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

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Review Article

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Abstract

Objectives. The aim was to identify determinants of nurse spiritual/existential care practices toward 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 toward adult end-of-life patients.
Results. The review identified 42 studies and included the views of 4,712 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.

Introduction

Nurses can play a significant role in providing spiritual/existential care to enhance the well-being of patients at the end of life (Dalgaard et al., 2010) 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 the 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 the 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 the end of life, and Gijsberts et al. (2019) aimed to identify requisite factors to the implementation of spiritual care at the 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, and 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); view spiritual/existential care as part of their role (Rodin et al., 2015; Palmer et al., 2021); provide spiritual care more frequently (Bar-Sela 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

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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 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 (Rosário 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 the 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", and "distress") (Gijsberts 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 the 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 April 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 the 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 the 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 et al. (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.

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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 et al. (2014), which provided descriptions, definitions, and examples of each domain within the TDF. The coding sheet is shown in Supplementary 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 were extracted from authors' descriptions of results and participant quotations; and for survey studies, data were 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 (Michie 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 a 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 5-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 4,712 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 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 the 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 5-year time periods and shows that the identification of domains influencing spiritual/existential care practice has increased steadily over time, reaching a peak during 2011–2015. 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 the end of life. The review pulled together the views of more than 4,712 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 the 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 (Grol and Grimshaw, 2003). A useful aspect of the TDF 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

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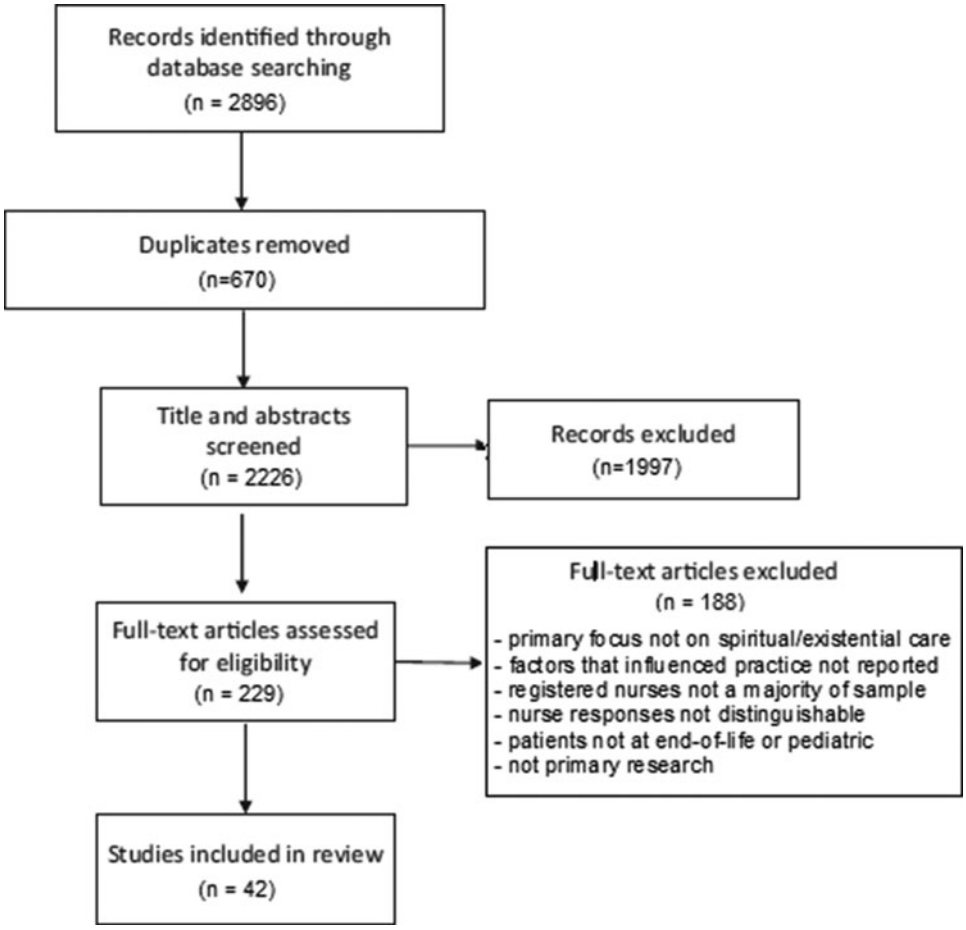

Fig. 1. Flow of studies included in the review.

identified the importance of training staff to recognize spiritual issues of religious groups and noted complexities in assessing and documenting spiritual distress. Gijsberts 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 well-being. 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 (Pittroff, 2013). As another example, Gijsberts 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*, *reinforcement*, 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.

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Table 1. Overview of studies included in the systematic review

Author (year)	Study aims	Nurse characteristics	Health setting, location	Methods	Quality score (%)[a]
Abu-El-Noor (2016)	To examine how nurses working in intensive care units understand spirituality and the provision of spiritual care at the end of life	*N* = 13; 5 females; age 26–47 years; ICU work experience 3–22 years; all nurses identified with religious belief	ICU, two hospitals, Gaza Strip	Semi-structured interviews	80
Arman (2007)	To explore and clinically validate nuances of witnessing as a caring act	*N* = 4; all had >3 years palliative care experience	An integrative hospital offering anthroposophic and conventional care, Sweden	Group discussion of one case	80
Bailey et al. (2009)	To describe nurses' experiences of delivering spiritual support in a palliative care setting	*N* = 22	A single hospice in Ireland	Semi-structured interviews	75
Belcher and Griffiths (2005)	To determine the extent to which nurses in hospice and other specialty care areas express spiritual values and integrate spiritual care into their role	*N* = 204; 93% female; mean age 50 years; median experience 30 years; 71% participated in regular religious practice	Hospice and palliative care, across USA.	Qualitative questionnaire	70
Bone et al. (2018)	To explore the effect of spiritual care on nurses and how nurses understand the role of spiritual care	*N* = 25; 88% female; mean age 44 years; mean nurse experience 21 years	One ICU ward in a faith-based hospital in Canada	Semi-structured interviews	85
Browall et al. (2014)	To describe nurses' experiences of existential situations when caring for patients severely affected by cancer	*N* = 83; all female; mean age 46 years; mean palliative care experience 2 years.	Three urban in-patient hospices, one surgery clinic, and one oncology clinic, in Sweden	Critical incident technique	85
Bush and Bruni (2008)	To explore the meaning of spiritual care as described by a group of palliative care professionals	*N* = 4; all female; age range ~28–45 years; median palliative care experience ~5–10 years	Home-based palliative care in Australia	In-depth interviews	70
Carroll (2001)	To explore the experiences of nurses' personal spiritual beliefs and of providing spiritual care for patients with advanced cancer	*N* = 15; 93% female; median hospice experience 5–10 years; 80% identified as spiritual/religious	Hospice in England	In-depth interviews	70
Doorenbos et al. (2006)	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	*N* = 229; mean experience 11 years	Government-run and private hospitals, India	Qualitative and quantitative survey	86
Ellington et al. (2015)	To identify naturally occurring, spiritually relevant conversations and elucidate challenges for nurses in home hospice	*N* = 5; all female, mean age 42 years, mean nurse experience 12 years; mean hospice nurse experience 7 years	One hospice in USA	Conversation analysis	80
Fay and OBoyle (2019)	To explore how palliative care nurses identify patients with existential distress and manage their needs.	*N* = 10, all female; range of palliative care experience 2–28 years	Community and inpatient palliative care in one hospice in Ireland	Semi-structured interviews	80
Ferrell et al. (2014)	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	*N* = 339	Palliative care in USA, Belize, India, Romania, and Philippines	Qualitative questionnaire	85
Guedes-Fontoura and de Oliveira Santa (2013)	To analyze the experience of nurses' care for dying persons	*N* = 14; 93% female; age range 28–55 years; range of experience 2–30 years	Long stay unit in one general hospital in Brazil	Interviews	45
Harrington (1995)	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	*N* = 20, 90% female; mean age 28 years; mean nursing experience 16 years; 50% identified with a faith tradition.	One hospice and various acute care settings in Australia	Interviews	65

(*Continued*)

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Table 1. (*Continued.*)

Author (year)	Study aims	Nurse characteristics	Health setting, location	Methods	Quality score (%)[a]
Harrington (2006)	To develop a better understanding of what constitutes spiritual caregiving	*N* = 10	One hospice in Australia	Interviews	75
Highfield et al. (2000)	To identify the formal and experiential spiritual care preparation of oncology and hospice nurses.	*N* = 181 oncology, *N* = 645 hospice; 97% female; mean age 45 years; mean nursing experience 18 years; 7% never attended religious service	Oncology care in five regions in USA; hospice care across USA	Quantitative survey	82
Johansson and Lindahl (2012)	To describe the meanings of nurses' experiences of caring for palliative care patients	*N* = 8; all female; range of work experience 3–32 years	Acute care in two hospitals in Sweden	Interviews	85
Johnston-Taylor (2013)	To measure how comfortable hospice nurses in New Zealand are conducting spiritual assessment and identifying associated factors	*N* = 60 hospice; mean age 53 years, mean nursing experience 26 years, self-reported spirituality (/religiosity) 3.7(/2.6) out of 5	Three hospices in New Zealand	Qualitative and quantitative survey	86
Kale (2011)	To examine how spiritual care is perceived in an African context by recording the lived experiences of palliative care workers	*N* = 13; all identified with a religion	Hospice service in Uganda	Interview	75
Karlsson et al. (2017)	To understand nurses' existential questions when caring for dying patients	*N* = 14; all female; age range 36–61 years; work experience range 6 months to over 10 years	One community care center, one hospice care center, one hospital palliative care unit, Sweden	Focus groups	75
Keall et al. (2014)	To investigate the facilitators, barriers, and strategies that Australian palliative care nurses identify in providing existential and spiritual care	*N*=20; 95% female; age range 25-65 years; experience range 1-40 years; 12 identified with spiritual/ religious belief	Community, inpatient unit, and acute units across Australia	Interviews	80
Kisvetrová et al. (2013)	To investigate the use and feasibility of in the "Spiritual Support" interventions for patients diagnosed with "Death Anxiety"	*N* = 468; mean age 38 years; median work experience 14 years; 43% religious believers	Long-term, hospice, oncology, geriatrics, homes for elderly, home care in Czech Republic	Quantitative and qualitative survey	86
Kisvetrová et al. (2016)	To assess nurse' practice regarding dying care and spiritual support interventions, and identify factors influencing the intervention usage	*N* = 277; 94% female; mean age 34 years, mean experience 9 years.	29 ICUs in Czech Republic	Quantitative survey	91
Kisvetrová et al. (2018)	To determine the utilization rate of comfort-supporting nursing activities in end-of-life patients and identify associated factors	*N* = 907; mean age 38 years; mean work experience 15 years	Intensive, acute, long-term, hospice care in 49 institutions, Czech Republic	Quantitative survey	91
Kociszewski (2004)	To describe critical care nurses' lived experience of providing spiritual care to critically ill patients and their families	*N* = 10; 90% female; mean age 32 years; mean nursing experience 16 years	Critical care units, USA	Interviews	80
Kristeller et al. (1999)	To describe how oncologists and oncology nurses respond to spiritual distress	N = 267 oncology nurses; 99% female; mean age 43 years; mean oncology experience 10 years;	Range of settings (medical oncology, community private practice, and hospitals), USA	Quantitative survey	95
Kuuppelomaki (2001)	To find out how nursing staff provides spiritual support and factors that influence the provision of spiritual support	*N* = 328; 98% female; 86% were over 36 years age; 44% had <10 years experience; 91% identified as Lutheran	In-patient wards in 32 community health centres, Finland	Qualitative and quantitative survey	91
Minton et al. (2018)	To describe nurses' communication strategies while providing spiritual care	*N* = 10; age range 30–60 years; experience range 10–30 years; all Christian	One faith-based health system providing hospice/ palliative care in home, nursing home, acute care, and hospice, USA	Interviews	85

(*Continued*)

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Table 1. (*Continued.*)

Author (year)	Study aims	Nurse characteristics	Health setting, location	Methods	Quality score (%)[a]
Morita et al. (2009)	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	*N* = 40; general practice nurses; all female; mean age 31 years, mean clinical experience 9 years	General practice, in a single general hospital, Japan	Experimental intervention	81
Nåden (2009)	To understand the confirmation of cancer patients from the nurse perspective	*N* = 8; all female; age range 25–46 years	Four cancer wards in Norway	Interviews	85
Nixon et al. (2013)	To identify how nurses manage the spiritual needs of neuro-oncology patients	*N* = 12	Neuro-cancer unit in a teaching hospital, UK	Qualitative questionnaire	80
Pittroff (2013)	To describe how palliative care nurses provide spiritual care and how they acquired these skills, and to discover the personhood of these nurses	*N* = 10; all female; median age 54 years; median nursing experience 31 years; all active in a faith tradition	In-patient palliative care in a range of settings in USA	Semi-structured interviews	65
Ronaldson et al. (2012)	To identify and compare spiritual caring practice by palliative and acute care nurses, and to investigate correlates and barriers to spiritual caring	*N* = 92; 82% female; mean age 38 years; mean nursing experience 14 years	One community palliative care service, and three palliative care and three acute care units in large hospitals in Australia	Quantitative survey	91
Taylor et al. (1999)	To identify factors that contribute to oncology and hospice nurses' spiritual care perspectives and practices	*N* = 818; mean age 46 years; mean nursing experience 18 years; mean spirituality 4.2 (out of 5)	Members of Oncology Nursing Society, and Hospice Nurses Association in USA	Quantitative survey	91
Tornøe et al. (2014)	To describe the meaning of hospice nurses' lived experience with alleviating dying patients' spiritual and existential suffering	*N* = 6, age range 41–61 years; nursing experience range 8–35 years	Hospice, Norway	Interviews	85
Tornøe et al. (2015)	To describe nurses' experiences with spiritual and existential care for dying patients in a general hospital	*N* = 6; age range 37–61 years; nursing experience range 9–21 years	A combined medical and oncological ward in a general hospital in Norway	Interviews	85
Van Meurs et al. (2018)	To gain insights in the way and extent to which nurses during daily caregiving observe and explore spiritual issues of hospitalized patients with cancer	*N* = 4; 75% female	Medical oncology ward of a teaching hospital, Netherlands	Observation, interviews	80
Vosit-Steller et al. (2010)	To characterize the nursing actions practiced by nurses affiliated with Hospices of Hope that promote dignified dying	*N* = 43 hospice nurses; 72% under 40 years age; 56% ≤10 years of experience, and 19% had ≥21 years experience.	Members affiliated with Hospices of Hope in Romania	Qualitative and quantitative questionnaire	75
Walker and Waterworth (2017)	To explore nurses' experiences providing spiritual care to patients who are facing a life-limiting illness	*N* = 9 palliative care nurses; mean age 53 years; mean palliative care experience 9 years.	Three hospices in New Zealand	Semi-structured interviews	80
Wittenberg et al. (2017)	To explore the spiritual care experiences of nurses to learn more about nurse communication involving spirituality.	*N* = 57 oncology nurses; mean clinical experience 16 years;	Range of settings (home care, hospital, and outpatient) in USA	Qualitative survey	85
Yingting et al. (2018)	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	*N* = 15, 87% female; mean age 21–30 years, 80% attended religious activities	ED of a public tertiary teaching hospital, Singapore	Focus group	75
Zerwekh (1993)	To identify hospice practice competencies of spiritual caring	*N* = 32 hospice nurses	Home care in USA	Interviews	55

[a]Scores are based on the quality appraisal tool by Kmet et al. (2004).

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Table 2. Thematic synthesis of TDF domains

TDF Domain	Synthesized finding	Themes Examples of supporting data from included studies (+ facilitator, – barrier, ± factor with unspecific direction, ≠ no relationship)
Knowledge	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	**Theme: Knowledge of spiritual/existential care practices** + knowledge of care practice (Johansson and Lindahl, 2012) + pastoral care knowledge (Pittroff, 2013) + knowledge about the timing of spiritual care (e.g., when to begin and stop) (Bailey et al., 2009)
		Theme: Knowledge related to spiritual assessment and identification + intuitive knowing when patient is experiencing spiritual distress (Walker and Waterworth, 2017) – not knowing what to ask or how to approach spiritual assessment (Belcher and Griffiths, 2005)
		Theme: Knowledge regarding spirituality and death + knowledge about life and death issues, and human existence (Arman, 2007) – lack of knowledge of different religious practices/beliefs and spirituality (Kuuppelomaki, 2001; Belcher and Griffiths, 2005)
		Theme: Self-knowledge + knowledge of oneself as a person and how to use one's lived knowledge (Johansson and Lindahl, 2012)
Skill	Skills in spiritual assessment and identification, and in the 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 and 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 were not facilitators. A randomized, controlled study examining the effect of a workshop on the care of terminally ill patients (Morita et al., 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.	**Theme: Skills related to spiritual assessment and identification** + ability to sense, recognize, observe patient need (Carroll, 2001; Bailey et al., 2009; Minton et al., 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)
		Theme: Skills in delivery of spiritual/existential care + skills in verbal and non-verbal communication (e.g., meaningful conversation and body language) (Bailey et al., 2009) + a professional nurse chooses right time for spiritual conversations (van Meurs et al., 2018) – scarce skills and competencies (Kuuppelomaki, 2001; Bailey et al., 2009; Keall et al., 2014)
		Theme: Experience + experience providing spiritual care (Bailey et al., 2009; Tornøe et al., 2014) + frequent experience of caring for dying (Kociszewski, 2004) ≠ work experience in years (Kisvetrová et al., 2018)
		Theme: Training/education + training in spiritual assessment (Johnston-Taylor, 2013) + then ≠ : training in care of patients feeling meaninglessness has a significant short-term effect, but returned to the baseline after 9 months (Morita et al., 2009) ≠ qualifications (Ronaldson et al., 2012) and education level (Taylor et al., 1999; Kisvetrová et al., 2018)
		Theme: Self-reflection + self-reflection, reflective practice (Vosit-Steller et al., 2010)
		Theme: Learning from others + watching and learning from chaplains
		Theme: Basic nursing skills + mastered the technical stuff and can take extra step (Kociszewski, 2004)
Social or professional role and identity	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** + spiritual assessment and care is part of nurse role (Belcher and Griffiths, 2005) – spiritual assessment not in nurse role (Nixon et al., 2013; Belcher and Griffiths, 2005; Ronaldson et al., 2012)
		Theme: Sub-components of spiritual care role + part of role is to ensure family presence at death (Zerwekh, 1993) + showing compassion (Bone et al., 2018) + accept it is not nurse's job to fix feelings, just accept how patient feels (Minton et al., 2018)
		Theme: Role conflict – conflict between personal and professional spirituality (Belcher and Griffiths, 2005)

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Table 2. (*Continued.*)

TDF Domain	Synthesized finding	Themes Examples of supporting data from included studies (+ facilitator, – barrier, ± factor with unspecific direction, ≠ no relationship)
		– conflict between personal beliefs and patient requests (Belcher and Griffiths, 2005) – confusion between proselytizing and delivery of spiritual care (Ronaldson et al., 2012)
		Theme: Patient–nurse boundaries – boundaries blurred when nurse identifies with patient (e.g., has children same age (Browall et al., 2014)) ± need closeness but not too close (Johansson and Lindahl, 2012)
		Theme: Work commitment + love this work (Bailey et al., 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 tending 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 and Griffiths, 2005; Keall et al., 2014) + accept/know limits of expertise and ready to work with other team members (Pittroff, 2013; Keall et al., 2014)
		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 et al., 2014)
		Theme: Life experiences + maturity (Tornøe et al., 2015) + personal experience of loss and illness (Pittroff, 2013) – personal experience of loss can interfere with spiritual care when personal self-disclosure supersedes awareness of client needs (Pittroff, 2013)
		Theme: Reflection/acceptance of one's own existential issues + reflection on own existence/death (Johansson and Lindahl, 2012) + comfortable with own feelings of death and dying (Kociszewski, 2004) ≠ attitudes to death, death avoidance, death as better life, and death as escape (Kisvetrová et al., 2016)
		Theme: Participation/identification with faith tradition + participation in faith community (Pittroff, 2013) – nurse religiosity (Kuuppelomaki, 2001; Kisvetrová et al., 2013) ≠ religiosity (Johnston-Taylor, 2013)
		Theme: Nurse demographics + age (Taylor et al., 1999; Tornøe et al., 2015) ≠ age (Johnston-Taylor 2003; Kisvetrová et al., 2018; Kuuppelomaki, 2001; Ronaldson et al., 2012) ≠ gender (Ronaldson et al., 2012), English-speaking background (Ronaldson et al., 2012)
Beliefs about consequences	Some studies reported patient well-being 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 the 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 and well-being (Bush and Bruni, 2008; Kale, 2011) + spiritual care brings patients relaxation, comfort (Bailey et al., 2009; Abu-El-Noor, 2016) – relieving suffering extends time for suffering (Guedes-Fontoura and de Oliveira Santa, 2013) – spiritual support does not help patient (Nixon et al., 2013)
		Theme: Consequences of specific nurse actions on patients + beneficial effects of nurse actions on patient, e.g., eye contact (Arman, 2007), sharing silence (Tornøe et al., 2014) + prayer is used as it suits patient of all faiths (Kale, 2011) – spiritual questions are potentially intrusive (Johnston-Taylor, 2013) and off-putting to patient (Walker and Waterworth, 2017) – spiritual conversations might be stressful for patient or unwanted by patient (van Meurs et al., 2018)
		Theme: Consequences of care work on nurse – spiritual conversations take a long time (van Meurs et al., 2018)
Reinforcement	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,	**Theme: Positive reinforcers** + rewarding to be part of patient's life (Minton et al., 2018) + feel honoured when patients choose to confide in them (Tornøe et al., 2015)

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Table 2. (*Continued.*)

TDF Domain	Synthesized finding	Themes Examples of supporting data from included studies (+ facilitator, – barrier, ± factor with unspecific direction, ≠ no relationship)
	and needing to see good results of care work acted as barriers.	**Theme: Negative reinforcers** – when nurses need to see good results of their work (Tornøe et al., 2015) – too demanding to do frequently (van Meurs et al., 2018)
Motivation and goals	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 and 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 prioritization 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** + aim to provide best care for patients (Johansson and Lindahl, 2012) + want patient to feel comfortable and cared for (Kociszewski, 2004) and not alone (Arman, 2007) – to help patient recover from illness (Guedes-Fontoura and de Oliveira Santa, 2013)
		Theme: Relationship goals + need to establish trusting relationship with the patient (Tornøe et al., 2015) + aim to fully participate in the encounter and enter patient's personal space (Arman, 2007; Minton et al., 2018)
		Theme: Empathy goals + to respect the way patient sees things (Harrington, 1995) + to put oneself in patient shoes (Browall et al., 2014)
		Theme: Self-oriented goals + strive for completeness (i.e., feeling they have done all they can) (Johansson and Lindahl, 2012) – to stay away from distressed patient for self-protection (Fay and OBoyle, 2019) – try to avoid potential anxiety about their own suffering/dying (Tornøe et al., 2015)
		Theme: Task priorities + prioritize spiritual/existential above other activities (Belcher and Griffiths, 2005; Arman, 2007; Bailey et al., 2009; Browall et al., 2014) – unable to tend to spiritual domain when technical aspects have to be dealt with first (Bone et al., 2018)
		Theme: Goals related to other persons + utilize expertise of team members (e.g., chaplain) (Pittroff, 2013) + commitment to refer to chaplain if nurse is not spiritual (Zerwekh, 1993);
		Theme: Goal features + limit goals to what is achievable (Zerwekh, 1993)
Memory, attention, and decision-processes	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.	**Theme: Conscious focus on patient need** + attention to patient spoken and unspoken signals (Zerwekh, 1993; Nåden, 2009) + stop and think that patient and families are experiencing existential distress (Tornøe et al., 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" (Tornøe et al., 2014)
		Theme: Attention deflectors – full attention needed to complete checklists for which they are accountable (van Meurs et al., 2018) – attention focused primarily on physical care and ignore spiritual care (Bush and Bruni, 2008)
Environment context and resources	Many studies referred to aspects of time: lack of time generally due to work demand, lack of time with the patient, and lack of time for learning impeded spiritual/existential care. The care setting and organizational priorities influence spiritual/existential care behaviors. For example, spiritual/existential care is facilitated in a hospice setting, in organizations 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.	**Theme: Time-related aspects** *Temporal demand* – shortage of time (Kuuppelomaki, 2001; Belcher and Griffiths, 2005; Kale, 2011; Kisvetrová et al., 2013; Keall et al., 2014) – low staff-patient ratio (Bailey et al., 2009; Tornøe et al., 2015; Kisvetrová et al., 2016) – workload (Belcher and Griffiths, 2005; Kale, 2011; Kisvetrová et al., 2013; Walker and Waterworth, 2017) *Duration of time that the patient is in unit* – short-term stay (Belcher and Griffiths, 2005) – patient referred too late to palliative care (Keall et al., 2014) *Duration of time with an individual patient* – unable to spend as much time as like with the patient (Bone et al., 2018) *Time for learning* – lack of time for self-reflection (Kale, 2011)

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Table 2. (*Continued.*)

TDF Domain	Synthesized finding	Themes Examples of supporting data from included studies (+ facilitator, – barrier, ± factor with unspecific direction, ≠ no relationship)
	Ethnic culture influenced the type of religious rituals nurses used to help patients, but not whether they encouraged patients to speak about dying.	**Theme: Care setting** + hospice setting (Harrington, 1995; Belcher and Griffiths, 2005) – acute care (Harrington, 1995)
		Theme: Organiational priorities + organization prioritizes/supports spiritual care (Taylor et al., 1999; Belcher and Griffiths, 2005; Walker and Waterworth, 2017) + health centers that focused on raising care standards (Kuuppelomaki, 2001)
		Theme: Facility/amenities + specially decorated rooms enhance calmness, harmony, rest, and security (Johansson and Lindahl, 2012) + privacy (Minton et al., 2018; Yingting et al., 2018)
		Theme: Availability of spiritual care providers + chaplain availability (Kristeller et al., 1999)
		Theme: Care tools – no tool for spiritual assessment (Belcher and Griffiths, 2005) ± documentation of spiritual care conversations (Keall et al., 2014) + documentation of spiritual care (Walker and Waterworth, 2017)
		Theme: Ethnic culture ± ethnic culture is related to the use of Jesus- versus Hindi-focused religious rituals (Doorenbos et al., 2006) ≠ ethnic culture reurging patient to speak about dying (Doorenbos et al., 2006)
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 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 were 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.	**Theme: Patient diagnosis/prognosis** + terminal illness diagnosis (Belcher and Griffiths, 2005; Abu-El-Noor, 2016) + short prognosis (Kristeller et al., 1999; Kociszewski, 2004; Fay and OBoyle, 2019)
		Theme: Patient demographics + patient proneness to existential distress, e.g., young mothers (Fay and OBoyle, 2019) ≠ patient gender (Kristeller et al., 1999)
		Theme: Patient's cues of distress and spiritual needs + patient behavior and utterances and indicators (Carroll, 2001; Belcher and Griffiths, 2005; Johnston-Taylor, 2013) + patient cues regarding spiritual needs … non-verbal behavior, (Nixon et al., 2013; Abu-El-Noor, 2016) + patient cues regarding spiritual needs … emotions (Nixon et al., 2013; Karlsson et al., 2017)
		Theme: Patient openness and ability to communicate needs + patient "permits" nurse to talk about spiritual/existential questions (Belcher and Griffiths, 2005; Tornøe et al., 2015) + patient ability to communicate verbally and nonverbally (Zerwekh, 1993; Belcher and Griffiths, 2005; Tornøe et al., 2015) – 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 and Waterworth, 2017; Yingting et al., 2018) ± patient beliefs (Harrington, 1995; Ellington et al., 2015), values and culture (Harrington, 1995)
		Theme: Patient's social situation ± patient–family relationship quality (Ferrell et al., 2014) ± patients' family situation and social network (Tornøe et al., 2015)
		Theme: Patient too demanding – unreasonably demanding patient (Browall et al., 2014) or bothersome (van Meurs et al., 2018) – patient has too many physical, psychological, and spiritual needs to meet (Nixon et al., 2013)
		Theme: Nurse–patient relationship + nurse–patient rapport, trustful relationship (Carroll, 2001; Vosit-Steller et al., 2010; Keall et al., 2014; Walker and Waterworth, 2017; Fay and OBoyle, 2019) + nurse has deep involvement/engagement with the patient (Johansson and Lindahl, 2012; Karlsson et al., 2017; Minton et al., 2018)

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Table 2. (*Continued.*)

TDF Domain	Synthesized finding	Themes Examples of supporting data from included studies (+ facilitator, – barrier, ± factor with unspecific direction, ≠ no relationship)
		Nurse–patient homophily + patient–nurse share beliefs Carroll, 2001) ≠ patient–nurse different beliefs (Wittenberg et al., 2017) – difference between patient– nurse spirituality (Ronaldson et al., 2012; Keall et al., 2014)
		Theme: Nurse-perceived norms regarding care of patient – religion is a taboo subject and/or private matter (Kuuppelomaki, 2001; Kisvetrová et al., 2013; Tornøe et al., 2015)
Social influence: other than the patient	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.	**Theme: Relationship/collaboration with colleagues** + support/sharing with colleagues (Kociszewsk, 2004; Bush and Bruni, 2008; Johansson and Lindahl, 2012; Tornoe et al., 2014, Fay and OBoyle, 2019) + good relationship with pastoral care (Belcher and Griffiths, 2005; Pittroff, 2013)
		Theme: Nurse relationship with patients' family + bond with family (Minton et al., 2018) + partnership and trust between nurses and families (Vosit-Steller et al., 2010)
		Theme: Relationship with nurse personal social network + nurses' connection with family and friends (Bush and Bruni, 2008)
Emotions	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, and emotionally draining) act as barriers to care	**Theme: Positive emotions** + feels great to share a patient's life (Johansson and Lindahl, 2012)
		Theme: Negative emotions – feeling agonized/anxious/weary when patient is young (Browall et al., 2014) – frustration when nurse cannot help (Fay and OBoyle, 2019), when patient dies (Guedes-Fontoura and de Oliveira Santa, 2013) – emotionally draining (Tornøe et al., 2014, 2015)
Behavioral self-regulation	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 (Nåden, 2009) + self-preparation (e.g., praying for wisdom) (Minton et al., 2018)
		Theme: Behavior during encounter + regulate own body language (Keall et al., 2014) ± manage touch and tone during physical care (Tornøe et al., 2014) + be open, honest, caring, respectful, compassionate (Keall et al., 2014), show genuine desire to care (Walker and Waterworth, 2017)

For a more complete listing of examples of supporting data from included studies, see Supplementary Table S2.

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 (van Leeuwen et al., 2009; Attard et al., 2019; McSherry et al., 2020). 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 toward 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 toward 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

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Table 3. Frequency of studies that identified each domain at least once

	TDF domains[a]													
Included studies	Knowledge	Skills	Social/ professional role and identity	Beliefs about capabilities	Optimism	Beliefs about consequences	Reinforcement	Intentions and goals[b]	Memory, attention, and decision	Environment context and resources	Social influence–patient[c]	Social influence–other than patient	Emotion	Behaviour regulation
Abu-El-Noor (2016)			1			1	1	1			1			
Arman (2007)	1			1		1		1	1		1			
Bailey et al. (2009)	1	1	1			1		1		1	1			
Belcher and Griffiths (2005)	1	1	1	1				1		1	1	1		
Bone et al. (2018)		1	1	1				1		1		1		
Browall et al. (2014)		1	1	1		1		1	1	1	1		1	
Bush and Bruni (2008)	1	1	1	1		1	1		1			1		
Carroll (2001)		1	1	1				1			1			
Doorenbos et al. (2006)										1				
Ellington et al. (2015)											1			
Fay and OBoyle (2019)								1		1	1	1	1	
Ferrell et al. (2014)		1									1		1	
Guedes-Fontoura and de Oliveira Santa (2013)				1		1		1		1			1	
Harrington (2006)											1			
Harrington (1995)		1	1	1		1		1		1	1			1
Highfield et al. (2000)		1												
Johansson and Lindahl, (2012)	1		1	1			1	1		1	1	1	1	
Johnston-Taylor (2013)		1		1		1					1			1
Kale (2011)			1	1		1				1	1			
Karlsson et al. (2017)				1				1		1	1			
Keall et al. (2014)		1		1				1		1	1		1	1
Kisvetrová et al. (2018)		1		1						1				
Kisvetrová et al. (2016)		1		1						1				

Kisvetrová et al. (2013)	1	1	1	1						1	1				
Kociszewski (2004)		1	1	1				1			1	1			
Kristeller et al. (1999)			1							1	1				
Kuuppelomaki (2001)	1	1	1	1				1		1	1				1
Minton et al. (2018)		1	1	1			1	1		1	1	1			1
Morita et al. (2009)		1													
Nåden (2009)			1					1	1						1
Nixon et al. (2013)		1	1			1				1	1				
Pittroff (2013)	1	1		1			1	1	1			1			1
Ronaldson et al. (2012)		1	1	1						1	1	1			
Taylor et al. (1999)		1	1	1						1	1				
Tornøe et al. (2014)		1	1	1		1	1	1	1	1	1	1	1		1
Tornøe et al. (2015)		1	1	1		1	1	1	1	1	1	1	1		
Van Meurs et al. (2018)		1	1			1	1	1		1	1				1
Vosit-Steller et al. (2010)		1		1							1	1			
Walker and Waterworth (2017)	1	1	1	1		1		1		1	1		1		1
Wittenberg et al. (2017)		1				1		1			1				
Yingting (2018)								1		1	1				
Zerwekh (1993)	1	1	1	1				1	1		1				1
Number of studies with evidence in the domain	10	29	24	27	0	15	8	25	8	26	32	12	9		11

[a]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 the 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).
[b]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 (Michie et al., 2005) also combined these two domains.
[c]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.

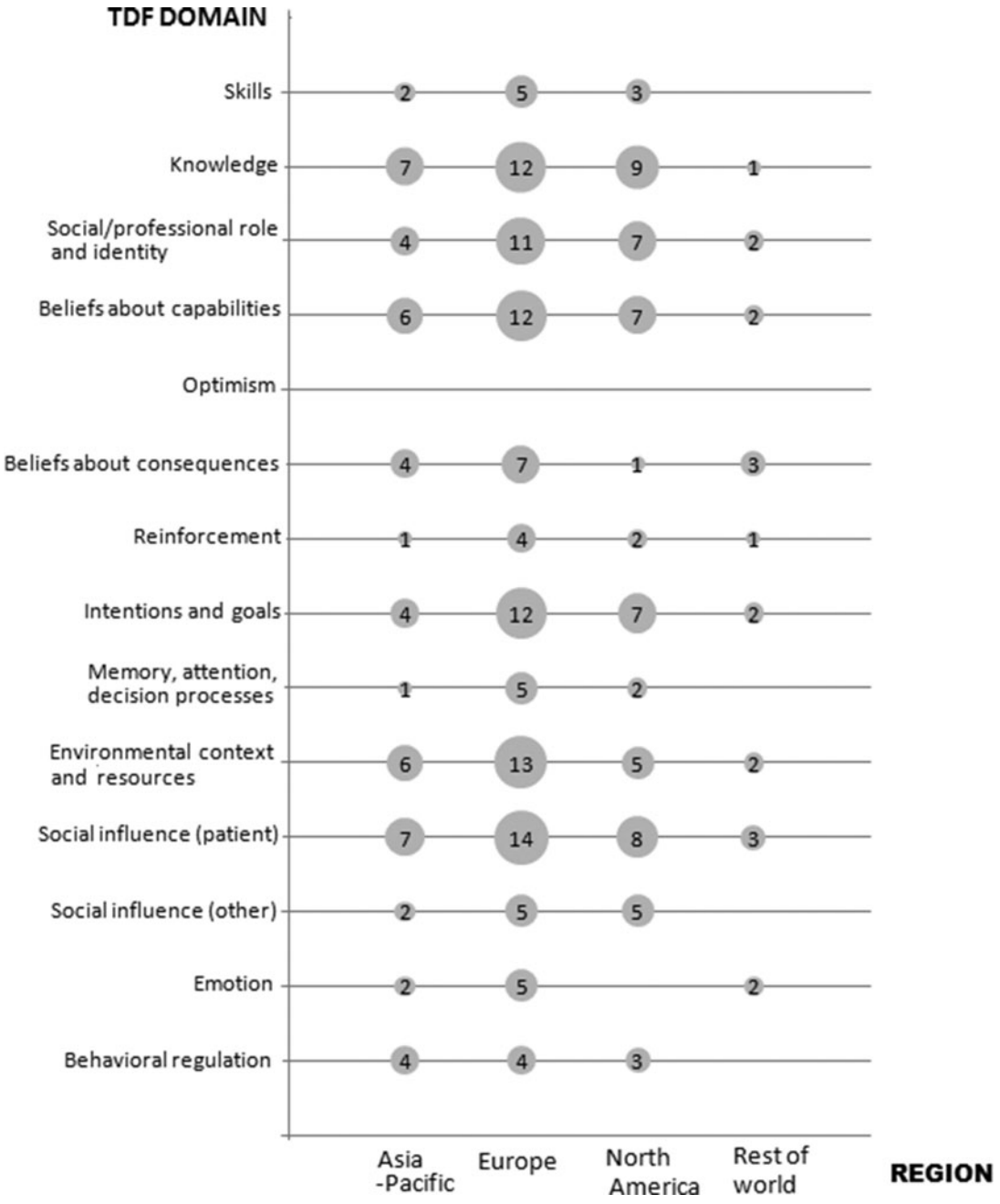

Fig. 2. Depiction of domains by the region. (Each circle represents the number of studies mentioning the domain at least once. Studies were assigned to regions based on the locations of nurses sampled.)

competence among helping professionals (Chan and Tin, 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 the 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 and 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.

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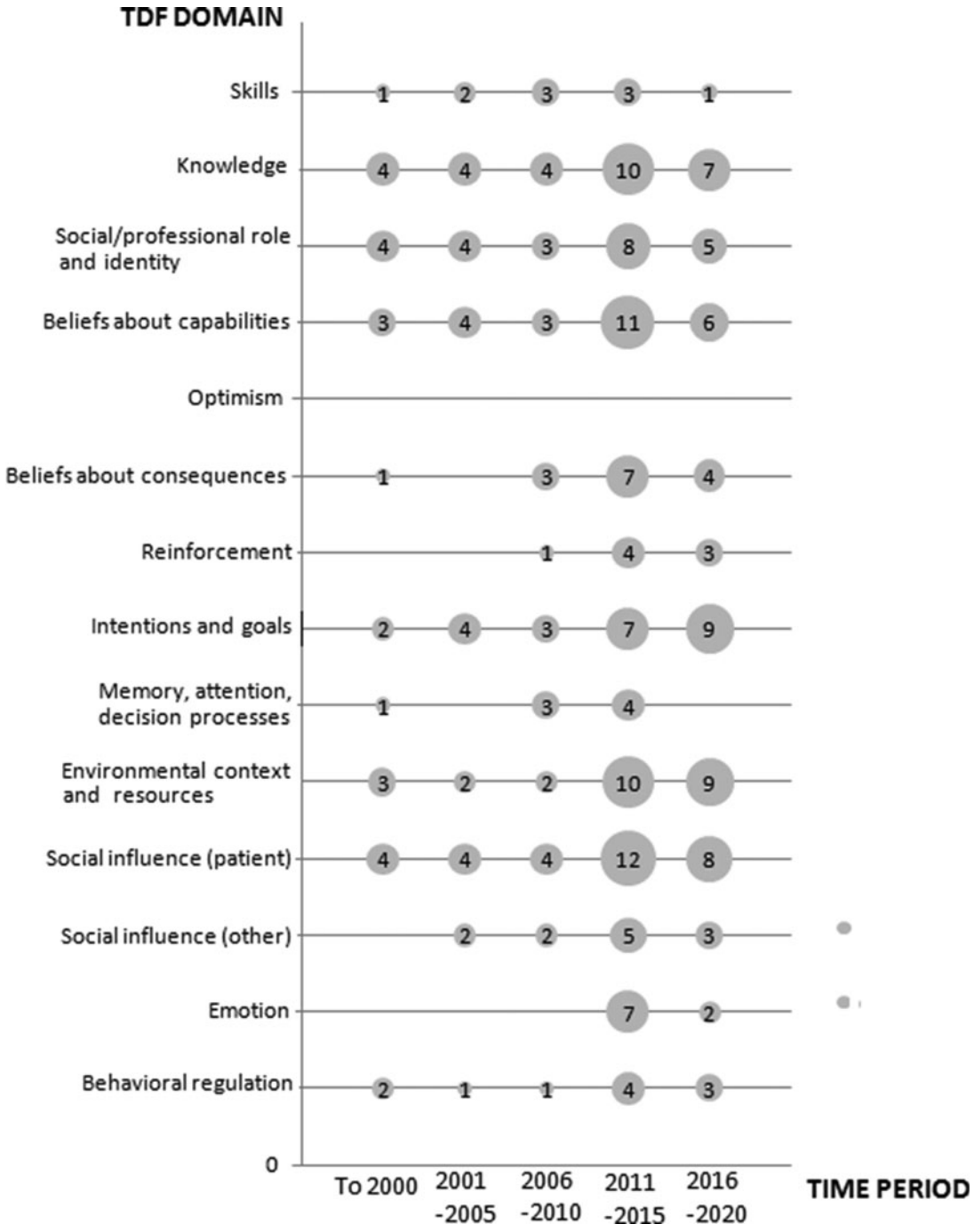

Fig. 3. Depiction of domains across 5-year time periods. (Each circle represents the number of studies mentioning the domain at least once.)

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

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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 et al. (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 the 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 the 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 (Kisvetrová et al., 2013), facilitator (Pittroff, 2013), and unrelated (Johnston-Taylor, 2013) to spiritual/existential care practices); discrepant findings suggest that 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 toward 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).

Supplementary material. The supplementary material for this article can be found at: https://doi.org/10.1017/S1478951521001851.

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