spiritual care by enabling a patient to find meaning and purpose in their illness** *
Mark only one oval per row.

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
g)	⬭	⬭	⬭	⬭	⬭

9. **h) I believe spirituality is about having a sense of hope in life** *
Mark only one oval per row.

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
h)	⬭	⬭	⬭	⬭	⬭

10. **i) I believe spirituality is to do with the way one conducts one's life here and now** *
Mark only one oval per row.

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
i)	⬭	⬭	⬭	⬭	⬭

11. **j) I believe nurses can provide spiritual care by listening to and allowing patients time to discuss and explore their fears, anxieties and troubles** *
Mark only one oval per row.

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
j)	⬭	⬭	⬭	⬭	⬭

12. **k) I believe spirituality is a unifying force which enables one to be at peace with one self and the world** *
Mark only one oval per row.

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
k)	⬭	⬭	⬭	⬭	⬭

13. **l) I believe spirituality does not include areas such as art, creativity and self expression** *
Mark only one oval per row.

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
l)	⬭	⬭	⬭	⬭	⬭

14. **m) I believe nurses can provide spiritual care by having respect for privacy, dignity and religious and cultural beliefs of a patient** *
Mark only one oval per row.

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
m)	⬭	⬭	⬭	⬭	⬭

15. **n) I believe spirituality involves personal friendships, relationships** *
Mark only one oval per row.

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
n)	◯	◯	◯	◯	◯

16. **o) I believe spirituality does not apply to Atheists (non believers) or Agnostics (sceptics)** *
Mark only one oval per row.

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
o)	◯	◯	◯	◯	◯

17. **p) I believe spirituality includes people's morals** *
Mark only one oval per row.

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
p)	◯	◯	◯	◯	◯

18. **q) I believe nurses can provide spiritual care by arranging a visit by a religious leader or the patient's own religious leader if requested** *
Mark only one oval per row.

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
q)	◯	◯	◯	◯	◯

Part 2 - RESPONSIBLE FOR THE PROVISION OF SPIRITUAL CARE

19. **1) Who do you feel should be responsible for providing Spiritual Care? (Please tick box(es) which apply)** *
Tick all that apply.

- ☐ Nurses
- ☐ Local Religious Leader
- ☐ Patients Themselves
- ☐ Patients Family and Friends
- ☐ Patients Own Spiritual/Local Religious Leader
- ☐ Combination of all
- ☐ Other: ____________________

Part 3 - RECOGNISING PATIENTS' SPIRITUAL NEEDS

20. **2) In your clinical practice have you ever encountered a patient(s) with a spiritual need(s)?** *
Mark only one oval.

- ◯ Yes
- ◯ No

21. **If Yes how did you become aware of this need(s)? (Please tick the box(es) which apply)**
Tick all that apply.

	YES
Patient himself/herself	☐
Patient's relatives/friends	☐
Nursing care plan	☐
Other Nurses	☐
Chaplains/religious leaders	☐
Listening to and observing the patient	☐
Other	☐

22. **(If other please give details ....)**

23. **Do you feel that you are [usually] able to meet your patients' Spiritual Needs?** *
Mark only one oval.

- ◯ Yes
- ◯ No

24. **(If No please give details) ....**

Part 4 - TRAINING IN THE PROVISION OF SPIRITUAL CARE

25. **During the course of your nurse training do you recall receiving any lessons/lectures covering Spiritual Care?** *
Mark only one oval.

- ◯ Yes
- ◯ No

26. **(If Yes please give details) ....**

27. **Since qualifying as a nurse have you been on any training courses (e.g. study day, events) which covered Spiritual Care?** *

Mark only one oval.

- Yes
- No

28. **If you had any training, please state whether you feel it has enabled you to better meet your patient's spiritual needs.**

29. **Do you feel nurses receive sufficient training on matters concerning Spiritual Care?** *

Mark only one oval.

- Yes
- No

30. **Please explain your response to question 6.** *

31. **If nurses are to receive instruction concerning Spiritual Care which of the following do you feel should be responsible for this?** *

Tick all that apply.

- [ ] Governing Bodies
- [ ] Universities or Colleges of Nursing/Health
- [ ] Local Training Resources
- [ ] Nurses Themselves
- [ ] A combination of all the above
- [ ] Other: ____________________

Interviews

The aim of the interviews is to gain a greater insight into GPNs understanding about the concept of spirituality. Themes that emerge from the analysis of this questionnaire will be used to create questions for the interviews.

Remember there are no right or wrong answers - all perspectives are welcomed.

All correspondence will be kept confidential.

32. **I am happy to be interviewed.** *

Mark only one oval.

- ( ) Yes
- ( ) No *Stop filling out this form.*

To be interviewed...

33. **Please leave your name.**

____

34. **Please leave your email address.**

____

Appendix 4: Definition and Question Document

Definitions and Questions sheet

Spiritual Care in Healthcare: A Critical Realist Investigation into General Practice Nurses' Perceptions and Practices

Please read the definitions below, and choose one that you feel best reflects your definition of spiritual care. We will discuss this in the interview.

1. Spiritual care engages a person as a unique spiritual being, in ways that will provide them with a sense of meaning and purpose, connecting or reconnecting with a community where they experience a sense of wellbeing, addressing suffering and developing coping strategies to improve their quality of life (Rogers & Wattis, 2015).
2. Spiritual care will help a patient find confidence, faith, hope, love, meaning, values, belief, forgiveness, strength, trust, self-expression and creativity (RCN, 2011b).
3. Spiritual care is a loving approach that attends to an individual's emotional, social, psychological and physical needs (Puchalski, 2001).
4. Spiritual care is an essential element in healing and growth, and is essential to holistic care and person-centred care (NHS Education for Scotland, 2009).
5. Spiritual care involves presence, compassion and encouragement of hope to patients (Anandarajah and Hight, 2001).
6. Spiritual care is asking questions to patients to discover their needs.

Below are the questions that I will be asking you during the interview:

1. Which of the definitions best reflects how you would define spiritual care?
2. Tell me of any experience you feel you have had in giving spiritual care.
3. What types of problems/concerns have you had (if any) that have prevented you from delivering spiritual care?
4. What factors influence the way you give or [not] spiritual care?
5. What would help you to develop confidence in delivering spiritual care?
6. What do you feel would be the best way to develop your knowledge in delivering spiritual care?

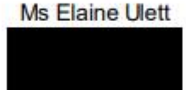
If you have any questions, please contact either Elaine at XXXX or phone XXXX. Elaine's supervisors are Director of Studies, XXXX and Supervisor, XXXX.

The research has been reviewed by the Faculty of Health and Life Sciences Research Ethics Committee FREC 2018/09 at Oxford Brookes University. The study has also been reviewed by the Health Research Authority - IRAS ID (XXXX).

Elaine Ulett

Appendix 5: NHS Health Research Authority Approval

Ms Elaine Ulett



Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

27 January 2019

Dear Ms Ulett

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Spiritual Wellbeing in Healthcare: A Critical Realist Investigation into General Practice Nurses' Perceptions and Practices**
IRAS project ID:	
Sponsor	**Oxford Brookes University**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?
You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Participating NHS organisations in England and Wales **will not** be required to formally confirm capacity and capability before you may commence research activity at site. As such, you may commence the research at each organisation immediately following sponsor provision to the site of the local information pack, so long as:

- You have contacted participating NHS organisations (see below for details)
- The NHS organisation has not provided a reason as to why they cannot participate
- The NHS organisation has not requested additional time to confirm.

You may start the research prior to the above deadline if the site positively confirms that the research may proceed.

If not already done so, you should now provide the local information pack for your study to your

Appendix 6: Research Region Approval

16th October 2018

Oxford Brookes University Research Degrees Committee,
Oxford Brookes University
Headington Campus
Gipsy Lane
Headington
Oxford
OX3 0BP

To Oxford Brookes University Research Degrees Committee,

agrees to participate as a collaborating establishment in Elaine Ulett's proposed research project entitled "Spiritual Wellbeing in Healthcare: A Critical Realist Investigation into General Practice Nurses' Perceptions and Practices."

The will allow Elaine to send a questionnaire, via a gatekeeper, to General Practice Nurses within the region. After the dissemination of the questionnaire, Elaine is permitted to carry out focus groups within the region, with General Practice Nurses who have indicated that they would like to take part in a focus group.

Elaine will have access to General Practice Nurses and facilities, in order to carry out her research including the focus group meetings, for the duration of her research.

Yours sincerely,

Appendix 7: Oxford Brookes University Approval

E3/FH&LS

Oxford Brookes University

Faculty of Health and Life Sciences

Decision on application for ethics approval

The Departmental Research Ethics Officer (DREO) / Faculty Research Ethics Committee (FREC) has considered the application for ethics approval for the following project:

Project Spiritual wellbeing in healthcare: A critical realist investigation into General Practice Nurses' perceptions and practices

FREC Study Number: 2018/09

Name of Applicant: Elaine Ulett

Name of Supervisor: [redacted]

Please tick one box

1. The Faculty Research Ethics Committee gives ethical approval for the research project. √ ☐

   Please note that the research protocol as laid down in the application and hereby approved must not be changed without the approval of the DREO / FREC

2. The Departmental Research Ethics Officer / Faculty Research Ethics Committee gives ethical approval for the research project, subject to the following: ☐

3. The Departmental Research Officer / Faculty Research Ethics Committee cannot give ethical approval for the research project. The reasons for this and the action required are as follows: ☐

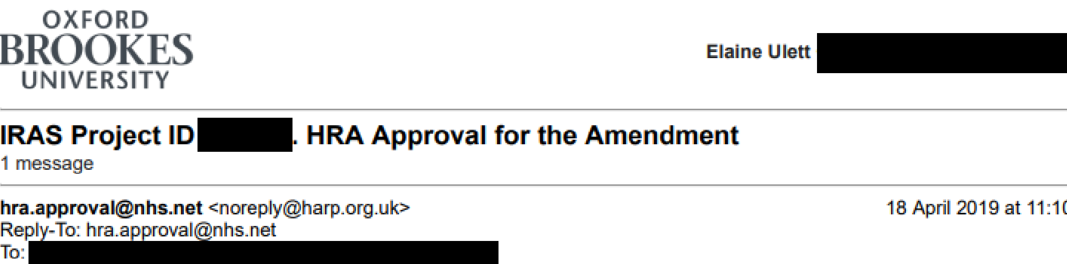
Signed: ..[redacted]....... Approval Date: 14 December 2018 ....

Designation: Departmental Research Ethics Officer

(Signed on behalf of the Faculty Research Ethics Committee)

Date when application reviewed (*office use only*): 13 November 2018 ....

Appendix 8: NHS Health Research Authority Approval



Elaine Ulett

IRAS Project ID . HRA Approval for the Amendment

1 message

hra.approval@nhs.net <noreply@harp.org.uk> 18 April 2019 at 11:10
Reply-To: hra.approval@nhs.net
To:

Dear Ms Ulett,

IRAS Project ID:	
Short Study Title:	Spiritual Wellbeing in Healthcare: GPNs Perceptions and Practices
Amendment No./Sponsor Ref:	Version 2.0 - 16-03-2019
Amendment Date:	16 March 2019
Amendment Type:	Non Substantial Non-CTIMP

I am pleased to confirm **HRA and HCRW Approval** for the above referenced amendment.

You should implement this amendment at NHS organisations in England and Wales, in line with the conditions outlined in your categorisation email.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.

Please contact hra.amendments@nhs.net for any queries relating to the assessment of this amendment.

Kind regards

Approvals Specialist
Health Research Authority
Ground Floor | Skipton House | 80 London Road | London | SE1 6LH
E.hra.amendments@nhs.net
W. www.hra.nhs.uk

Appendix 9: Participant Information Sheet

Participant Information Sheet

Research title:

Spiritual Wellbeing in Healthcare: An Investigation into General Practice Nurses' Perceptions and Practices

Invitation paragraph

You are being invited to take part in a questionnaire. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it would involve. Please take time to read the following information carefully.

Aim of the project

The aim of the project is to investigate General Practice Nurses' perceptions of the concept of spirituality and practices in delivering spiritual care.

What is the purpose of the research?

National healthcare reforms have been about shifting care closer to home into general practice. In the new NMC standards of proficiency for registered nurses (to be applied from 28th January 2019), GPNs will have to prioritise the needs of people when assessing and reviewing their needs, including their spiritual needs, to identify the priorities and requirements for person-centred and evidence-based nursing interventions and support. However, research has identified that the concepts of spirituality and spiritual care confuses and challenges healthcare staff as to what constitutes as the boundaries and support between patients and staff. The purpose of this research is to explore General Practice Nurses' perceptions of the concept of spirituality, and to analyse how these perceptions inform their practice.

Why have I been invited to participate?

You have been invited to participate in a questionnaire because your role within [redacted] is that of a General Practice Nurse. At the end of the questionnaire, you would have the opportunity to opt into being interviewed.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, you would be given this information sheet to keep.

What will happen to me if I take part?

You would be asked to record your consent to participate, on the questionnaire. You can withdraw from the questionnaire before submission; however data from the questionnaire cannot be withdrawn once it has been submitted. The questionnaire has 26 questions (mainly tick boxes) which should take a maximum of 10 minutes to complete. The focus of the questionnaire is to generate a description of GPN's perception of spirituality.

At the end of the questionnaire, you would have the opportunity to leave your name and email address if you would like to participate in an interview; to be held within the region. You would be given a privacy notice. You would be asked to record your consent on a consent form at the start of the interview. The focus of the interview is to further investigate the practices of GPNs in delivering spiritual care. You would be asked to set aside around 45 minutes for the interview. You would be able to withdraw from the interview at any point; however data from the interview cannot be withdrawn once it has been submitted. All information would be kept private and confidential.

The interviews would be held at a time and place suitable for you, which might be outside your normal working hours. The interviews would be conducted in a health care site (GP Surgery or office) within the Berkshire West.

What are the possible benefits of taking part?

There are no direct benefits, and participation, non-participation or withdrawal would have no impact on your employment. The findings from the research would contribute to the limited knowledge of spirituality and spiritual care in healthcare in this under-researched area.

What are the disadvantages of participation?

While the study is low risk, there is a possibility that you start to question your practice and thus feel anxious, and show signs of psychological distress; you will have the option not to answer further questions and/or to withdraw from the interview at any point without giving a reason. Should you require further support then Elaine may direct you to contact your clinical educator and external, local support groups/organizations e.g. MIND, 0300 123 3393 (https://www.mind.org.uk) and Talking Therapies in ██████████, (www.talkingtherapies█████nhs.uk), that may be able to help you deal with any negative experiences.

A potential risk to participants might be the identification of poor practice/unmet training needs, or that they might disclose confidential information during the interview. This would be managed by the reassurance that all data would be de-identified. All names of people (staff, colleagues, organisations and venues) would be replaced with codes. Any information that might identify a person would be changed. However, any malpractice will be escalated in line with trust policy.

Would what I say in this research be kept confidential?

The questionnaire will be anonymous, except where participants opt to be interviewed. Their names and email addresses will be extracted from the questionnaire data and then the data will be stored electronically and anonymously in Excel. In the interviews, Elaine will anonymised data by replacing any identifiers by a code. Codes will be numbers and they will be kept in a register of codes. However this register of codes will be stored separately to any study data and stored in a locked filing cabinet. Consent forms for interviews will be locked away in a filing cabinet separate from other data.

Oxford Brookes University is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Oxford Brookes University will keep de-identifiable information about you for 10 years after the study has finished.

Your rights to access, change or move your information is limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum, personally-identifiable information possible.

The researchers will keep your name, and contact details confidential and will not pass this information to Oxford Brookes University. The researchers will use this information as needed, to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. Certain individuals from Oxford Brookes University and regulatory organisations may look at your research records to check the accuracy of the research study. Oxford Brookes University will only receive information without any identifying information. The people who analyse the information will not be able to identify you and will not be able to find out your name, or contact details.

The researchers will keep identifiable information about you from this study for 10 years after the study has finished.

What should I do if I want to take part?

If you would like to take part, please click on the web-based questionnaire link below. You would be asked to opt in to completing the questionnaire at the start. At the end of the questionnaire, you would have the opportunity to opt to be interviewed by leaving your name and email address; participating in an interview is optional.

What will happen to the results of the research?

Participants would be able to access a summary of the results should they wish to published on a dedicated blog, Click for Elaine's blog (XXXXX). The results would be published in a Doctoral dissertation and this would be published in academic and professional journals. Findings would be presented at conferences and in publications, but would not contain any personal information about you. The researcher would provide feedback to the gatekeeper and Professor Wilfred McSherry because his tool (the questionnaire) is used in this researcher.

Participants would be anonymised in any data captured and no data would be retained that identifies you as a participant. Participants would be able to contact Elaine after June 2020 in order to receive a summary of results.

Who is organising and funding the research?

The research would be conducted by Elaine Ulett; she is a part time research student completing a professional doctorate in education. This research forms part of this programme of study.

Who has reviewed the research?

The research has been reviewed by the Faculty of Health and Life Sciences Research Ethics Committee at Oxford Brookes University. The study has also been reviewed by the Health Research Authority - IRAS ID (XXXXX).

Contact for Further Information

Contact Information

If you have any questions/comments please contact me (contact details to be added)

Appendix 10: Privacy Statement (GDPR)

Privacy Notice

Oxford Brookes University (OBU) will usually be the Data Controller of any data that you supply for this research. This means that we are responsible for looking after your information and using it properly. The exception to this is joint research projects where you would be informed on the participant information sheet as to the other partner institution or institutions. This means that they will make the decisions on how your data is used and for what reasons. You can contact the University's Information Management Team on 01865 485420 or email info.sec@brookes.ac.uk.

Why do we need your data?
The purpose of this research is to explore General Practice Nurses' perceptions of the concept of spirituality, and to analyse how these perceptions inform their practice.

OBUs legal basis for collecting this data is:
- You are consenting to providing it to us; and / or,
- Processing is necessary for the performance of a task in the public interest such as research

If the university asks you for sensitive data such as; racial or ethnic origin, political opinions, religious or philosophical beliefs, trade-union membership, data concerning health or sexual life, genetic/biometric data or criminal records OBU will use these data because:
- You have given OBU explicit consent to do so; and / or
- Processing is necessary for scientific or research in the public interest.

What type of data will Oxford Brookes University use?
OBU will be two types of data. There will be data generated from;
1. an online questionnaire – Google spreadsheets will be used to store survey responses, and Statistical Package for the Social Sciences (SPSS) software will be used to provide the themes during analysis.
2. the interview – the data will be stored as audio files in Google Drive until they are transcribed after which they would be deleted. The transcripts will be stored in Google documents, and will be used in NVIVO (qualitative data analysis computer software) software for analysis.

Who will OBU share your data with?
Data may be shared with the supervisory team. Anonymised data may also be accessed by members of Oxford Brookes University and regulatory bodies for auditing and monitoring purposes. Data will be stored on the Google Drive, for which the University has a security agreement.

Will OBU transfer my data outside of the UK?
No

What rights do I have regarding my data that OBU holds?
- You have the right to be informed about what data will be collected and how this will be used
- You have the right of access to your data
- You have the right to correct data if it is wrong
- You have the right to ask for your data to be deleted
- You have the right to restrict use of the data we hold about you
- You have the right to data portability
- You have the right to object to the university using your data
- You have rights in relation to using your data automated decision making and profiling.

Where did OBU source my data from?
If you consent to the study, the data would be sourced from an online (anonymous) questionnaire and interview.

Are there any consequences of not providing the requested data?
There are no legal consequences of not providing data for this research. It is purely voluntary.

Will there be any automated decision making using my data?

Privacy Notice

There will be no use of automated decision making in scope of UK Data Protection and Privacy legislation."

How long will OBU keep your data?
In line with Oxford Brookes policies data generated in the course of research must be kept securely in paper or electronic form for a period of time in accordance with the research funder or University policy.

Who can I contact if I have concerns?
If you have any questions/comments please contact me (contact details to be added)

The research has been reviewed by the Faculty of Health and Life Sciences Research Ethics Committee FREC 2018/09 at Oxford Brookes University. The study has also been reviewed by the Health Research Authority.

Elaine Ulett

Appendix 11: Consent Form

Consent Form for Interviews

Spiritual Wellbeing in Healthcare: An Investigation into General Practice Nurses' Perceptions and Practices

Name of Researcher: Elaine Ulett at Oxford Brookes University.

Contact address: Oxford Brookes University, Gipsy Lane, Oxford OX3 0BP

		Please initial box
1.	I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.	☐
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.	☐
3.	I agree to the interview being audio recorded	☐
4.	I agree to take part in the above research.	☐

		Please initial box	
		Yes	No
5.	I agree to the use of anonymised quotes in publications	☐	☐
6.	I agree that an anonymised data set, gathered for this study may be stored in a specialist data centre/repository relevant to this subject area for future research.	☐	☐
7.	I understand that anonymised data may be accessed by staff from Oxford Brookes University and regulatory organisations for monitoring and auditing purposes.	☐	☐

____________________ ____________ __________________

Name of Participant Date Signature

____________________ ____________ __________________

Name of Researcher Date Signature

Contact Information
If you have any questions/comments please contact me (contact details to be added)

Appendix 12: Six Phases of Thematic Analysis

(Adopted from Braun and Clarke, 2006)

Phase	Description of the process
1. Familiarising yourself with your data	Transcribing data, reading and re-reading the data, noting down initial ideas.
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes	Collating codes into potential themes, gathering relevant data under each theme.
4. Reviewing themes	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the data.
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report	The final opportunity for analysis. Selection of vivid, compelling and representative extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Appendix 13: Instances of Training in Spiritual Care was provided

During palliative care courses
But that depends, what you mean by spiritual care
Holistic care would also include patient's own beliefs and attitude to their illness
A lecture was given by a chaplain from the hospital
Lecture in spirituality
Trained in a Catholic school so part of training
Holistic care was part of my training
Holistic care of patient involves looking at the patient's needs
Studied in a Catholic school

Appendix 14: Data from the SSCRS

SSCRS statements	Strongly Disagree		Disagree		Uncertain		Agree		Strongly Agree		% of GP nurses
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	
m) I believe nurses can provide spiritual care by having respect for privacy, dignity and religious and cultural beliefs of a patient	0	0	0	0	0	0	15	38.5	24	61.5	100
c) I believe spirituality involves only going to Church/Place of Worship	24	61.5	14	36	1	2.5	0	0	0	0	97.5
f) I believe nurses can provide spiritual care by spending time with a patient giving support and reassurance especially in time of need	0	0	0	0	1	2.5	18	46.2	20	51.3	97.5
j) I believe nurses can provide spiritual care by listening to and allowing patients time to discuss and explore their fears, anxieties and troubles	0	0	0	0	2	5.1	23	59	14	35.9	94.9
a) I believe nurses can provide spiritual care by showing kindness, concern and cheerfulness when giving care	0	0	0	0	3	7.7	12	30.8	24	61.5	92.3
e) I believe spirituality is about finding meaning in the good and bad events of life	0	0	2	5.1	3	7.7	27	69.2	7	18	87.2
i) I believe spirituality is to do with the way one conducts one's life here and now	0	0	3	7.7	2	5.1	26	66.7	8	20.5	87.2

l) I believe spirituality does not include areas such as art, creativity and self-expression	7	18	25	64.1	6	15.4	1	2.5	0	0	82.1
o) I believe spirituality does not apply to Atheists (non-believers) or Agnostics (sceptics)	11	28.2	21	53.9	6	15.4	1	2.5	0	0	82.1
n) I believe spirituality involves personal friendships, relationships	0	0	4	10.3	3	7.7	19	48.7	13	33.3	82
k) I believe spirituality is a unifying force which enables one to be at peace with oneself and the world	0	0	1	2.5	7	18	24	61.5	7	18	79.5
q) I believe nurses can provide spiritual care by arranging a visit by a religious leader or the patient's own religious leader if requested	0	0	5	12.8	4	10.3	24	61.5	6	15.4	76.9
h) I believe spirituality is about having a sense of hope in life	0	0	3	7.7	7	18	21	53.8	8	20.5	74.3
p) I believe spirituality includes people's morals	0	0	6	15.4	5	12.8	22	56.4	6	15.4	71.8
g) I believe nurses can provide spiritual care by enabling a patient to find meaning and purpose in their illness	0	0	3	7.7	9	23.1	21	53.8	6	15.4	69.2
b) I believe spirituality is concerned with a need to forgive and a need to be forgiven	1	2.5	6	15.4	11	28.2	15	38.5	6	15.4	53.9
d) I believe spirituality is not concerned with a belief and faith in a God or Supreme being	1	2.5	10	25.6	9	23.1	15	38.5	4	10.3	48.8