Factors influencing nurse spiritual care practices at the end of life: A systematic review

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Factors influencing nurse spiritual/existential care practices at end-of-life

- A systematic review -

ABSTRACT

Objectives: To identify determinants of nurse spiritual/existential care practices towards end-of-life patients. Nurses can play a significant role in providing spiritual/existential care, but they actually provide this care less frequently than desired by patients.

Methods: A systematic search was performed for peer-reviewed articles that reported factors that influenced nurses' spiritual/existential care practices towards adult end-of-life patients.

Results: The review identified 42 studies and included the views of 4712 nurses across a range of hospital and community settings. The most frequently-reported factors/domains that influenced nurse practice were patient-related social influence, skills, social/professional role and identity, intentions and goals, and environmental context and resources.

Significance of results: A range of personal, organizational and patient-related factors influence nurse provision of spiritual/existential care to end-of-life patients. This complete list of factors can be used to gauge a unit's conduciveness to nurse provision of spiritual/existential care, and can be used as inputs to nurse competency frameworks.

KEYWORDS: barriers and facilitators, nurse, spiritual/existential care, end-of-life, systematic review.
Introduction

Nurses can play a significant role in providing spiritual/existential care to enhance the wellbeing of patients at end-of-life (Dalgaard et al., 2009) for many reasons. They are the largest professional group to care for dying patients (Costello, 2006) and the most physically present to patients (Taylor et al., 2009). Patients often expect spiritual care to be part of the nurse's role, and most nurses accept this as part of their role (Edwards et al., 2010). Furthermore, they have a longstanding commitment to holistic care that includes spiritual/existential dimensions of life (Batstone et al. 2020). (Hereon we will use the term "spiritual/existential care" because a systematic review of spiritual care at end-of-life found that the terms 'spiritual' and 'existential' were used synonymously and interchangeably (Edwards et al. (2010)).

Health institutions worldwide (e.g., International Council of Nurses, 2012) therefore recommend that nurses provide spiritual/existential care, and some institutions (American Association of Colleges of Nursing, 2016; European Association of Palliative Care (Gamondi et al., 2013)) provide care guidelines for nurses. Despite these recommendations and guidelines, nurses actually provide spiritual/existential care at end-of-life less frequently than desired by patients (Balboni et al., 2013).

To understand why nurses provide spiritual/existential care less frequently than desired, numerous studies have sought to identify determinants, barriers and facilitators of spiritual/existential care provision. These studies are so numerous that two systematic reviews (to the authors' knowledge) have been conducted: Edwards et al. (2010) aimed to identify barriers and facilitators of spiritual care at end-of-life, and Gijsbert et al. (2019) aimed to identify requisite factors to the implementation of spiritual care at end-of-life as one objective. These reviews included factors that impacted spiritual care provision, such as confidence, training,
team support, time, workload and staffing.

One limitation of these reviews is that while they combined the perspectives of patients, family caregivers and healthcare providers (e.g., physicians, nurses, chaplains, volunteers, management), they had only limited focus on nurses' perspectives. Not only do nurses play a big role in spiritual/existential care, but their perspective of spiritual/existential health and practice is likely to be different from that of other practitioners (Daaleman et al., 2008). Nurses, compared to physicians for example, are more likely to: subscribe to a holistic model of health (Malik et al., 2018, Huber et al., 2016); view spiritual/existential care as part of their role (Palmer et al., 2021; Rodin et al., 2015); provide spiritual care more frequently (Barsela et al., 2019); have different spiritual care practices (Epstein et al., 2015; Palmer et al., 2021); and report different barriers to care practice (Balboni et al., 2014).

Another limitation of Edward et al.'s and Gijsbert et al.'s reviews is that they did not systematically synthesize determinants into a comprehensive theoretical framework. A theoretical framework enables intervention development to be guided by theory, enhancing implementation success (Michie et al., 2008). While a comprehensive tool for classifying barriers and facilitators of spiritual/existential care behaviors is currently lacking, one framework has frequently been used to understand clinicians’ behaviors, barriers and facilitators (Atkins et al., 2017): the Theoretical Domains Framework (TDF) (Cane et al., 2012), which integrates behavioral and psychological process theories operating at individual, social and organizational levels. The TDF comprises 14 key domains: (i) knowledge (an awareness of the existence of something); (ii) skills (ability or proficiency acquired through practice); (iii) social or professional role and identity (a coherent set of behaviors and displayed personal qualities of an individual in a social or work setting); (iv) beliefs about capabilities (self-efficacy or acceptance
of the truth, reality, or validity about an ability, talent or facility that a person can put to constructive use); (v) optimism (the confidence that things will happen for the best or that desired goals will be obtained); (vi) beliefs about consequences (acceptance of the truth, reality or validity about outcomes of a behavior in a given situation); (vii) reinforcement (a process in which the frequency of a response is increased by a dependent relationship or contingency with a stimulus); (viii) intentions (conscious decision to perform a behavior, or a resolve to act in a certain way); (ix) goals (mental representations of outcomes or end states that an individual wants to achieve); (x) memory attention and decision processes (the ability to retain information, focus selectively on aspects of the environment and choose between alternatives); (xi) environmental context and resources (a circumstance of a person’s situation or environment that discourages or encourages the development of skills and abilities, independence, social competence and adaptive behavior); (xii) social influences (interpersonal processes that can cause individuals to change their thoughts, feelings or behaviors); (xiii) emotion (a complex reaction pattern involving experiential, behavioral and physiological elements, by which an individual attempts to deal with personally significant matters or events); (xiv) behavioral regulation (anything aimed at managing or changing objectively observed actions) (see Supplementary Information Table S1 for further definitions of the domains). The TDF has been used to classify barriers and facilitators of a wide variety of clinician behaviors (e.g., prescribing behavior (Paksaite et al., 2020), maternal weight management (Heslehurst et al., 2014), alcohol screening (Rosario et al., 2021), and stroke management (Craig et al., 2016)). Our study will use the TDF as a theoretical lens to synthesize the determinants of nurse spiritual/existential care practices.

The aims of this systematic review are to: (1) identify determinants of nurse
spiritual/existential care practices at end-of-life; and (2) map these determinants into TDF constructs. In order to include as many studies on spiritual/existential care as possible, we did not predefine spiritual/existential care, but used search terms covering aspects of spiritual/existential care (e.g., care addressing ‘meaning’, ‘hope’, 'distress'). (Gijsbert et al. (2019) used a similar approach to include as many studies as possible). The determinants identified by this review will enhance our understanding of spiritual/existential care practices at end-of-life, as well as inform the development of improvement interventions. This research answers a call for more research into the development of spiritual care practices of palliative staff (Selman et al., 2014).

Method

This review was prospectively registered with PROSPERO (CRD42020186887).

Search strategy

We employed a multi-step approach to the development of search strategies, including the identification of search strategies from previous reviews of suffering (e.g., Cancer Australia 2013) team consensus on which terms to use as part of the search strategy, and piloting and refining of the search using the CINAHL database before adapting the strategy search for use in other databases. An experienced librarian assisted with development of search strategies and mapping terms across MEDLINE, PsycInfo, and Cochrane Library databases.

The search was performed on 22.4.20 using the following search string in all text fields: nurse* AND (spiritual OR existential OR psycho-spiritual OR religio* OR pastor*) AND ("end of life" OR "end-of-life" OR palliative OR hospice) AND (suffering OR pain OR distress OR crisis OR anguish OR meaning OR transcendence OR hope* OR faith OR peace OR "sense of
coherence" OR demoraliz* OR dignity OR "total pain"). A publication date restriction was not applied.

**Eligibility criteria**

Articles were eligible for inclusion if they: had a primary focus on practices that nurses used to provide spiritual/existential care to adults at end-of-life; referred to factors that influenced their practice; had registered nurses as the majority of the sample; and reported primary empirical data in peer-reviewed articles, written in English.

Articles were excluded if they: were non-empirical, theoretical, or review papers, reports or books; had a secondary focus on spiritual/existential care practices; comprised only a minority of nurses in their samples; did not allow nurse responses to be distinguished from other participants’ responses; or focused on care of pediatric or adolescent patients, or patients with stable, chronic conditions and not at end-of-life.

The reference list of each included study was hand-searched for additional relevant studies not identified in the electronic search, and assessed for inclusion using the same eligibility criteria.

**Selection of studies**

Study records from the electronic databases were imported into an Endnote file and de-duplicated. One reviewer screened all titles and abstracts. A second reviewer independently screened 20% of titles and abstracts Studies with titles or abstracts deemed irrelevant by both reviewers were excluded from further examination. Full papers of the remaining studies were screened and selected for inclusion by two authors, and agreed upon after discussion.
**Quality appraisal**

All papers were assessed using the quality appraisal tool for qualitative and quantitative research, as described by Kmet (2004). One reviewer assessed all papers, and a second reviewer independently checked 10% of them. Due to the nature of the extracted data, studies were not excluded on the grounds of poor quality to avoid omitting studies that might generate worthwhile insights.

**Data extraction and analysis**

One reviewer abstracted and systematically collated data about the studies' aims, designs and settings, sample characteristics, and data collection procedures.

Thematic analysis was used to extract and synthesize findings across the included studies, using the following process. First, a categorization matrix (Elo and Kyngäs, 2008) was constructed based on the pre-defined domains in the TDF. The matrix was located in a spreadsheet, with the included studies as rows and TDF domains as columns. Then a coding sheet was developed, adapted from Heslehurst (2014), which provided descriptions, definitions and examples of each domain within the TDF. The coding sheet is shown in Supplementary Information Table S1.

Next, all articles were read thoroughly several times, and data items describing factors influencing spiritual/existential care actions were extracted from sections labeled 'results' or 'findings': for qualitative studies, data was extracted from authors' descriptions of results and participant quotations; and for survey studies, data was extracted from results of tabulated statistical analyses and reported association between factors and delivery of spiritual/existential
care. The manifest content of the text was extracted, i.e., text that was overtly and obviously related to spiritual/existential care (Graneheim and Lundman, 2004) was extracted. Data items were extracted twice from all articles by the same reviewer, and data extraction of 20% of articles was checked by a second reviewer. Discrepancies were addressed by discussion.

After each data item was extracted, it was then assigned to a TDF domain using the coding sheet to guide categorization. During coding it was difficult to distinguish between intention and goal domains, so these two domains were combined; this was justified by noting that they are intertwined psychologically (Castelfranchi, 2014), and an earlier version of the TDF (Mitchie et al., 2005) combined these two domains. It also became obvious that many data items described patient-related social influence, so the social influence domain was split in two: social influence–patient; and social influence–other than patient. For data items that could be categorized under multiple domains, only the more obvious primary domain was chosen and reported (e.g., patient-nurse boundaries could be categorized under social/professional role as well as social influence–patient, but the former domain was chosen as the primary domain because the TDF framework formally includes 'professional boundaries' as a sub-domain).

After each data item was categorized into the most appropriate domain, a judgment was made as to whether it was a barrier, facilitator, or unspecified. A barrier was defined as a factor that prevents or makes difficult the carrying out of spiritual/existential care; a facilitator was defined as a factor that enables or is required to provide spiritual/existential care; factors that articles described as influencing spiritual/existential care behavior in some way without explicitly stating the direction of effect (i.e., whether it was a barrier or facilitator) were recorded as unspecific. When coding of data items into domains was complete, one reviewer read and re-read the data items in each domain and grouped similar/related items into themes. A second
reviewer checked the coding of data items into domains, and the grouping of data items into themes. Discrepancies were addressed by discussion.

After thematic analysis was completed, several frequency analyses were conducted. One analysis determined the number of studies that identified each domain at least once. Additional analyses were conducted to show the distribution of domains by five-year time periods and major geographical regions.

Results

Figure 1 shows the search process flow chart. Table 1 shows the characteristics of the 42 included studies. Quality assessment scores ranged from 45 to 95, averaging 80. Most studies (36/42) employed a qualitative design. A variety of methods were used, including semi-structured interviews, focus groups, surveys and observation. Seventeen studies were conducted in Europe, 10 in Asia-Pacific, 11 in North America, three in other regions, and one had an international sample. The 4712 nurse participants worked in a variety of hospital and community settings.

Table 2 displays synthesized findings for each domain, and supporting themes and illustrative data items for each finding. Table 3 shows the frequency of studies that identified each domain at least once. The most frequently reported domains were patient-related social influence (n=35), skill (n=29), environment (n=26), social/professional role (n=26) and intentions and goals (n=26). No study reported on the domain of optimism. The remaining domains were reported by between 7 and 16 studies. Removing the study that had an average quality assessment score of less than 50% (cf. Gravel et al. 2006) did not change the ranking of the top cited domains.
Figure 2 depicts the domains identified by geographical region of study, and shows that almost all domains were identified in all regions. This result suggests that similar factors influence nurse spiritual/existential care practices across diverse cultures, and concords with Neathery et al.'s (2020) observation that nurses across disparate cultures globally identify similar barriers to spiritual care. Figure 3 depicts the domains identified across five-year time periods, and shows that identification of domains influencing spiritual/existential care practice has increased steadily over time, reaching a peak during 2011-’15. The domains of memory, emotion and reinforcement emerged after 2005.

Discussion

This systematic review used the TDF to synthesize 42 studies that shed light on factors influencing nurses’ spiritual/existential care of patients at end-of-life. The review pulled together the views of more than 4712 nurses across a range of hospital and community settings to show that the most frequently-reported domains influencing nurse practice were patient-related social influence, skills, social/professional role and identity, intentions and goals, and environmental context and resources. This review offers several implications for research and practice.

Improved understanding of determinants of nurse behavior

This review identified a range of personal, organizational and patient-related factors influencing nurse provision of spiritual/existential care of end-of-life patients. Palliative care managers can use this information as a checklist to gauge a unit's conduciveness to nurse provision of spiritual/existential care, and to identify areas requiring attention. Understanding determinants of nurses’ spiritual/existential care practices is a first step to improving the quality of patient care.
A useful aspect of the Theoretical Domains Framework is that relevant interventions for behavior change in each domain have been identified (Michie et al., 2008).

The factors identified in this review as influencing nurses' spiritual/existential care practices incorporate many factors identified in previous reviews. Edwards et al. (2010) identified several facilitators, including reflection on an individual’s own spirituality, ample time, support of team members, and life experience; and several barriers, including high patient turnover, high workload, low staffing, lack of privacy and nurse continuity, task focus, lack of confidence, and feelings of ill-preparedness. They also identified the importance of training staff to recognize spiritual issues of religious groups, and noted complexities in assessing and documenting spiritual distress. Gijsbert et al. (2019) identified factors including feelings of incompetence, training, self-reflection, differences in the needs and convictions of patients and family members, weak integration of spiritual care in palliative care, and emphasis on patient physical wellbeing. Because our review collated evidence from nurses only – rather than from patients and health care providers, as in the Edwards et al. and Gijsbert et al. studies – the results provide greater precision regarding these factors. For example, similar to Edwards et al. (2010), we identified that while time was a factor influencing practice, different facets of time also influenced care. These include temporal demand, duration of a patient’s time in the unit, duration of nurses’ time spent with patients and time available for self-reflection. Also similarly to Edwards et al., we found that professional and personal life experience with loss was beneficial, but our review additionally found a qualification to this factor: that personal experience of loss can affect spiritual care when personal self-disclosure supersedes awareness of client needs (Pitroff, 2013). As another example, Gijsbert et al. (2019) found that feelings of incompetence influenced
spiritual/existential care; we also identified skills and beliefs about capabilities as factors, as well as aspects of felt competence, such as courage and learning from others and reflection on one's own existential issues.

Our study did not support the findings of previous reviews entirely, however. For example, we did not identify the potential barriers found in the Edwards et al. review of loss of human touch, and formal spiritual care training and education. These discrepancies may have arisen because the Edwards et al. review included mixed-sample studies (e.g., participants who "... performed a variety of roles: chief executive, manager, nurse, medical director, therapist, artist, volunteer and chaplain" (Wright 2002)). The discrepancies illustrate the value of a profession-specific review, because the findings of systematic reviews are often used in health policymaking and training design.

Our review adds to the findings of existing reviews, such as beliefs about consequences, intentions and goals, re-inforcement, and memory. From a psychological perspective, the emergence of these factors is not surprising as they have been well-studied in the organizational behavior field. These findings likely arose because the present study did not restrict itself to nurses' explicit statements of perceived barriers/facilitators (in response to an interviewer's explicit question), but widened the search to include studies presenting statistical findings or nurses' statements referring to factors influencing their behaviors.

**Contribution to nurse competence frameworks**

If competence is broadly defined as the ability to do something well (Cambridge Dictionary, 2021), then factors that help or hinder the 'doing' of those behaviors may also affect competence in that behavior. To the extent that this premise is true, our study contributes to frameworks of
nurse competence in spiritual/existential care, thus answering Selman et al.'s (2014) call for more research into this area.

The extant nursing literature generally views competence in spiritual/existential care as a set of knowledge, skills and attributes possessed by a nurse. Broad lists of competence items have been developed (Attard et al., 2019; McSherry et al., 2020; van Leeuwen et al., 2009). Many of these items appear to be congruent with factors identified in this review that are intrinsic to nursing (e.g., knowledge, skills and capability beliefs). For example, an item in Attard et al. (2019) is "[a]cknowledge personal limitations in providing spiritual care and consult other members of the multi-disciplinary team . . . as deemed necessary"; this factor seems concordant with an item that emerged in the beliefs about capabilities domain 'accept/know limits of their expertise and [be] ready to work with other team members'. Another example is an item in Van Leeuwen et al.'s (2009) study: "I have an accepting attitude in my dealings with a patient (concerned, sympathetic, inspiring trust and confidence, empathetic, genuine, sensitive, sincere and personal)"; this item seems concordant with items appearing under the behavioral regulation domain: 'be open, honest, caring, respectful, compassionate, and show genuine desire to care and love the patient'. An example from McSherry et al.'s (2020, p.63) framework is "... [awareness] of the different world/religious views..."; this factor seems concordant with an item that emerged in the knowledge domain: 'knowledge of different religious practices/beliefs and spirituality'.

These concordances, among others, support the idea that factors uncovered in our review can be viewed as aspects of competence, and could therefore be used to elaborate on competence frameworks already developed. For example, our study found courage as a sub-theme in beliefs about capabilities. Attard et al.’s (2019) competence list also refers to courage but only in a vague sense, directed towards all people with whom the nurse interacts, including clients, their
families and colleagues. This vague description of courage could be made more specific by adding details uncovered in our study of the many ways that nurses display courage towards patients: to encounter vulnerability, suffering, and death in patients; to be emotionally intimate; and to ask difficult questions and hear difficult answers. Future research could explore more fully the concordance between extant competence lists and our list of factors.

Another way that our study contributes to the understanding of nurse competence in spiritual/existential care is by proposing the notion of 'environment competence'. The notion of 'work environment competence' emerged as a category of death work competence among helping professionals (Chan et al., 2012), and was defined as a supportive working environment that included appropriate supervision, teamwork, and organizational support. This notion supports our starting premise that factors contributing to enactment of appropriate nurse behaviors also contribute to nurse competence. It also broadens the view of nurse competence in spiritual/existential care from being a purely individual characteristic, to being an interaction of individual and organizational characteristics. Support for an interactional view of competence is found in the organizational behavior field that considers employee performance (and hence competence) as being shaped by interacting individual and organizational characteristics (Kozlowski & Klein, 2000).

The interaction between individual and organizational characteristics is present in extant nursing spiritual care competence lists, but it is overlooked due to item wording that ignores barriers within the nurses' environment. For example, two items, one in Van Leeuwen et al. (2009, p.2868) stating "... I can in a timely and effective manner refer [patients] to another care worker (e.g. a chaplain...)" and another in Attard et al. (2019, p.100) stating "[f]acilitate ... privacy ... to maintain clients' dignity", assume that spiritual care providers and privacy are
readily available at the nurses' behest. Our study explicitly identifies 'availability of spiritual care providers' and ‘privacy’ as factors in the environment domain that influence care practice, and thus contribute to spiritual/existential care environment competence.

The suitability of the TDF to study spiritual/existential care practices

Our analysis showed that there were no factors derived from the review findings that could not be accounted for by one of the TDF domains. This indicates that the TDF framework is broadly relevant to nurse behavior in spiritual/existential care, albeit with some qualifications.

One qualification to the use of TDF to study spiritual/existential care is that the frequency of reporting of domains and factors does not necessarily reflect the relative importance or impact of identified factors on care practice. Discordance between reported frequency and effect on spiritual care behavior has been observed empirically by Neathery et al. (2020) and Balboni et al. (2014). In our study, several domains of the TDF had few or no factors (e.g. only seven studies reported factors related to memory, attention and decision-making, and no study reported factors related to optimism). But we know that they must affect behavior. Nurses are not automatons; they must be attentive to patient cues and use knowledge stored in memory to decide the most appropriate care actions in particular situations. The infrequent reports of some domains in our review could be because: (i) the primary studies did not question participants directly about these domains, and/or (ii) individuals find it difficult to recall affective attitudes (i.e., emotions) (Thomas and Diener, 1990) and may not even be conscious of factors affecting their behavior (e.g., Shantz and Latham, 2009). Future research could therefore explore which factors have the greatest effect on spiritual/existential care practices.

Another qualification to the use of TDF to study spiritual/existential care is that the
domains are not distinct, and relationships between domains are not explicit. The TDF identifies constituent domains but not the causal processes linking domains in a coherent explanation of behavior (Michie et al., 2005). This limitation in our review means that the frequency analysis should not be considered in isolation. During coding, we found that some factors could be represented by more than one domain. For example, patient-nurse boundaries could be categorized under social/professional role as well as under patient-social influence; this overlap is not surprising because professional boundaries are defined in terms of limits in social relationships, and palliative care clinicians are susceptible to such boundary challenges with patients (Lawton et al., 2019). Another example is the difficulty in distinguishing between intentions and goal domains using the data available. While intentions are intertwined psychologically, they are generally more proximal determinants of behavior than goals (Castelfranchi, 2014). Also we noted that optimism was not ostensibly identified as a factor in any study; however, factors that were the outcome of optimism/pessimism could be manifested in the data as beliefs about positive/negative consequences of care practices. This is supported by research that assesses clinician optimism by measuring their expectations (or beliefs) about treatment outcomes (e.g., Byrne et al., 2006). These examples illustrate how domains could form a causal network of distal and proximal factors influencing spiritual/existential care behavior. Future research could develop this network for spiritual/existential care.

**Strengths/limitations and future research**

One strength of the present review is that it is a mixed-methods review. Most of the studies investigating nurse spiritual/existential care practice were single, qualitative, interview-based studies. Individually these studies were not intended to be generalizable and used small samples;
but together they provide a more complete depiction of factors influencing spiritual/existential care. Conversely the few quantitative studies included in the review did not capture all domains, but did allow measurable investigation of factors not normally perceived by nurses. For example, the Doorenboos (2006) study showed statistically that ethnic culture influences whether nurses focused on religious rituals, but not whether nurses encouraged patients to talk about dying.

Some limitations of our review should be noted. Firstly, as the search was limited to peer-reviewed journal studies on end-of-life care published in English, the included studies were not representative of all cultural or work settings. Even though generalizability of findings was not an aim of this review, this drawback might reduce the applicability of the findings to some work/country or healthcare contexts. Most included studies involved lengthy, face-to-face interviews with a nurse researcher, which may have introduced bias by self-selection of nurses who valued spiritual/existential care. Future research should set out to overcome these limitations.

The current study provides ample opportunity for future empirical work. Some possibilities have been mentioned, but we will comment on three additional areas. One involves investigation of discrepancies and gaps in findings. Some factors were reported as both barriers and facilitators (e.g., participation/identification with faith tradition was identified both as a barrier (Kisvetrova 2013), facilitator (Pitroff 2013) and unrelated (Johnson 2013) to spiritual/existential care practices); discrepant findings suggest a contextual variable may be operating. One gap identified in the frequency analysis is that few studies were conducted in Middle East, Africa and South America, probably because only English language studies were included. Future research could include studies in other languages, which might better capture culture-specific aspects of spirituality (Schultz et al., 2014). Another gap is the relative absence
of studies identifying the emotion domain in the North American region; this might be due to North American nursing research generally lagging in emotion work (e.g., in a 2017 review of emotional labor in nursing work, of 16 relevant international empirical studies, only two were North American (Delgado et al., 2017)). Moreover even though the domain-by-time-period analysis showed how studies identified barriers over time, all studies were snapshot studies and therefore did not capture how barriers and facilitators – real or perceived – changed over time with individual nurses or their organizational milieus.

**Conclusion**

Because a nurse can play a significant role in providing spiritual/existential care to end-of-life patients, it is important to understand the determinants of nurse care practices towards these patients. This systematic review of 42 studies involving nurses across a variety of healthcare settings identified a range of personal, organizational and patient-related factors influencing nurse provision of spiritual/existential care. The most frequently reported factors were patient-related social influence, skills, social/professional role and identity, intentions and goals, and environmental context and resources. By improving our understanding of the determinants of nurse behavior, these factors can be used as inputs to nurse competency frameworks and to gauge a unit's conduciveness to nurse provision of spiritual/existential care. This research thus contributes to the development of spiritual care practices of palliative staff, which is an important research priority for clinicians and researchers in palliative care (Selman et al., 2014). □
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<tr>
<th>First Author (Year)</th>
<th>Study Aims</th>
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<th>Methods</th>
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<tr>
<td>Abu-El-Noor (2016)</td>
<td>To examine how nurses working in intensive care units understand spirituality and the provision of spiritual care at the end-of-life.</td>
<td>N=13; 5 female; Age 26-47 yrs ICU work experience 3-22 yrs; all nurses identified with religious belief</td>
<td>ICU, 2 hospitals, Gaza Strip</td>
<td>Semi-structured interviews</td>
<td>80</td>
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<td>Arman (2007)</td>
<td>To explore and clinically validate nuances of witnessing as a caring act</td>
<td>N=4; all had &gt;3 yrs palliative care experience</td>
<td>An integrative hospital offering anthroposophic and conventional care, Sweden</td>
<td>Group discussion of one case</td>
<td>80</td>
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<tr>
<td>Bailey (2009)</td>
<td>To describe nurses’ experiences of delivering spiritual support in a palliative care setting</td>
<td>N=22</td>
<td>A single hospice in Ireland</td>
<td>Semi-structured interviews</td>
<td>75</td>
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<td>Belcher (2005)</td>
<td>To determine the extent to which nurses in hospice and other specialty care areas express spiritual values and integrate spiritual care into their role.</td>
<td>N=204; 93% female; mean age 50 yrs; median experience 30 yrs; 71% participated in regular religious practice</td>
<td>Hospice and palliative care, across US.</td>
<td>Qualitative questionnaire</td>
<td>70</td>
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<tr>
<td>Bone (2018)</td>
<td>To explore the effect of spiritual care on nurses and how nurses understand the role of spiritual care</td>
<td>N=25; 88% female; mean age 44 yrs; mean nurse experience 21 yrs</td>
<td>1 ICU ward in a faith-based hospital in Canada</td>
<td>Semi-structured interviews</td>
<td>85</td>
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<td>Browall (2014)</td>
<td>To describe nurses’ experiences of existential situations when caring for patients severely affected by cancer</td>
<td>N=83; all female; mean age 46 yrs; mean palliative care experience 2 yrs.</td>
<td>3 urban in-patient hospices, 1 surgery clinic, 1 oncology clinic, in Sweden</td>
<td>Critical incident technique</td>
<td>85</td>
</tr>
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<td>Bush (2008)</td>
<td>To explore the meaning of spiritual care as described by a group of palliative care professionals</td>
<td>N=4; all female; age range ~28-45 yrs; median palliative care experience ~5-10 yrs</td>
<td>Home-based palliative care in Australia</td>
<td>In-depth interviews</td>
<td>70</td>
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<td>Carroll (2001)</td>
<td>To explore the experiences of nurses’ personal spiritual beliefs, and of providing spiritual care for patients with advanced cancer</td>
<td>N=15; 93% female; median hospice experience 5-10 yrs; 80% identified as spiritual/religious</td>
<td>Hospice in England</td>
<td>In-depth interviews</td>
<td>70</td>
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<td>Doorenbos (2006)</td>
<td>To describe the phenomenon of dignified dying, to describe nursing actions used to promote dignified dying, and to evaluate the validity of a dignified dying scale among practising nurses in India</td>
<td>N=229; mean experience 11 yrs;</td>
<td>Government-run and private hospitals, India</td>
<td>Qualitative &amp; quantitative survey</td>
<td>86</td>
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<tr>
<td>Ellington (2015)</td>
<td>To identify naturally occurring, spiritually relevant conversations and elucidate challenges for nurses in home hospice</td>
<td>N=5; all female, mean age 42 yrs, mean nurse experience 12 yrs; mean hospice nurse experience 7 years</td>
<td>1 hospice in US</td>
<td>Conversation analysis</td>
<td>80</td>
</tr>
<tr>
<td>Fay (2019)</td>
<td>To explore how palliative-care nurses identify patients with existential distress and manage their needs.</td>
<td>N=10, all female; range of palliative care experience 2-28yrs</td>
<td>Community and inpatient palliative care in 1 hospice in Ireland</td>
<td>Semi-structured interviews</td>
<td>80</td>
</tr>
<tr>
<td>Study (Year)</td>
<td>Objective</td>
<td>Sample Details</td>
<td>Setting</td>
<td>Methodology</td>
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<tr>
<td>Ferrell (2014)</td>
<td>To identify contexts in which nurses have witnessed expressions of regret or the need for forgiveness, and to describe nurses’ responses to these experiences related to forgiveness.</td>
<td>N=339</td>
<td>Palliative care in US, Belize, India, Romania, Philippines</td>
<td>Qualitative questionnaire</td>
<td>85</td>
</tr>
<tr>
<td>Guedes (2013)</td>
<td>To analyze the experience of nurses’ care for dying persons</td>
<td>N=14; 93% female; age range 28-55 yrs; range of experience 2-30 yrs</td>
<td>Long stay unit in 1 general hospital in Brazil</td>
<td>Interviews</td>
<td>45</td>
</tr>
<tr>
<td>Harrington (1995)</td>
<td>To discover the meaning that registered nurses ascribed to ‘spirituality’, the nature and role of spiritual care in nursing care, and perceptions of adequacy of spiritual care education</td>
<td>N=20, 90% female; mean age 28 yrs; mean nursing experience 16 yrs; 50% identified with a faith tradition.</td>
<td>1 hospice and various acute care settings in Australia</td>
<td>Interviews</td>
<td>65</td>
</tr>
<tr>
<td>Harrington (2006)</td>
<td>To develop a better understanding of what constitutes spiritual caregiving</td>
<td>N=10</td>
<td>1 hospice in Australia</td>
<td>Interviews</td>
<td>75</td>
</tr>
<tr>
<td>Highfield (2000)</td>
<td>To identify the formal and experiential spiritual care preparation of oncology and hospice nurses.</td>
<td>N=181 oncology, N=645 hospice; 97% female; mean age 45 yrs; mean nursing experience 18 yrs; 7% never attended religious service</td>
<td>Oncology care in 5 regions in US; hospice care across US.</td>
<td>Quantitative survey</td>
<td>82</td>
</tr>
<tr>
<td>Johansson (2011)</td>
<td>To describe the meanings of nurses’ experiences of caring for palliative care patients</td>
<td>N=8; all female; range of work experience 3-32 yrs;</td>
<td>Acute-care in two hospitals in Sweden</td>
<td>Interviews</td>
<td>85</td>
</tr>
<tr>
<td>Johnston-Taylor (2013)</td>
<td>To measure how comfortable hospice nurses in New Zealand are in conducting spiritual assessment and identify associated factors</td>
<td>N=60 hospice; mean age 53 yrs, mean nursing experience 26 yrs, self-reported spirituality(/religiosity) 3.7/(2.6) out of 5</td>
<td>3 hospices in New Zealand</td>
<td>Qualitative &amp; quantitative survey</td>
<td>86</td>
</tr>
<tr>
<td>Kale (2011)</td>
<td>To examine how spiritual care is perceived in an African context by recording the lived experiences of palliative care workers</td>
<td>N=13; all identified with a religion</td>
<td>Hospice service in Uganda</td>
<td>Interview</td>
<td>75</td>
</tr>
<tr>
<td>Karlsson (2017)</td>
<td>To understand nurses’ existential questions when caring for dying patients</td>
<td>N=14; all female; age range 36-61 yrs; work experience range 6 months to over 10 yrs</td>
<td>1 community care center, 1 hospice care center, 1 hospital palliative care unit, Sweden</td>
<td>Focus groups</td>
<td>75</td>
</tr>
<tr>
<td>Keall (2014)</td>
<td>To investigate the facilitators, barriers and strategies that Australian palliative care nurses identify in providing existential and spiritual care</td>
<td>N=20; 95% female; age range 25-65 yrs; experience range 1-40 yrs; 12 identified with spiritual/religious belief</td>
<td>Community, inpatient unit, acute units across Australia</td>
<td>Interviews</td>
<td>80</td>
</tr>
<tr>
<td>Kisvetrova (2013)</td>
<td>To investigate the use and feasibility of in the ‘Spiritual Support’ interventions for patients diagnosed with ‘Death Anxiety’</td>
<td>N=468; mean age 38 yrs; median work experience 14 yrs; 43% religious believers</td>
<td>Long-term, hospice, oncology, geriatrics, homes for elderly, home care in Czech Republic</td>
<td>Quantitative &amp; qualitative survey</td>
<td>86</td>
</tr>
<tr>
<td>Kisvetrova (2016)</td>
<td>To assess nurse’ practice regarding dying care and spiritual support interventions, and identify factors influencing intervention usage.</td>
<td>N=277; 94% female; mean age 34 yrs, mean experience 9 yrs.</td>
<td>29 ICUs in Czech Republic</td>
<td>Quantitative survey</td>
<td>91</td>
</tr>
<tr>
<td>Reference</td>
<td>Objective</td>
<td>Participants</td>
<td>Methodology</td>
<td>Setting</td>
<td></td>
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<tr>
<td>Kisvetrova (2018)</td>
<td>To determine the utilization rate of comfort-supporting nursing activities in end-of-life patients and identify associated factors.</td>
<td>N=907; mean age 38 yrs; mean work experience 15 yrs</td>
<td>Intensive, acute, long-term, hospice care in 49 institutions, Czech Republic</td>
<td>Quantitative survey</td>
<td></td>
</tr>
<tr>
<td>Kociszewski (2004)</td>
<td>To describe critical care nurses' lived experience of providing spiritual care to critically ill patients and their families</td>
<td>N=10; 90% female; mean age 32 yrs; mean nursing experience 16 yrs</td>
<td>Critical care units, US</td>
<td>Interviews</td>
<td></td>
</tr>
<tr>
<td>Kristeller (1999)</td>
<td>To describe how oncologists and oncology nurses respond to spiritual distress.</td>
<td>N= 267 oncology nurses; 99% female; mean age 43 yrs; mean oncology experience 10yrs;</td>
<td>Range of settings (medical oncology, community private practice, hospitals), US.</td>
<td>Quantitative survey</td>
<td></td>
</tr>
<tr>
<td>Kuuppelomaki (2001)</td>
<td>To find out how nursing staff provide spiritual support and factors that influence the provision of spiritual support</td>
<td>N=328; 98% female; 86% were over 36 yrs age; 44% had &lt;10 yrs experience; 91% identified as Lutheran</td>
<td>In-patient wards in 32 community health centres, Finland</td>
<td>Qualitative &amp; quantitative survey</td>
<td></td>
</tr>
<tr>
<td>Minton (2018)</td>
<td>To describe nurses' communication strategies while providing spiritual care</td>
<td>N=10; age range 30-60yrs; experience range 10-30 yrs; all Christian</td>
<td>1 faith-based health system providing hospice/palliative care in home, nursing home, acute care, and hospice, US</td>
<td>Interviews</td>
<td></td>
</tr>
<tr>
<td>Morita (2009)</td>
<td>To determine effects of an educational workshop focusing on patients' feelings of meaninglessness on nurses' confidence, self-reported practice, and attitudes toward caring for such patients</td>
<td>N=40; general practice nurses; all female; mean age 31 yrs, mean clinical experience 9 yrs</td>
<td>General practice, in a single general hospital, Japan</td>
<td>Experimental intervention</td>
<td></td>
</tr>
<tr>
<td>Naden (2009)</td>
<td>To understand confirmation of cancer patients from the nurse perspective</td>
<td>N=8; all female; age range 25-46 yrs</td>
<td>4 cancer wards in Norway</td>
<td>Interviews</td>
<td></td>
</tr>
<tr>
<td>Nixon (2013)</td>
<td>To identify how nurses manage the spiritual needs of neuro-oncology patients</td>
<td>N=12;</td>
<td>Neuro-cancer unit in a teaching hospital, UK</td>
<td>Qualitative questionnaire</td>
<td></td>
</tr>
<tr>
<td>Pitroff (2013)</td>
<td>To describe how palliative care nurses provide spiritual care and how they acquired these skills, and to discover the personhood of these nurses</td>
<td>N=10; all female; median age 54 yrs; median nursing experience 31 yrs; all active in a faith tradition</td>
<td>In-patient palliative care in a range of settings in US</td>
<td>Semi-structured interviews</td>
<td></td>
</tr>
<tr>
<td>Ronaldson (2012)</td>
<td>To identify and compare spiritual caring practice by palliative and acute care nurses, and to investigate correlates and barriers to spiritual caring.</td>
<td>N=92; 82% female; mean age 38 yrs; mean nursing experience 14 yrs</td>
<td>1 community palliative care service, and 3 palliative care and 3 acute care units in large hospitals in Australia.</td>
<td>Quantitative survey</td>
<td></td>
</tr>
<tr>
<td>Taylor (1999)</td>
<td>To identify factors that contribute to oncology and hospice nurses' spiritual care perspectives and practices</td>
<td>N= 818; mean age 46 yrs; mean nursing experience 18 yrs; mean spirituality 4.2(out of 5)</td>
<td>Members of Oncology Nursing Society, and Hospice Nurses Association in US.</td>
<td>Quantitative survey</td>
<td></td>
</tr>
<tr>
<td>Author</td>
<td>Title</td>
<td>Sample Information</td>
<td>Setting/Method</td>
<td>Score</td>
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<tr>
<td>Tornoe (2014)</td>
<td>To describe the meaning of hospice nurses’ lived experience with alleviating dying patients’ spiritual and existential suffering</td>
<td>N=6, age range 41-61 yrs; nursing experience range 8-35 yrs</td>
<td>Hospice, Norway Interviews</td>
<td>85</td>
<td></td>
</tr>
<tr>
<td>Tornoe (2015)</td>
<td>To describe nurses’ experiences with spiritual and existential care for dying patients in a general hospital.</td>
<td>N=6; age range 37-61 yrs; nursing experience range 9-21 yrs</td>
<td>A combined medical and oncological ward in a general hospital in Norway Interviews</td>
<td>85</td>
<td></td>
</tr>
<tr>
<td>Van Meurs (2018)</td>
<td>To gain insight in the way and extent to which nurses during daily caregiving observe and explore spiritual issues of hospitalized patients with cancer</td>
<td>N=4; 75% female</td>
<td>Medical oncology ward of a teaching hospital, Netherlands Observation, interviews</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>Vosit (2010)</td>
<td>To characterize the nursing actions practiced by nurses affiliated with Hospices of Hope that promote dignified dying</td>
<td>N=43 hospice nurses; 72% under 40 years age; 56% ≤10 yrs of experience, and 19% had ≥21 years experience.</td>
<td>Members affiliated with Hospices of Hope in Romania Qualitative&amp; quantitative questionnaire</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>Walker (2017)</td>
<td>To explore nurses’ experiences providing spiritual care to patients who are facing a life-limiting illness.</td>
<td>N= 9 palliative care nurses; mean age 53 yrs; mean palliative care experience 9 yrs. The nar</td>
<td>3 hospices in New Zealand Semi-structured interviews</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>Wittenberg (2017)</td>
<td>To explore the spiritual care experiences of nurses to learn more about nurse communication involving spirituality.</td>
<td>N=57 oncology nurses; mean clinical experience 16 yrs;</td>
<td>Range of settings (home care, hospital, outpatient) in US Qualitative survey</td>
<td>85</td>
<td></td>
</tr>
<tr>
<td>Yingting (2018)</td>
<td>To explore the perspectives of Emergency Department doctors and nurses in (i) spirituality, (ii) spiritual care domain in end-of-life care and (iii) factors influencing spiritual care provision in the Emergency Department.</td>
<td>N=15, 87% female; mean age 21-30yrs, 80% attended religious activities</td>
<td>ED of a public tertiary teaching hospital, Singapore Focus group</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>Zerwekh (1993)</td>
<td>To identify hospice practice competencies of spiritual caring</td>
<td>N=32 hospice nurses</td>
<td>Home care in US. Interviews</td>
<td>55</td>
<td></td>
</tr>
</tbody>
</table>

* Scores are based on quality appraisal tool by Kmet et al., (2004)*
Table 2. Thematic synthesis of TDF domains.
(For a more complete listing of examples of supporting data from included studies, see Supplementary Table 2)

<table>
<thead>
<tr>
<th>TDF DOMAIN</th>
<th>Synthesized finding</th>
<th>Themes</th>
<th>Examples of supporting data from included studies (+ facilitator, - barrier, ± factor with unspecific direction, ≠ no relationship)</th>
</tr>
</thead>
<tbody>
<tr>
<td>KNOWLEDGE</td>
<td>Three types of knowledge were frequently reported as facilitating spiritual/existential care: knowing how to identify and assess spiritual/existential distress; knowledge of spiritual care and care practices, which ranged from general knowledge, such as the meaning of spiritual care, to specific elements, such as the timing of spiritual care; and knowledge related to issues of spirituality and death. Knowledge of oneself as a person also aided care</td>
<td>Theme: Knowledge of spiritual/existential care practices</td>
<td>+ knowledge of care practice (Johansson 2011) + pastoral care knowledge (Pitroff 2013) + knowledge about timing of spiritual care (e.g., when to begin and stop) (Bailey 2009)</td>
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<tr>
<td></td>
<td></td>
<td>Theme Knowledge related to spiritual assessment and identification</td>
<td>+ intuitive knowing when patient is experiencing spiritual distress (Walker 2017) - not knowing what to ask or how to approach spiritual assessment (Belcher 2005)</td>
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<tr>
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<td></td>
<td>Theme: Knowledge regarding spirituality and death</td>
<td>+ knowledge about life and death issues, and human existence (Arman 2007) - lack of knowledge of different religious practices/beliefs and spirituality (Belcher 2005, Kuuppelomaki)</td>
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<tr>
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<td>Theme: Self knowledge</td>
<td>+ knowledge of oneself as a person and how to use one’s lived knowledge (Johansson 2011)</td>
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<tr>
<td>SKILL</td>
<td>Skills in spiritual assessment and identification, and in delivery of spiritual/existential care, acted as facilitators of spiritual/existential care, and vice versa. Specific experience in spiritual care acts as a facilitator, while general experience (i.e., work experience, nurse experience) was unrelated. Studies that reported training/education showed that training specifically in spiritual/existential care acted as a facilitator, but qualifications and education level alone was not a facilitator. A randomized, controlled study examining the effect of a workshop on the care of terminally-ill patients (Morita, 2009) found that training had only short-term effects on care practice, which petered out in the longer-term. Opportunities for self-reflection, and watching and learning from others, facilitated the provision of spiritual/existential care. All these skills relied on first having mastered technical nursing skills.</td>
<td>Theme: Skills related to spiritual assessment and identification</td>
<td>+ ability to sense, recognize, observe patient need (Bailey 2009, Carroll 2001, Minton 2018) + skill to identify spiritual need/distress from verbal and uncontrolled symptoms (Zerwekh 1993) - inability to pick up patient spiritual needs, and identify spiritual anxiety (Kuuppelomaki 2001)</td>
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<td>Theme: Skills in delivery of spiritual/existential care</td>
<td>+ skills in verbal and non-verbal communication (e.g., meaningful conversation, body language) (Bailey 2009, Tornoe 2014) + a professional nurse chooses right time for spiritual conversations (van Meur 2018) - scarce skills and competencies (Bailey 2009, Keall 2014, Kuuppelomaki 2001)</td>
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<tr>
<td></td>
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<td>Theme: Experience</td>
<td>+ experience providing spiritual care (Bailey 2009, Tornoe 2014) + frequent experience of caring for dying (Kociszewski 2004) ≠ work experience in years (Kisvetrova 2018)</td>
</tr>
<tr>
<td></td>
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<td>Theme: Training/education</td>
<td>+ training in spiritual assessment (Johnson 2013) + then ≠ : training in care of patients feeling meaninglessness has a significant short-term effect, but returned to baseline after nine months (Morita 2009) ≠ qualifications (Ronaldson 2012) and education level (Kisvetrova 2018, Taylor 1999)</td>
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<tr>
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<td>Theme: Self-reflection</td>
<td>+ self-reflection, reflective practice (Vosit 2010)</td>
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<td>Theme: Learning from others</td>
<td>+ watching and learning from chaplains</td>
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<tr>
<td></td>
<td></td>
<td>Theme: Basic nursing skills</td>
<td>+ mastered the technical stuff and can take extra step (Kociszewski 2004)</td>
</tr>
<tr>
<td>SOCIAL OR PROFESSION</td>
<td>An acceptance that spiritual assessment and care was part of the nurse role acts as a facilitator, and vice versa. Specific experience in spiritual care acts as a facilitator, while general experience (i.e., work experience, nurse experience) was unrelated. Studies that reported training/education showed that training specifically in spiritual/existential care acted as a facilitator, but qualifications and education level alone was not a facilitator. A randomized, controlled study examining the effect of a workshop on the care of terminally-ill patients (Morita, 2009) found that training had only short-term effects on care practice, which petered out in the longer-term. Opportunities for self-reflection, and watching and learning from others, facilitated the provision of spiritual/existential care. All these skills relied on first having mastered technical nursing skills.</td>
<td>Theme: Spiritual care in nursing role content</td>
<td>+ spiritual assessment and care is part of nurse role (Belcher 2005)</td>
</tr>
</tbody>
</table>
### Identity

Components of the spiritual care role and what it includes (such as showing ensuring the family is present at death) and excludes (such as not needing to fix patient feelings). Role conflict (e.g., when discord arises between personal beliefs and patient request) and erosion of patient-nurse boundaries (e.g., when nurse identifies too closely with the patient) discomfit spiritual/existential care, while work commitment aids such care.

**Theme: Sub-components of spiritual care role**
- Part of role is to ensure family presence at death (Zerwekh 1993)
- Showing compassion (Bone 2018)
- Accept it is not nurse's job to fix feelings, just accept how patient feels (Minton 2018)

**Theme: Role conflict**
- Conflict between personal and professional spirituality (Belcher 2005)
- Conflict between personal beliefs and patient requests (Belcher 2005)
- Confusion between proselytizing and delivery of spiritual care (Ronaldson 2012)

**Theme: Patient-nurse boundaries**
- Boundaries blurred when nurse identifies with patient (e.g., has children same age (Browall 2014)
- Need closeness but not too close (Johansson 2011)

**Theme: Work commitment**
- Love this work (Bailey 2009)

### Belief about capabilities

Feeling confident and comfortable in providing spiritual/existential care was a facilitator, and vice versa. Studies reported that a specific personal facility that aided spiritual/existential care was personal courage to face daunting situations, such as encountering vulnerability in a patient, and to be emotionally intimate with a patient. Maturity and life experiences (such as personal experience of loss) generally facilitated the provision of spiritual/existential care, however, personal experience could interfere with care, when personal self-disclosure superseded awareness of client needs. Studies generally reported that nurses' resolution of their own existential issues and tendency to their own spirituality were facilitators, but there were exceptions. Nurse religiosity and age had mixed effects, while gender and non-English background had no reported influence.

**Theme: General capabilities**
- Comfortable/confident providing spiritual care (Belcher 2005, Keall 2014)
- Accept/know limits of expertise and ready to work with other team members (Keall 2014, Pitroff 2013)

**Theme: Courage**
- Courage to encounter vulnerability, suffering, death in patient (Arman 2007)
- Courage to ask difficult questions and hear difficult answers and patient fears (Zerwekh 1993)
- Courage to be emotionally intimate (Browall 2014)

**Theme: Life experiences**
- Maturity (Tornoe 2015)
- Personal experience of loss and illness (Pitroff 2013)
- Personal experience of loss can interfere with spiritual care, when personal self-disclosure supersedes awareness of client needs (Pitroff 2013)

**Theme: Reflection/acceptance of one's own existential issues**
- Reflection on own existence/death (Johansson 2011)
- Comfortable with own feelings of death and dying (Kociszewsk 2004)
- Attitudes to death, death avoidance, death as better life, death as escape (Kisvetrova 2016)

**Theme: Participation/identification with faith tradition**
- Participation in faith community (Pitroff 2013)
- Nurse religiosity (Kisvetrova 2013, Kuuppelomaki 2001)
- No religiosity (Johnson 2013)

**Theme: Nurse demographics**
- Age (Taylor 1999, Tornoe 2015)
- Gender (Ronaldson 2012), English-speaking background (Ronaldson 2012)

### Beliefs about consequences

Some studies reported patient wellbeing as a consequence of spiritual/existential care, but other studies reported the reverse. Several studies reported beliefs in the consequences of specific nurse actions, such as engaging in conversation or eye contact, but some studies reported negative consequences if patients viewed nurse actions as undesired/unhelpful. Spiritual conversations that are perceived by nurses as beneficial effects of nurse actions on patient, e.g., eye contact (Arman 2007), sharing silence (Tornoe 2013)

**Theme: Consequences of general spiritual care and assessment on patient**
- Spiritual care leads patient health & wellbeing (Bush 2008, Kale 2011)
- Spiritual care brings patients relaxation, comfort (Abu-El-Noor 2016, Bailey 2009)
- Relieving suffering extends time for suffering (Guedes 2013)
- Spiritual support does not help patient (Nixon 2013)

**Theme: Consequences of specific nurse actions on patients**
- Beneficial effects of nurse actions on patient, e.g., eye contact (Arman 2007), sharing silence (Tornoe 2013)
- Prayer is used as it suits patient of all faiths (Kale 2011)
- Spiritual questions are potentially intrusive (Johnson 2013) and off-putting to patient (Walker 2017)
<table>
<thead>
<tr>
<th>REINFORCEMENT</th>
<th>Positive personal feelings, meaningful work, and satisfaction at being part of a patient's life, facilitated the provision of spiritual/existential care. However, feeling drained, and needing to see good results of care work acted as barriers.</th>
</tr>
</thead>
</table>
| Theme: Positive reinforcers | + rewarding to be part of patient's life (Minton 2018)  
+ feel honoured when patients choose to confide in them (Tornoe 2015) |
| Theme: Negative reinforcers | - when nurses need to see good results of their work (Tornoe 2015)  
- too demanding to do frequently (van Meur 2018) |

<table>
<thead>
<tr>
<th>MOTIVATION AND GOALS</th>
<th>A variety of goals/intentions influenced nurse spiritual/existential care behavior. These goals varied in their target (whether for patient, relationship, self, task, or colleagues). Patient-oriented goals ranged from general goals of patient care, such as providing the best care for patients, to more specific outcomes for the patient, such as for the patient to feel comfortable and cared for. Almost all these goals facilitated the provision of spiritual/existential care, except for the goal of helping patient recover from illness, which impeded such care. Relationship goals (i.e., that promote a trusting, secure connection with the patient) and empathy goals (i.e., that enhance understanding/feeling of what the patient is experiencing) facilitated spiritual/existential care. Self-benefit goals refer to states of being that nurses desired to achieve, such as striving for completeness. Most of these types of goals facilitated spiritual/existential care, except when the goal was to protect themselves from suffering. The prioritisation of spiritual/existential care above other activities facilitated the provision of spiritual/existential care, and vice versa. Goals associated with colleagues included an intention to use the expertise of team members and chaplain, if necessary. Underscoring these goals, was a recognition that goals should be achievable to facilitate caring.</th>
</tr>
</thead>
</table>
| Theme: General goals of patient care | + aim to provide best care for patients (Johansson 2011)  
+ want patient to feel comfortable and cared for (Kociszewski 2004) and not alone (Arman 2007)  
- to help patient recover from illness (Guedes 2013) |
| Theme: Relationship goals | + need to establish trusting relationship with patient (Tornoe 2015)  
+ aim to fully participate in the encounter and enter patient's personal space (Arman 2007, Minton 2018) |
| Theme: Empathy goals | + to respect the way patient sees things (Harrington 1995)  
+ to put oneself in patient shoes (Browall 2014) |
| Theme: Self-oriented goals | + strive for completeness (i.e. feeling they've done all they can) (Johansson 2011)  
- to stay away from distressed patient for self-protection (Fay 2019)  
- try to avoid potential anxiety about their own suffering/dying (Tornoe 2015) |
| Theme: Task priorities | + prioritise spiritual/existential above other activities (Arman 2007, Bailey 2009, Belcher 2005; Browall 2014)  
- unable to tend to spiritual domain when technical aspects have to be dealt with first (Bone 2018) |
| Theme: Goals related to other persons | + utilize expertise of team members (e.g., chaplain) (Pitroff 2013)  
+ commitment to refer to chaplain if nurse is not spiritual (Zerwekh 1993) |
| Theme: Goal features | + limit goals to what is achievable (Zerwekh 1993) |

<table>
<thead>
<tr>
<th>MEMORY, ATTENTION AND DECISION-PROCESSES</th>
<th>Spiritual/existential care requires nurses to make conscious effort to focus attention on patients needs while being aware of their own mental stance. Barriers to care occur when other priorities deflect nurse attention, such as completing workload or filling in checklists.</th>
</tr>
</thead>
</table>
| Theme: Conscious focus on patient need | + attention to patient spoken and unspoken signals (Naden 2009, Zerwekh 1993)  
+ stop and think that patient and families are experiencing existential distress (Tornoe 2015) |
| Theme: Consciousness of self | + attempt to be in the 'here and now' (Arman 2007)  
+ need mental shift from "doing for patient" to "being with patient" (Tornoe 2014) |
| Theme: Attention deflectors | - full attention needed to complete checklists for which they are accountable (van Meur 2018)  
- attention focused primarily on physical care, ignore spiritual care (Bush 2008) |
## Environment

**Context and Resources**

Many studies referred to aspects of time: lack of time generally due to work demand, lack of time with patient and lack of time for learning impeded spiritual/existential care. The care setting and organisational priorities influence spiritual/existential care behaviors. For example, spiritual/existential care is facilitated in a hospice setting, in organisations that make spiritual care a priority, and where spiritual care providers are readily available. Facilities with specially decorated rooms that allow privacy aid the provision of spiritual/existential care. The use of care tools seems to have mixed effects. Ethnic culture influenced the type of religious rituals nurses used to help patients, but not whether they encouraged patients to speak about dying.

### Theme: Time-related aspects

#### Temporal demand
- low staff-patient ratio (Bailey 2009, Kisvetrova 2016, Tornoe 2015)

#### Duration of time that patient is in unit
- short-term stay (Belcher 2005)
- patient referred too late to palliative care (Keall 2014)

#### Duration of time with individual patient
- unable to spend as much time as like with patient (Bone 2018)

#### Time for learning
- lack of time for self-reflection (Kale 2011)

### Theme: Care setting

+ hospice setting (Belcher 2005, Harrington 1995)
- acute care (Harrington 1995)

### Theme: Organisational priorities

+ health centres that focused on raising care standards (Kuuppelomaki 2001)

### Theme: Facility/amenities

+ specially decorated rooms enhance calmness, harmony, rest, security (Johansson 2011)
+ privacy (Minton 2018, Yingting 2018)

### Theme: Availability of spiritual care providers

+ chaplain availability (Kristeller 1999)

### Theme: Care tools

- no tool for spiritual assessment (Belcher 2005)
± documentation of spiritual care conversations (Keall 2014)
+ documentation of spiritual care (Walker 2017)

### Theme: Ethnic culture

± ethnic culture is related to use of Jesus- vs Hindi-focused religious rituals (Doorenbos 2006)
≠ ethnic culture re urging patient to speak about dying

## Social Influence: Patient

Nurses use the patient’s diagnosis and prognosis (whether terminal or short prognosis) and their proneness to distress as indicators of spiritual/existential need. Nurses also use other cues, such as patient's verbal and non-verbal behavior and emotions. Nurses assess the patient's openness to spiritual/existential help by their willingness to communicate regarding spiritual/existential matters (e.g., the patient asking the nurse about her beliefs). Sometimes, though spiritual needs are difficult to detect and isolate, especially when the patient is unable to communicate. The patient's unique beliefs and worldviews, and their social situation (i.e., family relationships and wider network) are other cues that influence how nurses provide spiritual/existential care. A patient who is too demanding, by having too many needs to meet for

### Theme: Patient diagnosis/prognosis

+ terminal illness diagnosis (Abu-El-Noor 2016, Belcher 2005)
+ short prognosis (Fay 2019, Kociszewsk 2004, Kristeller 1999)

### Theme: Patient demographics

+ patient proneness to existential distress e.g., young mothers (Fay 2019)
≠ patient gender (Kristeller 1999)

### Theme: Patient’s cues of distress and spiritual needs

+ patient behavior and utterances and indicators (Belcher 2005, Carroll 2001, Johnson 2013)
+ patient cues regarding spiritual needs ... non-verbal behavior, (Abu-El-Noor 2016, Nixon 2013)
+ patient cues regarding spiritual needs ... emotions (Karlsson 2017, Nixon 2013)

### Theme: Patient openness and ability to communicate needs

+ patient ‘permits’ nurse to talk about spiritual/existential questions (Belcher 2005, Tornoe 2015)
+ patient ability to communicate verbally & nonverbally (Belcher 2005, Tornoe 2015, Zerwekh 1993)
- patient unable (Kuuppelomaki 2001) or unwilling to express spiritual needs (Kuuppelomaki 2001)

### Theme: Patient unique needs and beliefs

+ spiritual care tailored to patient's belief/meaning system (Walker 2017, Yingting 2018)
example, obstructs the provision of spiritual/existential care. Several studies reported that a trusting nurse-patient relationship and nurse-patient affinity facilitate spiritual/existential care. Whether nurses and patients shared beliefs was reported to facilitate, impede and have no effect on care. Holding to the social norm that religion is a private matter for the individual impeded the provision of spiritual/existential care.

<table>
<thead>
<tr>
<th>SOCIAL INFLUENCE: OTHER THAN PATIENT</th>
<th>Support from colleagues, especially pastoral care and personal social network, and the quality of the relationship with the patient's family were factors that influenced the provision of spiritual/existential care.</th>
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</thead>
<tbody>
<tr>
<td>Theme: Nurse relationship with patients' family</td>
<td>+ bond with family (Minton 2018) + partnership and trust between nurses and families (Vosit 2010)</td>
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<tr>
<td>Theme: Relationship with nurse personal social network</td>
<td>+ nurses' connection with family, friends (Bush 2008)</td>
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</table>

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<tr>
<th>EMOTIONS</th>
<th>Nurses experienced a range of emotions that influenced their practice. While positive emotions facilitate spiritual/existential care, a range of negative emotions (e.g., anxiety, frustration, pain, sadness, fear, emotionally draining) act as barriers to care.</th>
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<tbody>
<tr>
<td>Theme: Positive emotions</td>
<td>+ feels great to share a patient's life (Johansson 2011)</td>
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<tr>
<td>Theme: Negative emotions</td>
<td>- feeling agonised/anxious/weary when patient is young (Browall 2014) - frustration when nurse can't help (Fay 2019), when patient dies (Guedes 2013) - emotionally draining (Tornoe 2014, Tornoe 2015)</td>
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</table>

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<tr>
<th>BEHAVIORAL SELF-REGULATION</th>
<th>Nurses need to prepare emotionally, spiritually and mentally for an encounter with a patient; and during the encounter, they try to regulate their verbal and non-verbal body language to convey care.</th>
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<tbody>
<tr>
<td>Theme: Preparation before the encounter:</td>
<td>+ prepare before difficult encounters (Naden 2009) + self-preparation (e.g., praying for wisdom) (Minton 2018)</td>
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<td>Theme: Behavior during encounter</td>
<td>+ regulate own body language (Keall 2014) ± manage touch and tone during physical care (Tornoe 2014) + be open, honest, caring, respectful, compassionate (Keall 2014), show genuine desire to care (Walker 2010)</td>
</tr>
</tbody>
</table>
Table 3. Frequency of studies that identified each domain at least once

<table>
<thead>
<tr>
<th>Included studies</th>
<th>Knowledge</th>
<th>Skills</th>
<th>Social/professional role, identity</th>
<th>Beliefs about capabilities</th>
<th>Optimism</th>
<th>Beliefs about consequences</th>
<th>Reinforcement</th>
<th>Intentions and goals †</th>
<th>Memory, attention, decision</th>
<th>Environment context and resources</th>
<th>Social influence-patient §</th>
<th>Social influence-other than patient</th>
<th>Emotion</th>
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Vosit (2010) 10
Walker (2017) 29
Wittenberg (2017) 24
Yinting (2018) 27
Zerwekh (1993) 0

Number of studies with evidence in domain

15
8
25
8
26
32
12
9
11

† Some factors could be categorized under multiple domains, but only the more obvious primary domain was chosen and reported (e.g., patient-nurse boundaries could be categorized under social/professional role as well as under patient-social influence, but the former domain was chosen as the primary domain because the TDF framework formally includes ‘professional boundaries’ as a sub-domain).

‡ It was difficult to distinguish between ‘intentions’ and ‘goals’ domains, so these two domains were combined; this was justified by noting that they are intertwined psychologically (Castelfranchi, 2014) and an earlier version of the TDF (Mitchie et al., 2005) also combined these two domains.

§ During coding, it became obvious that many factors could be categorized under patient-associated social influence, so the ‘social influence’ domain was split into a patient-related social influence, and ‘other’ social influence.
FIGURE 1. Flow of studies included in the review

Records identified through database searching (n=2896)

Duplicates removed (n=670)

Title and abstracts screened (n=2226)

Records excluded (n=1997)

Full-text articles excluded (n=188)
- primary focus not on spiritual/existential care
- factors that influenced practice not reported
- registered nurses not a majority of sample
- nurse responses not distinguishable
- patients not at end-of-life or pediatric
- not primary research

Full-text articles assessed for eligibility (n=229)

Studies included in review (n=42)
FIGURE 2. Depiction of domains by region
(Each circle represents the number of studies mentioning the domain at least once. Studies were assigned to regions based on the locations of nurses sampled).
FIGURE 3. Depiction of domains across five-year time periods (Each circle represents the number of studies mentioning the domain at least once).
### Domains and Constructs

#### 1: Knowledge (An awareness of the existence of something)
- This domain includes aspects such as: Knowledge (including knowledge of condition/scientific rationale)
  - Procedural knowledge (Knowing how to do something)
  - Knowledge of task environment (Knowledge of the social and material context in which a task is undertaken)
- Examples of relevant data
  - Statements about having/not having factual or procedural knowledge of when and how to do the behaviour
  - Statements about having/not having an understanding of the rationale behind performing the behaviour
    - I know/do not know/want to know how/when to do the behaviour
    - I know/do not know/want to know why I should do the behaviour
- In the context of this study, knowledge of the condition/scientific rationale could relate to knowledge of dying and death processes, patient signs of spiritual distress, etc. Knowledge of these factors may be both correct and incorrect knowledge.

#### 2: Skills (An ability or proficiency acquired through practice)
- This domain includes aspects such as:
  - Skills development (The gradual acquisition or advancement through progressive stages of an ability or proficiency acquired through training and practice)
  - Competence (One’s repertoire of skills, and ability especially as it is applied to a task or set of tasks)
  - Ability (Competence or capacity to perform a physical or mental act. Ability may be either unlearned or acquired by education and practice)
  - Interpersonal skills (An aptitude enabling a person to carry on effective relationships with others, such as an ability to cooperate, to assume appropriate social responsibilities or to exhibit adequate flexibility)
  - Practice (Repetition of an act, behaviour, or series of activities, often to improve performance or acquire a skill)
  - Skill assessment (A judgment of the quality, worth, importance, level, or value of an ability or proficiency acquired through training and practice)
- Examples of relevant data
  - Statements describing techniques/capability/skills used/how they do the behaviour in practice
  - Statements about wanting to develop/improve skills in doing the behaviour
    - I would like training in how best to do the behaviour /we haven’t had any training in how to do the behaviour
- In the context of this study, skills may be interpersonal skills (e.g. using empathy, practice, encouragement, sensitivity, practical advice, non-judgemental approach, terminology, communication skills etc).

#### 3: Social or Professional Role and Identity (Self-standards) (A coherent set of behaviours and displayed personal qualities of an individual in a social or work setting)
- This domain includes aspects such as:
  - Professional identity (The characteristics by which an individual is recognised relating to, connected with or befitting a particular profession)
  - Professional role (The behaviour considered appropriate for a particular kind of work or social position)
  - Social identity (The set of behavioural or personal characteristics by which an individual is recognizable [and portrays] as a member of a social group)
  - Identity (An individual’s sense of self in social/professional settings defined by a) a set of physical and psychological characteristics that is not always shared with any other person and b) a range of social and interpersonal affiliations [e.g., ethnicity] and social roles)
  - Professional boundaries (The bounds or limits relating to, or connected with a particular profession or calling)
  - Group identity (The set of behavioural or personal characteristics by which an individual is recognizable [and portrays] as a member of a group)
  - Leadership (areas of proficiency or competence in which an individual is recognised (and portrays) as being an ‘expert’)
  - Organisational commitment (An employee’s dedication to an organisation and wish to remain part of it. Organisational commitment is often described as having both an emotional or moral element and a more prudent element)
- Examples of relevant data
  - Statements relating to how nurses see themselves
  - Statements relating to the extent they view the behaviour as a characteristic/ feature/ meaningful aspect/ representative of their professional role
  - Statements relating to the extent their personal identity influences doing the behaviour
    - I do/don’t feel confident/able/capable/competent to do the behaviour
    - My [professional identity] impacts on how/whether I perform the behaviour
  - In the context of this study, professional role may relate to the extent that nurses feel that providing spiritual/existential care is part of their professional role. Personal identity may relate to nurse awareness of their own spirituality and the impact this has on providing spiritual/existential care.

#### 4: Beliefs about Capabilities (Self-efficacy) (Acceptance of the truth, reality, or validity about an ability, talent, or facility that a person can put to constructive use)
- This domain includes aspects such as:
  - Self-confidence (Self-assurance or trust in one’s own abilities, capabilities and judgment)
  - Perceived competence (An individual’s belief in his or her ability to learn and execute skills)
  - Self-efficacy (An individual’s capacity to act effectively to bring about desired results, as perceived by the individual)
  - Perceived behavioural control (An individual’s perception of the ease or difficulty of performing the behaviour of interest)
  - *Self-esteem (The degree to which the qualities and characteristics contained in one’s self-concept are perceived to be positive)
  - *Empowerment (The promotion of the skills, knowledge and confidence necessary to take great control of one’s life as in certain educational or social schemes; the delegation of increased decision-making powers to individuals or groups in a society or organisation)
  - *Professional confidence (An individual’s belief in his or her repertoire of skills, and ability especially as it is applied to a task or set of tasks)
  - *Examples expressing optimism/pessimism of effectively providing spiritual/existential care
  - o I feel optimistic/pessimistic about my attempts to help patients
  - o I’m known around here as someone who’s optimistic about things
- Examples of relevant data
  - Evaluative statements of nurse confidence, judgements about their competence and control in their ability (or inability) to perform the behaviour
    - I do/don’t feel confident/able/capable/competent to do the behaviour
    - I find it difficult/easy etc to do the behaviour
    - I feel that I have/don’t have control in doing the behaviour
  - Statements relating to expectations of carrying out a behaviour due to beliefs of competency in performing the behaviour
    - I know [behaviour] will be/won’t be successful because I am/am not very efficient at that task
  - In the context of this study, beliefs about capabilities relates to nurses making evaluative judgments on their ability to do the behaviour, for example their confidence in being able to sensitively probe spiritual/existential distress with patients.

#### 5: Optimism (the confidence that things will happen for the best or that desired goals will be obtained)
- This domain includes aspects such as:
  - Optimism
- Examples of relevant data
  - Statements expressing optimism/pessimism of effectively providing spiritual/existential care
  - o I feel optimistic/pessimistic about my attempts to help patients
  - o I’m known around here as someone who’s optimistic about things
<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
<th>Examples</th>
</tr>
</thead>
</table>
| **6: Beliefs about Consequences** | (Anticipated outcomes/attitude) (Acceptance of the truth, reality, or validity about outcomes of a behaviour in a given situation). This domain includes aspects such as: | - Statements relating to nurse’s beliefs/views etc on the outcome/consequences of doing/not doing the behaviour
- Statements can include positive or negative consequences of doing/not doing the behaviour
- Statements can include consequences of doing/not doing the behaviour on themselves or their patients
- If I do/don’t do the behaviour, x,y,z will happen
- Doing the behaviour will have a beneficial/adverse impact on me/my patient
In the context of this study, beliefs about consequences could relate to nurse’s beliefs that doing the behaviour will result in negative reactions from patients. Also willingness to perform the behaviour based on expectations of outcomes (e.g. spiritual care is pointless if the patient also has dementia, etc) |

| **7: Reinforcement** | (Increasing the probability of a response by arranging a dependent relationship, or contingency, between the response and a given stimulus. A process in which the frequency of a response is increased by a dependent relationship or contingency with a stimulus). This domain includes aspects such as: | - Statements relating to doing the behaviour being directly contingent on receiving rewards or punishments
- I do/don’t do x, y, z because otherwise x, y, z will/will not happen
- Getting praise/thanked etc for doing the behaviour encourages me to do it
- I do the behaviour because I will be in trouble/get told off/be reported/get reprimanded etc if I don’t
- In the context of this study, reinforcement could relate to doing behaviours to avoid litigation and complaints from patient’s family, or to obtain rewards such as personal satisfaction/patient satisfaction rewards etc. |

| **8: Intentions** | (A conscious decision to perform a behaviour or a resolve to act in a certain way)). This domain may include: | - Statements relating to nurse’s resolve/to the extent they plan to perform the behaviour
  - o I plan to/set out to/aim to/am determined to/want to/don’t want to do the behaviour
  - o In the context of this study, intentions may be a nurse stating how she aims to always discuss spiritual issues when she sees a patient in distress or conversely weak intentions may be a lack of intention to discuss such issues (e.g. I don’t always make a point to discuss it) |

| **9: Goals** | (Mental representations of outcomes or end states that an individual wants to achieve) | - Statements relating to the nurses goals/aims/desired end result of doing the behaviour
- Statements relating to other goals which may interfere with doing the behaviour
- Statements relating to how prioritising goals influences whether or not to do the behaviour
  - o Competing priorities mean I do/don’t do the behaviour
  - o I do/don’t do the behaviour as it will/won’t meet my main goals
  - o I prioritise other behaviours which are more important
- Statements relating to nurses resolve/to the extent they plan to perform the behaviour
  - o I plan to/set out to/aim to/am determined to/want to/don’t want to do the behaviour
In the context of this study, nurses’ goals may relate to wanting to support patients during the journey of resolving existential issues to improve their health, their family’s health, to make their job easier etc. (Intentions – things I want to do; Goals – things I want to achieve) |

| **10: Memory Attention and Decision Processes** | (The ability to retain information, focus selectively on aspects of the environment and choose between two or more alternatives) | - Statements relating to time/situations etc when nurses would remember or forget to do the behaviour
- Statements relating to relying on cognitive approaches to perform the behaviour/make a quick decision |

| | This domain includes aspects such as: Memory (The ability to retain information or a representation of a past experience, based on the mental processes of learning or encoding retention across some interval of time, and retrieval or reactivation of the memory; specific | |

| | - Unrealistic optimism (The inert tendency for humans to over-rate their own abilities and chances of positive outcomes compared to those of other people); Identity (how individuals perceive or define themselves in a situation as being optimistic/pessimistic) | |

<p>| | - Pessimism (The expectation that things will go wrong and that people’s wishes or aims are unlikely to be fulfilled) | |</p>
<table>
<thead>
<tr>
<th>Information of a specific past</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Attention (A state of awareness in which the senses are focussed selectively on aspects of the environment and the central nervous system is in a state of readiness to respond to stimuli)</td>
</tr>
<tr>
<td>• Attention control (The extent to which a person can concentrate on relevant cues and ignore all irrelevant cues in a given situation)</td>
</tr>
<tr>
<td>• Decision making (The cognitive process of choosing between two or more alternatives, ranging from the relatively clear cut to the complex)</td>
</tr>
<tr>
<td>• Cognitive overload / tiredness (The situation in which the demands placed on a person by mental work are greater than a person's mental abilities)</td>
</tr>
<tr>
<td>• Statements relating to cognitive limitations such as forgetting/overseeing/not being able to make the decision</td>
</tr>
<tr>
<td>• We have to discuss so many issues that I forget to do the behaviour</td>
</tr>
<tr>
<td>• There are so many problems with doing the behaviour that I can't decide/feel overwhelmed/don't know where to start</td>
</tr>
<tr>
<td>• I don't do the behaviour because I can't make the decision in the pressure of the situation and competing demands/feel too tired at the end of the day to concentrate to make the right decision</td>
</tr>
</tbody>
</table>

In the context of this study memory, attention and decision processes may relate to the nurses' ability to remember to discuss spiritual/existential issues at specific times, or due to the complexity of the issue not knowing where to start, or due to having to discuss many difficult topics. They feel overwhelmed and find it difficult to make the decision on how much information or the priority of information to give.

<table>
<thead>
<tr>
<th>11: Environmental Context and Resources (Any circumstance of a person's situation or environment that discourages or encourages the development of skills and abilities, independence, social competence, and adaptive behaviour)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• This domain includes aspects such as: Environmental stressors (External factors in the environment that cause stress)</td>
</tr>
<tr>
<td>• Resources / material resources (availability and management) (Commodities and human resources used in enacting a behaviour)</td>
</tr>
<tr>
<td>• Organisational culture/climate (A distinctive pattern of thought and behaviour shared by members of the same organisation and reflected in their language, values, attitudes, beliefs and customs)</td>
</tr>
<tr>
<td>• Salient events / critical Incidents (Occurrences that one judges to be distinctive, prominent or otherwise significant)</td>
</tr>
<tr>
<td>• Person x environment interaction (Interplay between the individual and their surroundings)</td>
</tr>
<tr>
<td>• Barriers and facilitators (In psychological contexts barriers/facilitators are mental, emotional or behavioural limitations/strengths in individuals or groups)</td>
</tr>
<tr>
<td>• Statements expressing the influence of others on doing the behaviour (social support, group norms etc)</td>
</tr>
<tr>
<td>o I do/don't do the behaviour because others condone/support/advocate/ disapprove/dictate/ demand it</td>
</tr>
</tbody>
</table>

In the context of this study, others may include individuals or groups of peers, other healthcare professional groups, management/authoritative organisations etc. Additionally, when nurses state that patients' experiences influence their own behaviour this would be a social influence (e.g. when nurses state that they learn about spirituality from patients).

<table>
<thead>
<tr>
<th>12: Social Influences (Those interpersonal processes that can cause individuals to change their thoughts, feelings, or behaviours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Social pressure (The exertion of influence on a person or group by another person or group)</td>
</tr>
<tr>
<td>• Social norms (Socially determined consensual standards that indicate a) what behaviours are considered typical in a given context and b) what behaviours are considered proper in the context)</td>
</tr>
<tr>
<td>• Group conformity (The act of consciously maintaining a certain degree of similarity to those in your general social circles)</td>
</tr>
<tr>
<td>• Social comparisons (The process by which people evaluate their attitudes, abilities, or performance relative to others)</td>
</tr>
<tr>
<td>• Group norms (Any behaviour, belief, attitude or emotional reaction held to be correct or acceptable by a given group in society)</td>
</tr>
<tr>
<td>• Social support (The appreciation or provision of assistance or comfort to others, typically in order to help them cope with a variety of biological, psychological and social stressors. Support may arise from any interpersonal relationship in an individual's social network, involving friends, neighbours, religious institutions, colleagues, caregivers or support groups)</td>
</tr>
<tr>
<td>• Power/hierarchy (The capacity to influence others, even when they try to resist this influence)</td>
</tr>
<tr>
<td>• Intergroup conflict (Disagreement or confrontation between two or more groups and their members. This may involve physical violence, interpersonal discord, or psychological tension)</td>
</tr>
<tr>
<td>• Alienation ( Estrangement from one's social group; a deep seated sense of dissatisfaction with one's personal experiences that can be a source of lack of trust in one's social or physical environment or in oneself, the experience of separation between thoughts and feelings)</td>
</tr>
<tr>
<td>• Group identity (The set of behavioural or personal characteristics by which an individual is recognizable (and portrays) as a member of a group)</td>
</tr>
<tr>
<td>• Modelling (In developmental psychology the process in which one or more individuals or other entities serve as examples (models) that a child will copy)</td>
</tr>
<tr>
<td>• Leadership (The processes involved in leading others, including organising, directing, coordinating and motivating their efforts toward achievement of certain group or organisation goals)</td>
</tr>
<tr>
<td>• Statements expressing the influence of others on doing the behaviour (social support, group norms etc)</td>
</tr>
<tr>
<td>o I do/don't do the behaviour this because 'others' condone/support/advocate/ disapprove/dictate/ demand it</td>
</tr>
</tbody>
</table>

In the context of this study, others may include individuals or groups of peers, other healthcare professional groups, management/authoritative organisations etc. Additionally, when nurses state that patients' experiences influence their own behaviour this would be a social influence (e.g. when nurses state that they learn about spirituality from patients).

<table>
<thead>
<tr>
<th>13: Emotion (A complex reaction pattern, involving experiential, behavioural, and physiological elements, by which the individual attempts to deal with a personally significant matter or event)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Fear (An intense emotion aroused by the detection of imminent threat, involving an immediate alarm reaction that mobilises the organism by triggering a set of physiological changes)</td>
</tr>
<tr>
<td>• Anxiety (A mood state characterised by apprehension and somatic symptoms of tension in which an individual anticipates impending disaster)</td>
</tr>
<tr>
<td>• Statements expressing the influence of others on doing the behaviour (social support, group norms etc)</td>
</tr>
<tr>
<td>o I do/don't want to do the behaviour because it is embarrassing/upsetting/elating etc</td>
</tr>
</tbody>
</table>

An expression of their own personal emotional reaction/state to performing the behaviour

Expressing how their emotional reaction/state positively or negatively impacts on them doing the behaviour

I get embarrassed/ upset/ scared/ anxious/ stressed/ depressed/ uncomfortable/ happy/ elated/ relaxed/ pleased etc when doing the behaviour

I do/don't want to do the behaviour because it is embarrassing/ upsetting/ elating etc
- Affect (An experience or feeling of emotion, ranging from suffering to elation, from the simplest to the most complex sensations of feelings, and from the most normal to the most pathological emotional reactions)
- Stress (A state of physiological or psychological response to internal or external stressors)
- Depression (A mental state that presents with depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration)
- Positive / negative affect (The internal feeling/state that occurs when a goal has/has not been attained, a source of threat has/has not been avoided, or the individual is/is not satisfied with the present state of affairs)
- Burn-out (Physical, emotional or mental exhaustion, especially in one’s job or career, accompanied by decreased motivation, lowered performance and negative attitudes towards oneself and others)

| 14: Behavioural Regulation (Anything aimed at managing or changing objectively observed or measured actions) | Statements where nurses want feedback on their behaviour
| | Statements about processes in place/needed to monitor doing the behaviour
| | Statements about prompts/processes etc used or required to make the behaviour sustainable/routine/habit
| | Statements about using conscious effort to ensure the behaviour is carried out
| | • I plan in advance/make notes/use prompts so I don’t forget to do the behaviour

In the context of the this study, behavioural regulation may relate primarily to the need for/use of prompts relating to the behaviour such as having specific sections of patient notes that relate to the spiritual/existential aspects etc.

- I feel sympathy / empathy / sorry for the patient which makes me want to do the behaviour
In the context of this study, emotion relates to the emotional response of the nurse in relation to performing the behaviour, and not the emotional response of the patients to the behaviour (e.g. nurses being anxious about prying in personal spiritual matters, rather than patients getting upset by risks etc). Would include emotive response to performing a behaviour irrespective of competence in performing behaviour (e.g. apprehensive of conducting a spiritual assessment regardless of whether good or bad at doing the assessment)
**Supplementary Table 2. Illustrative data items, themes, and synthesized finding classified by TDF domain.**

Legend: + facilitator, - barrier, ± factor with non-specific direction, ≠ no relationship

<table>
<thead>
<tr>
<th>TDF DOMAIN</th>
<th>Synthesized findings relating to TDF domain</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Themes encompassed within this domain</td>
</tr>
<tr>
<td></td>
<td>Data items extracted from included studies illustrating theme</td>
</tr>
</tbody>
</table>

**TDF DOMAIN: KNOWLEDGE**

Synthesized finding: Three types of knowledge were frequently reported: knowing how to identify and assess spiritual/existential distress; knowledge of spiritual care and care practices, which ranged from general knowledge, such as the meaning of spiritual care, to specific elements, such as the timing of spiritual care; and knowledge related to issues of spirituality and death. Knowledge of oneself as a person also aided care.

**Theme: Knowledge of spiritual/existential care practices**
+ knowledge of care practice (Johansson 2011)
+ pastoral care knowledge (Pitroff 2013)
+ knowledge about timing of spiritual care (e.g., when to begin and stop) (Bailey 2009)
- uncertainty about meaning of spiritual care (Bush 2008)
- scarce knowledge of spiritual care (Kuuppelomaki 2001) and spiritual interventions (Kisvetrova 2013)

**Theme: Knowledge related to spiritual assessment and identification**
+ intuitive knowing when patient is experiencing spiritual distress (Walker 2017)
- not knowing what to ask or how to approach spiritual assessment (Belcher 2005)

**Theme: Knowledge regarding spirituality and death**
+ knowledge about life and death issues, and human existence (Arman 2007)
+ knowledge of dying process (Zerwekh 1993)
- lack of knowledge of different religious practices/beliefs and spirituality (Belcher 2005, Kuuppelomaki 2001)

**Theme: Self knowledge**
+ knowledge of oneself as a person and how to use one’s lived knowledge (Johansson 2011)

**TDF DOMAIN: SKILL**

Synthesized finding: Skills in spiritual assessment and identification, and in delivery of spiritual/existential care, acted as facilitators. Specific experience in spiritual care seems to act as facilitator, while general experience (i.e., work experience, nurse experience) was unrelated. Studies that reported training/education showed that training specifically in spiritual/existential care acted as a facilitator, but education qualifications and education level alone was not a facilitator. A randomized, controlled study examining the effect of a workshop on the care of terminally-ill patients (Kooper et al.) found that post-workshop general and specific knowledge, feelings of personal impact, and confidence in caring increased. Further research needs to be done on the effect of training in spiritual care.
reflection, and watching and learning from others, facilitates the provision of spiritual/existential care. All these skills relied on first having mastered technical nursing skills.

**Theme: Skills related to spiritual assessment and identification**
- ability to sense, recognize, observe patient need (Bailey 2009, Carroll 2001, Minton 2018)
- recognizing signs when patient wants to talk (Browall 2014) and to adapt quickly (Tornoe 2015)
- sense of timing, situational understanding, ability to tune in to patient verbal and non-verbal cues (Tornoe 2014)
- skill to identify spiritual need/distress from verbal, uncontrolled symptoms (Zerwekh 1993)
- skill to identify when distress has physical components (Walker 2017)
- inability to pick up patient spiritual needs, and identify spiritual anxiety (Kuuppelomaki 2001)
- mistake patient's spiritual concerns for physical concerns (Keall 2014), expect patient to manifest spiritual needs in a concrete, 'religious' way and to be literally reported by patient (Nixon 2013)

**Theme: Skills in delivery of spiritual/existential care**
- skills in verbal and non-verbal communication (e.g., being present, listening, meaningful conversation, asking the right questions, touch, right use of body language, holding patient's hand (Bailey 2009, Bush 2008, Keall 2014, Minton 2018, Wittenberg 2017, Zerwekh 1993)
- competent in: helping patient let go of attachments and life, anticipating dying process and providing guidance about dying, fostering reconciliation and integration of life experiences and beliefs, sharing mystical death experiences (Zerwekh 1993)
- skill in timing of intervention (Bailey 2009)
- ability to be non-judgemental (Pitroff 2013, Zerwekh 1993)
- skill of openness (Browall 2014)
- clinical skills/intuition about how far to go with patient (Keall 2014)
- a professional nurse chooses right time for spiritual conversations (van Meur 2018)
- scarce skills and competencies; (Bailey 2009, Keall 2014, Kuuppelomaki 2001)

**Theme: Experience**
- experience providing spiritual care (Bailey 2009, Tornoe 2014)
- experience in cancer nursing (Carroll 2001)
- frequent experience of caring for dying (Kociszewski 2004)
- years experience in palliative care nursing (Ronaldson 2012)
- years of experience (Keall 2014)
- work experience in years (Kisvetrova 2018)
- years work experience as nurse (Kuuppelomaki 2001, Taylor 1999) or hospice nurse (Johnson 2013)
- work experience (Kisvetrova 2013)
- frequency of patient care at the end of life (Kisvetrova 2016)
- no experience providing spiritual care (Nixon 2013)

**Theme: Training/education**
- training in spiritual assessment (Johnson 2013)
- palliative care education (Kisvetrova 2016)
- frequent participation in training seminars dealing with the care of terminally ill patients (Kuuppelomaki 2001) and continuing education in
spiritual care (Pitroff 2013)
+ extensive reading about care of terminally ill (Kuuppelomaki 2001), Harrington 1995)
+ then ≠, training in care of patients’ feeling meaninglessness has a significant effect on short-term practice, but returned to baseline after nine months (Morita 2009)
≠ qualifications (Ronaldson 2012)
≠ education level (Kisvetrova 2018, Taylor 1999)

Theme: Self-reflection
+ self-reflection, reflective practice (Vosit 2010)

Theme: Learning from others
+ watching and learning from chaplains (Bone 2018), or being mentored by chaplains (Pitroff 2013)
+ learning from patients (Highfield 2000, Kociszewsk 2004)
+ witnessing forgiveness interactions between patient and family (Ferrell 2014)

Theme: Basic nursing skills
+ mastered the technical stuff and can take extra step (Kociszewski 2004)

TDF DOMAIN: SOCIAL OR PROFESSIONAL ROLE AND IDENTITY

Synthesized finding: An acceptance that spiritual assessment and care was part of the nurse role acts as a facilitator, and vice versa. Some studies reported sub-components of the spiritual care role and what it includes (such as showing ensuring the family is present at death) and excludes (such as not needing to fix patient feelings). Role conflict (e.g., when discord arises between personal beliefs and patient request) and erosion of patient-nurse boundaries (e.g., when nurse identifies too closely with the patient) discomfit spiritual/existential care, while work commitment aids such care.

Theme: Spiritual care in nursing role content
+ professional obligation to support patient sources of faith (Tornoe 2014)
- spiritual care is someone else's role (Kisvetrova 2013) e.g., chaplain (Kristeller 1999, Nixon 2013)

Theme: Sub-components of spiritual care role
+ showing compassion (Bone 2018)
+ part of role is to ensure family presence at death (Zerwekh 1993)
+ need to change roles for each unique patient situation (Johansson 2011)
+ nurses function as emotional containers when patients vent thoughts/feeling (Tornoe 2015)
+ accept no need to "do things" to the patient (Walker 2017) but be there (Kociszewski 2004)
+ accept it's not nurse's job to fix feelings, just accept how patient feels (Minton 2018)
- as nurses want to fix things, hard to accept not always possible (Tornoe 2015)
**Theme: Role conflict**
- conflict between personal and professional spirituality (Belcher 2005)
- conflict between personal beliefs and patient requests (Belcher 2005)
- confusion between proselytizing and delivery of spiritual care (Ronaldson 2012)

**Theme: Patient-nurse boundaries**
- boundaries blurred when patient has children same age (Browall 2014) or nurse identifies with patient (e.g., both have babies) (Tornoe 2015)
  ± need closeness but not too close (Johansson 2011)

**Theme: Work commitment**
  + love this work (Bailey 2009)

**TDF DOMAIN: BELIEF ABOUT CAPABILITIES**
Synthesized finding: Feeling confident and comfortable in providing spiritual/existential care was a facilitator, and vice versa. Studies reported that a specific personal facility that aided spiritual/existential care was personal courage to face daunting situations, such as encountering vulnerability in a patient, and to be emotionally intimate with a patient. Maturity and life experiences (such as personal experience of loss) generally facilitated the provision of spiritual/existential care, however, personal experience could interfere with spiritual/existential care, when personal self-disclosure superseded awareness of client needs. Studies generally reported that nurses’ resolution of their own existential issues and tending to their own spirituality to be facilitators, but there were exceptions. Nurse religiosity and age had mixed effects, while gender and non-English background had no influence.

**Theme: General capabilities**
  + comfortable/confident providing spiritual care (Belcher 2005, Keall 2014)
  + accept/know limits of expertise and ready to work with other team members (Keall 2014, Pitroff 2013)
  - experience powerlessness, uncertainty, insufficiency, inadequacy in some situations (Browall 2014, Kuuppelomaki 2001) such as when can't cure patient (Guedes 2013), or relieve suffering (Karlsson 2017)

**Theme: Courage**
  + personal courage (Tornoe 2014, Tornoe 2015)
  + courage to encounter vulnerability, suffering, death in patient (Arman 2007)
  + courage to enter into sacred space of patient (Minton 2018)
  + courage to be emotionally intimate (Browall 2014)
  + courage as caregiver and human being (Karlsson 2017)
  + courage to ask difficult questions and hear difficult answers and hear patient fears (Zerwekh 1993)
  - lack of courage (Kuuppelomaki 2001)

**Theme: Life experiences**
  + life experiences (Carrol 200, Pitroff 2013, Tornoe 2014, Tornoe 2015)
  + variety of experiences in life (Harrington 1995)
  + maturity (Tornoe 2015)
Theme: Reflection/acceptance of one's own existential issues
+ reflection on own existence/death (Johansson 2011)
+ comfortable with own feelings of death and dying (Kociszewsk 2004)
+ come to terms with own vulnerability (Tornoe 2015)
+ able to encounter vulnerability, suffering, death in oneself (Arman 2007)
≠ beliefs about death, death avoidance, death as better life, death as escape (Kisvetrova 2016)

Theme: Nurse's own spirituality/belief system
- neglect of own spirituality (Ronaldson 2012)
- spirituality not important to nurse (Harrington 1995)
≠ spirituality (Johnson 2013)
+ for palliative care nurses, extent to which they consider that spirituality has an impact on their life and their engagement in interactions or activities that are spiritually related (Ronaldson 2012)
± own beliefs about death/dying (Karlsson 2017)
≠ for acute care nurses, extent to which they consider that spirituality has an impact on their life and their engagement in interactions or activities that are spiritually related (Ronaldson 2012)
± personal beliefs (Tornoe 2014)

Theme: Participation/identification with faith tradition
+ importance of religious values (Kuuppelomaki 2001, Pitroff 2013)
+ participation in faith community (Pitroff 2013)
- lack of belief in God (Belcher 2005, Kisvetrova 2013)
- nurse religiosity (Kisvetrova 2013, Kuuppelomaki 2001)
- absence of religious convictions (Kuuppelomaki 2001)
≠ religiosity (Johnson 2013)

Theme: Nurse demographics
+ age (Taylor 1999, Tornoe 2015)
≠ gender (Ronaldson 2012),
≠ English-speaking background (Ronaldson 2012)

TDF DOMAIN: BELIEFS ABOUT CONSEQUENCES
Synthesized finding: Some studies reported patient wellbeing as a consequence of spiritual/existential care, but other studies reported the reverse. Several studies reported beliefs in the positive consequences of specific nurse actions on patients, such as engaging in conversation or eye contact, but some studies reported negative consequences if patients viewed nurse actions as undesired/unhelpful. Spiritual conversations that are perceived
by nurses as taking too much time impede spiritual/existential care.

**Theme: Consequences of general spiritual care and assessment on patient**
+ spiritual care leads patient health & wellbeing  (Bush 2008, Kale 2011)
+ spiritual assessment is important for patient (Johnson 2013)
+ spiritual care brings patients relaxation, comfort (Abu-El-Noor 2016, Bailey 2009)
+ patient sometimes needed a push to embrace life (Tornoe 2014)
- dilemma involving giving patient hope versus being realistic and honest with patient (Browall 2014)
- relieving suffering extends time for suffering (Guedes 2013)
- spiritual support does not help patient (Nixon 2013)
- not accept patient's death as natural (Guedes 2013)

**Theme: Consequences of specific nurse actions on patients**
+ patient talking may help patient in their search (Harrington 1995)
+ beneficial effects of nurse actions on patient e.g., eye contact  (Arman 2007)
+ beliefs about effects of touch, presence, communication (Walker 2017)
+ prayer is used as it suits patient of all faiths (Kale 2011)
+ engaging in conversation important to provide patient spiritual/existential care (Tornoe 2015) and quality care (Wittenberg 2017)
+ sharing silence has consoling effect, and helps patients talk (Tornoe 2014)
+ alleviating physical pain a prerequisite to spiritual/existential care (Tornoe 2014)
- spiritual questions are potentially intrusive (Johnson 2013, Tornoe 2014) and off-putting to patient if done in checklist fashion (Walker 2017)
- spiritual conversations might be stressful for patient or unwanted by patient (van Meur 2018)

**Theme: Consequences of care work on nurse**
- spiritual conversations take a long time (van Meur 2018)

**TDF DOMAIN: REINFORCEMENT**

Synthesized finding: Positive personal feelings, meaningful work, and satisfaction at being part of a patient's life, facilitated the provision of spiritual/existential care. However, feeling inadequate, and needing to see good results of care work acted as barriers.

**Theme: Positive reinforcers**
+ rewarding to be part of patient's life (Minton 2018), feel honoured and privileged to be part of end of life (Pitroff 2013)
+ feel honoured when patients choose to confide in them (Tornoe 2015)
+ feel good about themselves, doing something useful for patients  (Abu-El-Noor 2016)
+ giving love means receiving love (Bush 2008)
+ derive a sense of fulfilment, confirmation, personal benefit and work satisfaction (Johansson 2011)
+ witnessing a good, peaceful, harmonious death is rewarding and fulfilling (Tornoe 2015)
+ work is deeply meaningful and rewarding (Tornoe 2014)

**Theme: Negative re-inforcers**
- when nurses need to see good results of their work (Tornoe 2015)
Synthesized finding: A variety of goals/intentions influenced nurse spiritual/existential care behavior. These goals varied in their target (whether for patient, relationship, self, or task). Patient-oriented goals varied from general goals of patient care, such as providing the best care for patients, to more specific outcomes for the patient, such as for the patient to feel comfortable and cared for. Almost all of these goals facilitated the provision of spiritual/existential care, except for the goal of helping patient recover from illness, which impeded spiritual/existential care. Relationship goals (i.e., that promote a trusting and secure connection with the patient to help the patient share) and empathy goals (i.e., that enhance understanding/feeling of what the patient is experiencing) facilitated spiritual/existential care. Nurse-oriented goals include conduct goals and self-benefit goals. Conduct goals refer to the demeanor or manner that nurses tried to enact during an encounter, such as attempting to be in the 'here and now', and asking about worries at each visit. Self-benefit goals refer to states of being that nurses desired to achieve, such as striving for completeness or being myself. Most of these types of goals facilitated spiritual/existential care. The prioritisation of spiritual/existential care above other activities facilitated the provision of spiritual/existential care, and vice versa. Goals associated with colleagues included an intention to use the expertise of team members and chaplain if necessary. Underscoring these goals, was a recognition that goals should be achievable to facilitate caring.

**Theme: General goals of patient care**
- importance for patient to have a good end to life experience (Bone 2018, Johansson 2011)
- aim to provide best care for patients (Johansson 2011)
- aim to treat 'whole person' (Keall 2014)
- patient wellbeing (Naden 2009)
- bring peace to patient (Carroll 2001, Tornoe 2015, Yingting 2018)
- help patient make most of final days (Tornoe 2014)
- help patient and improve health (Abu 2016)
- to brace the patient (Minton 2018)
- help patient acquire balance, help alleviate patient suffering (Naden 2009)
- preserve patient dignity (Naden 2009)
- help patient achieve tranquility (Tornoe 2015)
- strive to help patients accept death, settle their practical affairs and achieve reconciliation with their past, their loved ones, and with God (Tornoe 2015)
- encourage family members to talk with each other (Tornoe 2015)
- want patient to feel comfortable and cared for (Kociolewski 2004) and not alone (Arman 2007)
- aim to get patient to share concerns while respecting autonomy (Tornoe 2014) and to talk (Harrington 1995)
- to respect patients' need to contemplate and have space alone with thoughts (Browall 2014)
- to help patient recover from illness (Guessed 2013)
- unwilling to support or respond to spiritual/existential/religious need (Kuuppelomaki 2001, Tornoe 2015)

**Theme: Relationship goals**
- aim to create sense of communion and security with patient (Karlsson 2017)
- need to establish trusting relationship with patient (Tornoe 2015)
- aim to fully participate in the encounter and enter patient's personal space (Arman 2007, Minton 2018)
- desire for a sense of deep connection with patient (Minton 2018)
Theme: Empathy goals
+ willingness to listen (Zerwekh 1993) and be open and present for whatever patient wanted to share (Wittenberg 2017)
+ to respect the way patient sees things (Harrington 1995)
+ to put oneself in patient shoes (Browall 2014)
+ desire to understand and respect patient thoughts, feeling, self-evaluations (Carroll 2001) and spiritual beliefs (Walker 2017) and wishes/preferences (Naden 2009)

Theme: Self-oriented goals
+ to respect the way patient sees things (Harrington 1995)
+ to put oneself in patient shoes (Browall 2014)
+ desire to understand and respect patient thoughts, feeling, self-evaluations (Carroll 2001) and spiritual beliefs (Walker 2017) and wishes/preferences (Naden 2009)
+ strive for completeness (i.e. feeling they've done all they can and feel satisfied with work) (Johansson 2011)
+ try to be myself (Harrington 1995)
+ want to care for and be responsible for patient (Karlsson 2017)
- to stay away from distressed patient for self-protection (Fay 2019)
- try to avoid potential anxiety about their own suffering/dying (Tornoe 2015)

Theme: Task priorities
+ to respect the way patient sees things (Harrington 1995)
+ to put oneself in patient shoes (Browall 2014)
+ desire to understand and respect patient thoughts, feeling, self-evaluations (Carroll 2001) and spiritual beliefs (Walker 2017) and wishes/preferences (Naden 2009)
+ to respect the way patient sees things (Harrington 1995)
+ to put oneself in patient shoes (Browall 2014)
+ desire to understand and respect patient thoughts, feeling, self-evaluations (Carroll 2001) and spiritual beliefs (Walker 2017) and wishes/preferences (Naden 2009)
+ strive for completeness (i.e. feeling they've done all they can and feel satisfied with work) (Johansson 2011)
+ try to be myself (Harrington 1995)
+ want to care for and be responsible for patient (Karlsson 2017)
- to stay away from distressed patient for self-protection (Fay 2019)
- try to avoid potential anxiety about their own suffering/dying (Tornoe 2015)

Theme: Goals related to colleagues
+ recognises and utilises expertise of team members (e.g., chaplain) (Pitroff 2013)
+ commitment to refer to chaplain if nurse is not spiritual (Zerwekh 1993)

Theme: Goal features
+ limit goals to what is achievable (Zerwekh 1993)

TDF DOMAIN: MEMORY ATTENTION AND DECISION-PROCESSES

Synthesized finding: Spiritual/existential care requires nurses to make conscious effort to focus attention on patients needs while being aware of their own mental condition. Barriers to care occur when other priorities deflect nurse attention, such as completing workload or filling in checklists.

Theme: Conscious focus on patient
+ attention to patient spoken and unspoken signals (Naden 2009, Zerwekh 1993) and to patient distress (Tornoe 2014)
+ try to keep in mind that patient needs help, when the patient is being difficult (Browall 2014)
+ view the patient as a physical, social, psychological, spiritual, complete human being (Naden 2009)
+ stop and think that patient and families are experiencing existential distress (Tornoe 2015)

Theme: Consciousness of self
+ being conscious of oneself and not confusing nurse's own wishes/concerns with patient wishes/concerns (Naden 2009)
+ constant awareness of difference between self-serving commentary (self-disclosure of personal loss and beliefs) and communication that meets


- attempt to be in the 'here and now' (Arman 2007)
- need mental shift from "doing for" patient to "being with patient" (Tornoe 2014)
± frame of mind affected by personal situations affects dealings with patient (van Meur 2018)

**Theme: Attention defectors**
- full attention needed to complete checklists for which they are accountable makes it hard to hear patient spiritual communication (van Meur 2018)
- attention focused primarily on physical care, ignore spiritual care (Bush 2008)

**TDF DOMAIN: ENVIRONMENTAL CONTEXT AND RESOURCES**

Synthesized finding: Several studies referred to staffing issues: low staff: patient ratio was a reported as a barrier to spiritual/existential care; but the availability of spiritual care providers seems to have mixed effects. Several studies referred to aspects of time: lack of time generally, or time with patient, or time for learning, acted as barriers. The care setting and organisational priorities influence spiritual/existential care behaviors. For example, a hospice setting, and organisations that make spiritual care a priority, are reported to facilitate spiritual/existential care more than other settings. Facilities with specially decorated rooms and ward designs that allow privacy aid the provision of spiritual/existential care. The use of care tools seems to have mixed effects. Ethnic culture influenced the type of religious rituals nurses used to help patients, but not not whether they encouraged patients to speak about dying.

**Theme: Time-related aspects**

*Temporal demand*
+ time availability (Browall 2014, Fay 2019)
≠ time (Kisvetrova 2016)
- low staff-patient ratio (Bailey 2009, Kisvetrova 2016, Tornoe 2015)
- many who need help at same time (Karlsson 2017)
- spend more time administering treatment due to medical advances (Tornoe 2014)

*Duration of time that patient is in unit*
+ The average length of stay of dying patient in the ICU (Guedes 2013, Kisvetrova 2016)
- short-term stay (Belcher 2005)
- patient referred too late to palliative care (Keall 2014)

*Duration of time with individual patient*
+ time to be with patient (Bailey 2009, Browall 2014, Walker 2017)
± limited time with patient (Karlsson 2017)
+ continuity of care (Keall 2014, van Meur 2018), including involvement with admission (Keall 2014)
- unable to spend as much time as like with patient (Bone 2018)

*Timing of care*
- frequent interruptions (Kuuppelomaki 2001, Tornoe 2015)
- unpredictability of suffering (Tornoe 2014)
- caring for acute & pall patient simultaneously (Kale 2011)
- untimely networking with different religious leaders (Kale 2011)

*For learning*
- lack of time for self-reflection (Kale 2011)

**Theme: Availability of spiritual care providers**
+ chaplain availability (Kristeller 1999)
+ where chaplain limited (Minton 2018)
± chaplain unavailable, so I have to do it (Bone 2018)
- lack of availability of chaplain (Kuuppelomaki 2001)
- lack of after-hours specialist providers (Walker 2017)

**Theme: Care setting**
+ hospice setting (Belcher 2005, Harrington 1995)
+ working in hospice vs intensive, acute or long-term department (Kisvetrova 2018)
+ hospice vs long-term care, oncology, geriatrics, home for elderly, home care (Kisvetrova 2013)
+ hospice vs oncology setting (Taylor 1999)
+ large health centres (Kuuppelomaki 2001)
+ home setting (Minton 2018)
+ nurses in office settings (Kristeller 1999)
+ palliative care vs acute care (Ronaldson2012)
- acute care (Harrington 1995)
- neuro-surgical setting (Nixon 2013)

**Theme: Organisational priorities**
+ organisation prioritises/supports spiritual care (Belcher 2005, Walker 2017)
+ organisation supports spiritual care (Taylor 1999)
+ health centres that focused on raising care standards (Kuuppelomaki 2001)

**Theme: Facility/amenities**
+ specially decorated rooms enhance calmness, harmony, rest, security (Johansson 2011)
+ privacy (Minton 2018, Yingting2018)
+ quiet room for eol patient (Yingting 2018)
- poor radios can't pick up spiritual programs (Kuuppelomaki 2001)
- unit not geared to offer spiritual support (Kisvetrova 2013)

**Theme: Care tools**
- no tool for spiritual assessment (Belcher 2005)
± documentation of spiritual care conversations (Keall 2014)
+ documentation of spiritual care (Walker 2017)

**Theme: Ethnic culture**
± ethnic culture is related to use of Jesus- vs Hindi-focused religious rituals (Doorenbos 2006)
≠ ethnic culture re urging patient to speak about dying (Doorenbos 2006)

**TDF DOMAIN: SOCIAL INFLUENCE-PATIENT**

Synthesized finding: Nurses use the patient's diagnosis and prognosis (whether terminal or short prognosis) as one indication of spiritual/existential need. Nurses also use other cues, such as patient's verbal and non-verbal behavior and emotions. Nurses assess the patient's openness to spiritual/existential help by their willingness to communicate regarding spiritual/existential matters (e.g., the patient asking the nurse about her beliefs). Sometimes, though spiritual needs are difficult to detect and isolate, especially when the patient is unable to communicate. The patient's unique beliefs and worldviews, and their social situation (i.e., family relationships and wider network) are other cues that influence how nurses provide spiritual/existential care. A patient who is too demanding, by having too many needs to meet for example, obstructs the provision of spiritual/existential care. Several studies reported that a trusting nurse-patient relationship and nurse-patient affinity facilitate spiritual/existential care. Whether nurses and patients shared beliefs had mixed effects on care delivery. Holding to the social norm that religion is a private matter for the individual impeded the provision of spiritual/existential care.

**Theme: Patient diagnosis/prognosis**
+ terminal illness diagnosis (Abu-El-Noor 2016, Belcher 2005)
+ short prognosis (Fay 2019, Kociszewsk 2004, Kristeller 1999)
- patient in terminal stages (Fay 2019)

**Theme: Patient demographics**
+ patient proneness to existential distress e.g., young mothers (Fay 2019)
≠ patient gender (Kristeller 1999)

**Theme: Patient's cues of distress and spiritual needs**
± how patient manifests distress (Ferrell 2014)
+ patient behavior and utterances and indicators (Belcher 2005, Carroll 2001, Johnson 2013)
+ patient verbal cues regarding spiritual needs (Abu-El-Noor 2016, Bailey 2009, Nixon 2013) e.g., ask to see clergy (Harrington 1995), never-ending requests for medication (Tornoe 2014)
+ patient non-verbal behavior cues regarding spiritual needs (Abu-El-Noor 2016, Nixon 2013)
+ patient emotion cues regarding spiritual needs (Karlsson 2017, Nixon 2013)
+ patient's admission notes regarding spiritual needs (Nixon 2013)
+ seeing patient in physical suffering (Karlsson 2017)
± patient physical and mental condition (Tornoe 2015)
± patient acceptance/fear of death (Walker 2017)
- when patient distress difficult to detect/isolate (Browall 2014, Carroll 2001; Kuuppelomaki 2001, Nixon 2013)
- witnessing significant bodily changes (Johansson 2011)

**Theme: Patient openness and ability to communicate needs**
+ patient openness (Browall 2014, Keall 2014)
+ patient chooses when to talk (Carroll 2001)
+ patient 'permits' nurse to talk about spiritual/existential questions (Belcher 2005, Tornoe 2015)
+ patient ask about nurse beliefs (Ellington 2015)
- patient unable (Kuuppelomaki 2001) or unwilling to express spiritual or religious needs (Kuuppelomaki 2001, Tornoe 2015)
+ patient ability to communicate verbally & nonverbally (Belcher 2005, Tornoe 2015, Zerwekh 1993)
+ gauge patient energy to talk, and willingness to talk (Tornoe 2014)
± some patients want to share, others don't (Carroll 2001)
- patient has tribal dialect (Kale 2011)
- patient blocks provision of spiritual care (Belcher 2005)

**Theme: Patient unique needs and beliefs**
+ adapt to patient needs (Harrington 2006), Tornoe 2014, Yingting 2018)
+ spiritual care tailored to patient's belief/meaning system(Walker 2017, Yingting 2018)
+ patient religiosity (Abu-El-Noor 2016)
± nurse perceptions of which activities the patient will accept (Belcher 2005)
± each patient is unique so use of spirituality tools only a guideline (Bailey 2009)
± patient beliefs (Ellington 2015, Harrington 1995), values and culture (Harrington 1995)
± spiritual, religious and existential beliefs (Tornoe 2015), e.g., if religious, chaplain called (Carroll 2001)
± patient personality (van Meur 2018)
- patient are non-believers (Kisvetrova 2013)
- nurse ignorance of patient religious convictions (Kuuppelomaki 2001)
- patient had traditional indigenous beliefs or tribal dialect, or searches for alternative spiritual explanations (Kale 2011)

**Theme: Patient's social situation**
± patient-family relationship quality (Ferrell 2014)
± patients’ family situation, social network (Tornoe 2015)
± family atmosphere around patient (Tornoe 2014)
- when patient and family have different acceptance levels of death (Browall 2014)
- lack of reconciliation between patient and family (Karlsson 2017)
- differences between patient and family religious convictions (Kuuppelomaki 2001)

**Theme: Patient too demanding**
- unreasonably demanding patient (Browall 2014) or bothersome (van Meur 2018)
- challenging patient situation (Belcher 2005)
- patient has too many physical, psychological and spiritual needs to meet (Nixon 2013)

**Theme: Nurse-patient relationship**
+ nurse has deep involvement/engagement with patient (Johansson 2011, Karlsson 2017, Minton 2018)
+ patient starts conversation with certain nurses (van Meur 2018)
+ nurse experiences affinity with patient (Browall 2014)
± depends on nurse-patient relationship (Harrington 1995) and connectedness (Bush 2008)
- not all patients want support from nurse (Kuuppelomaki 2001)
Theme: Nurse-patient homophily
+ patient-nurse share beliefs (Carroll 2001)
+ same age (Carroll 2001)
≠ patient-nurse different beliefs (Wittenberg 2017)
- difference between patient-nurse spirituality (Keall 2014, Ronaldson 2012)

Theme: Nurse-perceived norms regarding care of patient
+ patient needs more important than nurse needs (Harrington 2006)
± how a nurse should relate to patient's spirituality (Taylor 1999)
- support can only be provided if patient requests (Kuuppelomaki 2001)
- religion is a taboo subject and/or private matter (Kisvetrova 2013, Kuuppelomaki 2001, Tornoe 2015)

TDF DOMAIN: SOCIAL INFLUENCE: OTHER THAN PATIENT
Synthesized finding: Support from colleagues, especially pastoral care and personal social network, and the quality of the relationship with the patient's family were factors that influenced the provision of spiritual/existential care. Holding to the social norm that religion is a private matter for the individual impeded the provision of spiritual/existential care.

Theme: Relationship/collaboration with colleagues
+ interdisciplinary collaboration (Vosit 2010)
+ good relationship with pastoral care (Belcher 2005, Pitroff 2013)
± when chaplain with me, I don't feel guilty about having other things to do (Bone 2018)
- criticism from peers (Ronaldson 2012)

Theme: Nurse relationship with patients' family
+ bond with family (Minton 2018)
+ partnership and trust between nurses and families (Vosit 2010)
- challenging family situation (Belcher 2005)
- patient family blocks provision of spiritual care, questions nurse beliefs (Belcher 2005)
- patient family throw anger/frustration at nurse (Tornoe 2015)

Theme: Relationship with nurse personal social network
+ nurses' connection with family, friends (Bush 2008)

TDF DOMAIN: EMOTIONS
Synthesized finding: Nurses experienced a range of emotions that influenced their practice. While positive emotions facilitate spiritual/existential care, a range of negative emotions (e.g., anxiety, frustration, pain, sadness, fear, emotionally draining) act as barriers to care.
Theme: Positive emotions
+ feels great to share a patient's life (Johansson 2011)

Theme: Negative emotions
± feeling suffering, pain (Walker 2017)
- feeling agonised/anxious/weary when patient is young, when patient desires death, patient perceives injustice, patient convinced they're going to live (Browall 2014)
- frustration when nurse can't help (Fay 2019), when patient dies (Guedes 2013)
- painful caring for patient with no chance of living (Guedes 2013)
- sadness (Ferrell 2014)
- fear that I can't handle what comes out (Keall 2014)
- fear of witnessing death (Guedes 2013), that you may make a bad situation worse (Keall 2014)
- feel helpless and inadequate when can't console patient (Tornoe 2015)
- emotionally draining (Tornoe 2014, Tornoe 2015)
- feel helpless and vulnerable (Tornoe 2014)

TDF DOMAIN: BEHAVIORAL SELF-REGULATION
Synthesized finding: Nurses need to prepare emotionally, spiritually and mentally for an encounter with a patient; and during the encounter, they try to regulate their verbal and non-verbal body language to convey care

Theme: Preparation before the encounter:
+ prepare before difficult encounters (Naden 2009)
+ self-preparation (e.g., praying for wisdom) (Minton 2018)
+ personal grounding: deliberate work to replenish personal energy, maintain emotional wellbeing, healthy grieving, put aside personal agendas (Zerwekh 1993)
+ preparedness to conduct spiritual assessment (Johnson 2013) and discuss spiritual needs (Kuuppelomaki 2001)

Theme: Behavior during encounter
+ regulate own body language (Keall 2014)
+ manners and humbled relational stance of (i.e. humbling self, respecting other; subject-subject stance rather than subject-object distancing prevalent in healthcare) (Pitroff 2013)
+ ask about worries at each visit (Minton 2018)
+ be open, honest, caring, respectful, compassion (Keall 2014)
+ don't push them or rush them (Minton 2018)
+ actions guided by wanting to show genuine desire to care and love patient (Walker 2017)
± manage touch and tone during physical care (Tornoe 2014)
+ trying to be perceptive and emphasise patient needs (Harrington 1995)
+ always follow up actions/conversations (Naden 2009)
- want to avoid different nurses asking same patient about concerns (van Meur 2018)