Supporting spiritual care in patient care:

a qualitative study of barriers and facilitators
of hospital nurses in the role of Link Nurse Spiritual Care

Student:	A.H. Kuik
Student number:	6068421
Status:	Final
Date of submission:	June 17, 2020
Number of words:	3796
Number of words abstract English:	298
Number of words abstract Dutch:	299
Reference style:	Vancouver Superscript
Supervisor:	Dr. B. Cusveller
Lecturer:	Dr. J.M. de Man – van Ginkel
Internship institution:	Christian University of Applied Sciences Viaa, Zwolle
Intended journal:	Journal of Nursing Administration
Reporting guideline:	COREQ

Utrecht University, Master Clinical Health Sciences (KGW) Nursing Science, UMC Utrecht

ABSTRACT

TITLE: Supporting spiritual care in patient care: a qualitative study of barriers and facilitators of hospital nurses in the role of Link Nurse Spiritual Care.

BACKGROUND For many hospitalized patients, spiritual care is important. However, the spiritual dimension is not always an integrated part of nurses' professional behavior. Previous research showed that the appointment of Link Nurses Spiritual Care (LNSCs) in a hospital can lead, in the short term, to a greater awareness of the spiritual needs of patients in nurses and more regular and competent provision of spiritual care. It is therefore important to find strategies to sustain these positive outcomes. Identifying facilitators of and tackling barriers to spiritual care is therefore important to achieve consistent improvements.
AIM This study explores hospital nurses' experiences of the barriers to and facilitators of their ability to competently perform their role as LNSC with regard to spiritual care support, one year after implementation of the role.
METHOD A generic descriptive qualitative approach was used. Semi-structured interviews with LNSCs led by an interview guide were performed. Thematic analysis was used for data analysis.
RESULTS Eight LNSCs were interviewed. Four themes were identified: professional confidence, time, support and coaching, and team culture. These themes were theorized as factors, the presence of which act as a facilitator, while their absence acts as a barrier to performing the LNSC role competently. In this study, the lack of time for the role was the greatest barrier for the participants, while support and coaching was the most present factor, making it the greatest facilitator.
CONCLUSION AND RECOMMENDATIONS Results from this study indicate that to sustain the promising results from previous research, all four factors should be strengthened. Emphasis should be placed on the key factors of professional confidence and time. Organizations should focus on scheduling time monthly, and the LNSCs' professional confidence should be optimized by extending their intercollegiate meetings with educational sessions.

KEYWORDS Barriers, facilitators, link nurse, hospital, spiritual care

NEDERLANDSE SAMENVATTING

TITEL: Het bevorderen van aandacht voor zingeving in de patiëntenzorg: een kwalitatief onderzoek naar de ervaren belemmerende en bevorderende factoren van ziekenhuisverpleegkundigen in de rol van verpleegkundige aandachtsvelder zingeving.

ACHTERGROND: Voor veel ziekenhuispatiënten is aandacht voor zingeving belangrijk. Deze spirituele dimensie is echter niet altijd een geïntegreerd onderdeel van het professionele gedrag van verpleegkundigen. Eerder onderzoek toonde aan dat de benoeming van verpleegkundige aandachtsvelders zingeving (VAZ) in ziekenhuizen op korte termijn kan leiden tot meer aandacht van verpleegkundigen voor zingeving bij patiënten, en bij verpleegkundigen tot een meer regelmatige en competente verlening van zorg voor zingeving. Het is daarom belangrijk om strategieën te vinden om deze positieve resultaten te behouden. Het identificeren van bevorderende en belemmerende factoren voor het verlenen van zorg voor zingeving is daarom belangrijk om consistente verbeteringen te bereiken.
DOELSTELLING: Het verkennen van de ervaren bevorderende en belemmerende factoren van ziekenhuisverpleegkundigen om hun rol als VAZ op een competente wijze uit te oefenen, een jaar na implementatie.
METHODE: Er werd een generieke beschrijvende kwalitatieve benadering gebruikt. Alle participanten werden geïnterviewd, waarbij gebruik werd gemaakt van een interviewgids. Thematische analyse werd gebruikt voor de data-analyse.
RESULTATEN: Acht VAZ werden geïnterviewd. Vier thema's werden geïdentificeerd: professioneel zelfvertrouwen; tijd; ondersteuning en coaching; teamcultuur. Deze thema's werden getheoretiseerd als factoren, waarbij de aanwezigheid bevorderend werkt, terwijl hun afwezigheid een belemmering vormt voor het competent uitoefenen van de VAZ-rol. In deze studie was het gebrek aan tijd voor de rol de grootste belemmering; terwijl ondersteuning en coaching de meest aanwezige factor was, waardoor het de grootste bevorderende factor was.
CONCLUSIE EN AANBEVELINGEN: Resultaten uit dit onderzoek laten zien dat, om de veelbelovende resultaten van eerdere onderzoek te behouden, alle vier de factoren moeten worden versterkt. Nadruk moet liggen op de sleutelfactoren: professioneel zelfvertrouwen en tijd. Organisaties moeten zich richten op het maandelijks inplannen van uren voor de VAZ. Om het professionele zelfvertrouwen van de VAZ te optimaliseren moeten intercollegiale vergaderingen uitgebreid worden met educatieve sessies.

TREFWOORDEN: Verpleegkundigen, aandachtsvelders, ziekenhuis, zingeving.

INTRODUCTION

Every year between 1.7 and 1.8 million hospital admissions occur in the Netherlands[1]. Hospitalization has an impact on patients' perceived quality of life, and healthcare professionals' attention to this impact is a characteristic of good care [2,3]. Many hospitalized patients consider spiritual care an important part of their care[4]. Spirituality can be defined as a dynamic and intrinsic aspect of humanity through which people seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred[5].

Most hospitals underline the importance of spiritual care in their vision of nursing by emphasizing holistic care, a practice in which every person is considered unique and must be acknowledged and supported in their unique needs, including their spirituality[6–9]. Spiritual care provided by nurses can have a positive effect on patient outcomes, such as their ability to cope with pain, stress, and anxiety, and their quality of life[10–16].

According to the Dutch national professional profile for nurses, spiritual care should be a key nursing focus[17]. However, spiritual care is not always an integrated part of nurses' professional behavior as their work pressures often lead to the prioritization of physical care over spiritual care[18–23].

Literature describes various strategies to support spiritual care in patient care[24–30]. Examples of strategies include: offering training in spiritual care, requiring nurses to conduct a spiritual assessment of each patient, and using spiritual leadership to improve nurses' provision of spiritual care[24–30]. However, many of these strategies do not result in the consistent improvement of spiritual care[31].

An approach that can result in the incorporation of specific aspects of care into routine care is the appointment of team champions, recourse nurses, or as they will be referred to in this study, link nurses[32]. A link nurse can be described as a nurse who focuses on assisting fellow nurses in acquiring knowledge and skills in a specific area[33]. The task of link nurses is to support fellow nurses in analyzing their attitudes and minimizing factors that prevent them from performing tasks in that specific area. Link nurses have been proven to effectively improve safe patient handling by nurses, patient outcomes in diabetes care, palliative care, and infection prevention[34–39].

In a recent study by Cusveller et al.[40] at a regional general hospital in the Netherlands, twenty nurses from ten units were monitored after being appointed as Link Nurses Spiritual Care (LNSCs). Prior to the study, the researchers developed a competence profile for the LNSCs based on research and education as follows: assuring awareness of spirituality in the care process at ward level; supporting and coaching team members; working and collaborating inside and outside the organization; and contributing to the

profession[41]. This competence profile formed the basis of the training the LNSCs received. After the post-test, it was decided to appoint a LNSC Plus (LNP) as a liaison between the LNSCs and the chaplaincy[40].

Results from the study by Cusveller et al.[40] indicate that the appointment of LNSCs in hospitals can lead, in the short term, to nurses having a greater awareness of the spiritual needs of nurses. The appointment also appears to result in nurses providing spiritual care more regularly and becoming more competent in its provision in the short term. It is therefore important to find strategies to sustain these positive outcomes.

Research has shown that having the desired competencies as a link nurse does not always result in a consistent optimal fulfillment of the role as both favorable and unfavorable conditions can influence the role fulfillment in the long term[39,42]. Identifying facilitators and tackling barriers is important for achieving consistent improvements. Therefore, it is necessary to study the conditions for functioning competently in the role of LNSC by exploring the barriers and facilitators.

AIM

This study explores hospital nurses' experiences of the barriers to and facilitators of their ability to competently perform their role as Link Nurse Spiritual Care with regard to spiritual care support, one year after implementation of the role.

METHOD

Design

A general descriptive qualitative approach was selected because it can provide rich descriptive data on the barriers and facilitators experienced and can therefore contribute to theoretical knowledge and practical use[43,44]. The consolidated criteria for reporting qualitative studies (COREQ) was used to report all important aspects of the study[45].

Setting and sample

A convenience sample of LNSCs in a 200-bed hospital was recruited. As far as the researchers knew, this was the only hospital in the Netherlands that appoints LNSCs. The population was conceptualized around the following parameters: nurses with at least three months' experience performing the role of LNSC, who last performed the role no more than twelve months ago, and who spoke and understood fluent Dutch. The researchers were able to gain access to the LNSCs through the LNP. Invitation emails were sent to all eligible LNSCs (*n*=14), with follow-up emails sent two and six weeks after the initial email. Three LNSCs declined to participate because of the additional workload due to the COVID-19 pandemic, and three other LNSCs gave no reasons for declining.

Data collection

A female student researcher (AK) conducted semi-structured interviews with eight LNSCs. An interview guide, based on the LNSC competence profile, was used to ensure that all required information was obtained. The first interview was a pilot interview to test the interview guide, and the questions were further refined in response to this interview. The main questions in the interviews were: What are you doing to ensure awareness of spirituality in the care process in your unit? How do you support and coach your team members in their awareness of spirituality? How do you collaborate within and outside your organization to optimize spiritual care? What have you been able to convey about your role so far? The interviewer encouraged the LNSCs to provide in-depth information through deliberate probing. In addition, in relation to the competencies, each participant was asked what further resources they would need to be able to perform their role more effectively.

The first three interviews were conducted face-to-face at a location preferred by the participants. Five participants were interviewed by telephone or video call due to restrictions imposed related to the COVID-19 pandemic. Six participants were interviewed individually, and, at the participants' request, one interview was conducted with two participants. The interview with two participants was organized so that both participants were required to answer each question, and answering a question first was alternated between the two

participants. The interviews lasted an average of 24 minutes and were audio recorded. Specific observations made during the interviews were captured in observational memos[44].

Ethical considerations

This study was conducted in accordance with the Declaration of Helsinki, the quality standard Good Clinical Practice, and the Dutch Act on Implementation of the General Data Protection Regulation[46–48]. Approval was obtained from the Medical Research Ethics Committee of the hospital. This study did not fall under the scope of the Medical Research Involving Human Subjects Act. Participants were informed both in writing and orally about the aim and expected burden of the study. In addition, they were informed about the confidential treatment of the data and the fact that the results would be processed anonymously. All participants gave their informed consent to participate voluntarily and to have the interview recorded.

Data analysis

The analysis was an iterative process in which the researcher alternated data collection and data analysis[44]. Reflective thematic analysis (TA) was selected as the most appropriate method for the data analysis, because it can provide rich and detailed information[49,50]. An inductive data approach was chosen as previous studies had only examined the barriers and facilitators experienced by link nurses in other areas of care. A benefit of this approach is that it enables the identification of unforeseen themes in the data.

The student researcher transcribed all interviews verbatim and then read and re-read them while making preliminary notes with ideas about potential codes. The student researcher then carried out initial coding, after which themes were developed. Theme development was led by the student researcher in consultation with the principal investigator (BC) and a student researcher colleague (AP). Furthermore, the student researcher presented the data analysis in a meeting with experienced researchers and received feedback. The themes were then reviewed by re-reading all the transcribed interviews to determine whether the themes reflected the dataset and to encode previously missed data. Finally, the names of the themes were determined.

RESULTS

In total, eight LNSCs from six different units were interviewed between February and May 2020. Table 1 provides information about the demographics of the participants.

Table 1

Data analysis resulted in the identification of four themes: professional confidence, time, support and coaching, and team culture. These themes were theorized as factors to capture the way they influenced the participants' ability to competently perform the role of LNSC. The presence of these factors was experienced by the participants as a facilitator for competently performing the role, whereas if certain factors were insufficiently present or absent, this was experienced as a barrier by the participants. From the interviews, the researchers concluded that professional confidence and time were key factors. In comparison to the other two factors, these factors created great barriers in their absence. Participants had to go to great lengths to competently perform the role of LNSC if these factors were not present. Figure 1 provides a schematic representation of the factors and subfactors.

Figure 1

Factor 1: Professional confidence

Responses from the participants indicated that professional confidence was a key factor. Knowledge, implementation skills, and positioning oneself appeared to be subfactors of professional confidence.

a) Knowledge

From the interviews, the researchers concluded that knowledge was an important part of professional confidence. In 2018, all participants received training courses including basic information about spirituality. Half of the participants reported that, after the training courses, they had a conclusive picture of what spirituality entailed. This knowledge facilitated them in performing their role to optimize spiritual care in their units. They were therefore ready for further development: they wanted to learn more about spiritual care for their specific patient population.

> "Spirituality in children: other aspects are important than those for adults. A follow-up with a workshop on spiritual care for children would be nice: what age, what is important?" (Participant 7)

The other half of the participants felt that they still had limited knowledge after the training courses, and they experienced this as a barrier that caused difficulties in performing their role. For example, one participant was engaged in integrating notes on spirituality into patients' records. Her colleagues experienced a certain "vagueness" about what they could report under the heading *spirituality* in the records. She indicated that she was not always able to help them, because she struggled with this herself.

> "Sometimes I write something and I think: does it really fit? Is this really about spirituality?" (Participant 6)

a) Implementation skills

Another important part of professional confidence indicated by the participants was implementation skills. All participants were able to assess where there were opportunities for improving spiritual care in their unit. However, only a small minority of them took action to start improvement projects based on these opportunities. Examples of improvement projects they worked on were optimizing consultation requests for the chaplain and adding questions about spirituality to the anamnesis.

The participants who were not involved in improvement projects explained this mainly on the basis of the short length of stay of patients in their units. They indicated that providing spiritual care in such a unit is more difficult. For example, patients in day treatment units are often accompanied by a loved one, making it more difficult to talk to these patients privately.

> "People are staying here very briefly, which is kind of a challenge or something that prevents you from providing spiritual care. But you cannot change that. So, I have to honestly say that I'm not doing much at the moment. Because I don't think I can do much with it." (Participant 8)

a) Positioning oneself

A third important part of professional confidence was positioning oneself as LNSC. Positioning oneself here means: being visible as LNSC and showing what you are doing. The minority of participants that worked on improvement projects were also participants who were able to position themselves within the team because their attitude as LNSCs made them visible to the team. One year after implementation, a majority of the participants considered positioning themselves in the team a challenge. One participant described a situation wherein the chaplain had come to talk to her because he had received questions from her colleagues on a subject related to spirituality.

> “So yes, in that sense I think we should give more substance to our role. How can I put it- be more available or something?” (Participant 6)

Difficulty positioning themselves in the team was more common when there was resistance from the team and when participants felt less involved in the subject of spirituality than they initially expected. For example, because they expected spirituality to be more about the Christian faith. Sometimes they did not know how to broach improvement plans.

> “My colleagues didn’t really feel like it, perhaps because of the way I presented it.” (Participant 1)

Factor 2: Time

A second key factor identified in this study was time. The participants indicated they needed time to competently perform the role of LNSC, for example, for preparing improvement projects and case discussions. The participants in this study were given four hours per month to perform their role, but these hours were not scheduled in their timetables.

> “We try to use them, but is it simply not scheduled. And then you have to put them on the list [timetable] yourself. Anyway, now it’s often overtime.” (Participant 5)

As a result, the participants had to find the designated four hours outside of their shifts. A great majority of them therefore chose not to use this time.

Factor 3: Support and coaching

An important factor in the functioning of LNSCs was support and coaching. Important roles in this factor are occupied by the chaplain, the LNP, and intercollegiate meetings.

a) Chaplain

Participants’ responses indicated that the chaplain had an important role in the support and coaching of LNSCs. A great majority of the participants was positive about working with the chaplain to improve patients’ spiritual care. The chaplain supported and coached the LNSCs in their role by attending team case discussions and helping them to highlight different sides of the cases. The participants who experienced a lack of professional confidence seemed to particularly appreciate this support. An example of this was Participant 4, who experienced many difficulties in fulfilling her role due to a lack of professional confidence.

> “Well, then such a case is illuminated from different sides so that everyone can look at it slightly differently or something.” (Participant 4)

b) Link Nurse Spiritual Care Plus (LNP)

The role of the LNP was also indicated as important in the support and coaching of LNSCs. Half of the participants specifically mentioned the LNP as a facilitator for competently performing their role.

> “She is the one who stimulates, motivates others, the one you can ask questions.” (Participant 7)

The LNP coached new LNSCs in performing their roles and supported them in practical matters. For example, the LNP had provided posters with questions that could be used to start a conversation about spirituality with a patient, and the LNSCs could use these posters to help colleagues who were struggling to initiate such conversations. Such forms of support made it easier for the participants to competently perform their role.

> “I think she’s kind of pushing you forward, making sure we keep moving and pick up new things.” (Participant 6)

c) Intercollegiate meetings

Intercollegiate meetings played an important part in the coaching and support of LNSCs, according to the interviews. Regular meetings with all the LNSCs were experienced as a facilitator by a majority of the participants. The LNP organized the intercollegiate meetings, set the agenda, and provided everyone with minutes. The added value of the meetings was mainly in exchanging ideas between the LNSCs and learning from each other what worked and what did not work on their units.

> “That unit has been busy with that [program to enhance spiritual care]- well you will learn from that as a unit. So that sometimes gives us new insights and something like: yes, we can do that as well.” (Participant 6)

Improvement points for the meetings mentioned by the participants were more regular planning of the meetings and more attention for units with a short length of stay.

Factor 4: Team culture

The fourth factor identified in this study was team culture. Two subfactors were distinguished within this factor: cooperation and communication.

a) Cooperation

Cooperation within a team appeared to be an important part of team culture. A majority of the participants faced resistance from their teams. This resistance was especially noticeable at the beginning of 2018. In half of the teams, the resistance had diminished as the year progressed. In the other half, this had taken longer, or there was still resistance at the time of the interview.

> "And frankly, we might not have expected it to be like this. And if you face it [resistance from your team], you will hear that later, that it can happen. And then you think: okay. So, you just have to adjust that expectation and actually not have expectations." (Participant 3)

A lack of resistance made it easier to discuss matters regarding spiritual care. This also made it easier to introduce changes. In teams where there was little resistance, LNSCs were also more often given the opportunity to talk about spiritual care during work meetings.

b) Communication

Another important part of team culture was communication, according to the interviews. Performing the role of LNSC was experienced as easier in teams that had an open dialogue culture. In a majority of the units, the culture was characterized by nurses accepting each other as they were and as they worked, and therefore feedback was only given sparingly. In the units where there was an open dialogue culture, however, nurses did provide feedback regularly, and when the participants wanted to implement an improvement plan, this feedback worked as a facilitator. For example, LNSCs were able to give feedback if the plan was not followed, and they also observed that colleagues corrected each other if they did not follow the agreed procedure.

> "We also agreed to simply speak to each other about it. If you see something from each other, try to say, 'you cared for that patient but I think this and that." (Participant 5)

DISCUSSION

The results of the analysis suggest that professional confidence, time, support and coaching, and team culture are factors that influence hospital nurses' ability to competently perform the role of LNSC. Responses from the interviews indicate that professional confidence and scheduled time are key factors. In this study the lack of scheduled time was the greatest barrier for the participants, while support and coaching was the most present factor, making it the greatest facilitator.

The key intrapersonal factor of professional confidence divided the interviewed LNSC into two groups. One group LNSCs with professional confidence that were involved in various improvement projects, and one group with limited professional confidence that were struggling to support spiritual care in their units. Holland et al.[51] describe professional confidence as "a dynamic, maturing personal belief held by a professional or student. This includes an understanding of and a belief in the role, scope or practice, and significance of the profession, and is based on their capacity to competently fulfill these expectations, fostered through a process of affirming experiences." This description shows that professional confidence is comprehensive, and it is therefore not surprising that its absence or presence influences LNSCs' ability to function to such an extent.

Research shows that providing feedback, especially positive reinforcement, can enhance professional confidence[52,53]. In addition, according to Cotterell et al.[54] confidence to perform the role of link nurse can be enhanced by support and backup from link nurse colleagues and specialists in the area in which the link nurses operate. In various link nurse initiatives, this support is given the form of intercollegiate meetings, which is in line with the LNSC initiative in this study[42,54–58]. However, an additional feature implemented in many other studies is that the intercollegiate meetings were combined with educational sessions[54,56,59].

Allen et al.[60] studied the characteristics of Link Nurses Pain that contributed to sustainable evidence-based practice changes eight years after implementation. They indicate that link nurses feel more confident in their role if they receive ongoing educational support. Successful ongoing education should address challenges in practice and education could include topics such as implementation skills, change management training, and presentation skills[54,56,61,62].

Scheduled time was experienced as a precondition for performing the role of LNSC. Failure of healthcare organizations to meet preconditions is not a unique issue in link nurse initiatives[39,54–56]. Insufficient time can cause link nurses to feel unsupported and under-valued and therefore threatens the sustainability of link nurse programs[54,56].

An optimal team culture was also seen as a precondition by the LNSCs. However, the possibilities of changing the team culture seem limited, even though it could be valuable to

help LNSCs better deal with resistance in the team and the possible lack of an open dialogue culture. According to Horton[63], change management training is an important component of the educational program. In the study by Lloyd et al.[56], link nurses' ability to effect change increased through assistance from a change management specialist.

Strengths and limitations

One of the strengths of our study was the use of research triangulation to enhance reliability. This consisted of developing themes in consultation with the principal researcher, and presenting and receiving feedback on the analyses in a meeting with a group of experienced researchers. Trustworthiness and transferability were enhanced by using thick description of the themes[44].

There are a number of limitations in this study, the first of which is the composition of the study sample. The study was conducted in one small general hospital with little variation in the sample. All participants were female, and seven out of eight participants had a religious background. It was noteworthy that there were no bachelor-educated nurses included. Selection bias could therefore play a role: a more varied sample could have had the effect of making certain barriers and facilitators more or less prominent. Generalization to other settings may therefore be limited to health care organizations with LNSCs with a comparable educational level.

Second, during the data collection period, a number of LNSCs cancelled their interview appointment due to the COVID-19 pandemic. This resulted in a smaller number of participants than originally intended, making it impossible to conduct a control interview. Data saturation can therefore not be confirmed. Finally, the researchers intended to perform individual face-to-face interviews to make it easier to build rapport with the subjects; however, due to the COVID-19 pandemic, only three of the eight interviews could be performed face-to-face. In practice, however, rapport building by phone or video call did not cause any problems, which is in line with studies that show that telephone interviews can also be used productively in qualitative studies[64,65]. During one interview, two participants were interviewed together at their request. This may have led to them giving more socially desirable answers than expected at an individual interview. Despite these potential limitations, this study is useful for providing an impression of barriers and facilitators experienced by hospital nurses performing the role of LNSCs.

Conclusion

Responses from the interviews indicate that professional confidence, time, support and coaching, and team culture are factors that should be strengthened to sustain the promising results of previous research into the appointment of LNSC, with emphasis placed on the key

factors of professional confidence and scheduled time. Organizations must schedule time monthly for every LNSC, and the professional confidence of the LNSCs should be enhanced by extending intercollegiate meetings with educational sessions focusing on optimizing knowledge, implementation skills and positioning. Challenges in practice, like the length of stay of patients, must be taken into account when preparing these sessions. In addition, providing feedback should be encouraged by teaming up LNSCs with limited experienced with a LNSC who is involved with multiple improvement projects in her unit. Both LNSCs can then help each other to optimize spiritual care support in each other's units. After optimizing the professional confidence of the LNSCs and scheduled time, further expansion of the competences of the LNSCs could be considered through, for example, guest lessons from a change manager.

The composition of the sample limited the generalizability of the results of this study. Future research should therefore be aimed at bachelor-educated nurses to identify possible differences in the barriers and facilitators experienced. Subsequently, an evaluation study should be initiated to determine whether strengthening the factors identified has contributed to sustaining the promising outcomes from previous research.

REFERENCE LIST

1. Centraal Bureau voor de Statistiek. StatLine - Ziekenhuisopnamen; sterfte, urgentie, diagnose-indelingen CCS en VTV [Internet]. [cited 2020 Feb 13]. Available from: https://opendata.cbs.nl/statline/#/CBS/nl/dataset/84522NED/table?ts=1581587511401
2. Clark PA, Drain M, Malone MP. Addressing patients' emotional and spiritual needs. Jt Comm J Qual Saf. 2003;29(12):659–70.
3. Pearce MJ, Coan AD, Herndon JE, Koenig HG, Abernethy AP. Unmet spiritual care needs impact emotional and spiritual well-being in advanced cancer patients. Support Care Cancer. 2012 Oct;20(10):2269–76.
4. International Council of Nurses. The ICN code of ethics for nurses [Internet]. 2012 [cited 2020 Feb 13]. Available from: https://www.icn.ch/sites/default/files/inline-files/2012_ICN_Codeofethicsfornurses_ eng.pdf
5. Puchalski CM, Vitillo R, Hull SK, Reller N. Improving the spiritual dimension of whole person care: Reaching national and international consensus. J Palliat Med. 2014;17(6):642–56.
6. Medisch Centrum Leeuwarden. Visie op verpleegkundige professionaliteit [Internet]. [cited 2020 Feb 13]. Available from: https://www.mcl.nl/_library/69822/visie op verpleegkundige professionaliteit MCL 2017.pdf
7. Groene Hart Ziekenhuis. Visie op verpleegkundige zorg [Internet]. [cited 2020 Feb 13]. Available from: https://www.ghz.nl/media/6919871/visie-op-verpleegkundige-zorg.pdf
8. Universitair Medisch Centrum Groningen. Visie op verplegen in het UMCG [Internet]. [cited 2020 Feb 13]. Available from: https://www.umcg.nl/SiteCollectionDocuments/UMCG/Werken_in_het_UMCG/Visie op verplegen in het UMCG.pdf
9. British Holistic Medical Association. British Holistic Medical Association: It's time for a new vision of healthcare... [Internet]. [cited 2020 Feb 13]. Available from: https://bhma.org/
10. Yilmaz M, Cengiz HÖ. The relationship between spiritual well-being and quality of life in cancer survivors. Palliat Support Care. 2019 Jul 19;1–8.
11. Bai M, Lazenby M. A systematic review of associations between spiritual well-being and quality of life at the scale and factor levels in studies among patients with cancer. J Palliat Med. 2015 Mar 1;18(3):286–98.
12. Oh P-J, Kim SH. The effects of spiritual interventions in patients with cancer: a meta-analysis. Oncol Nurs Forum. 2014 Sep;41(5):290–301.
13. Heidari M, Ghodusi Borujeni M, Kabirian Abyaneh S, Rezaei P. The Effect of Spiritual Care on Perceived Stress and Mental Health Among the Elderlies Living in Nursing

Home. J Relig Health. 2019 Aug;58(4):1328–39.
14. Borji M, Mousavimoghadam SR, Salimi E, Otaghi M, Azizi Y. The Impact of Spiritual Care Education on Anxiety in Family Caregivers of Patients with Heart Failure. J Relig Health. 2018 Nov 7;58(6):1961–9.
15. Küçük Alemdar D, Kardaş Özdemir F, Güdücü Tüfekci F. The Effect of Spiritual Care on Stress Levels of Mothers in NICU. West J Nurs Res. 2018;40(7):997–1011.
16. Keivan N, Daryabeigi R, Alimohammadi N. Effects of religious and spiritual care on burn patients' pain intensity and satisfaction with pain control during dressing changes. Burns. 2019 Nov;45(7):1605–13.
17. Lambregts JAM, Grotendorst A. Leren van de toekomst : verpleegkundigen & verzorgenden 2020. Bohn Stafleu van Loghum; 2012.
18. Gijsberts MJHE, van der Steen JT, Muller MT, Hertogh CMPM, Deliens L. Spiritual End-of-Life Care in Dutch Nursing Homes: An Ethnographic Study. J Am Med Dir Assoc. 2013;14(9):679–84.
19. Van Meurs J, Smeets W, Vissers KCP, Groot M, Engels Y. Nurses Exploring the Spirituality of Their Patients with Cancer: Participant Observation on a Medical Oncology Ward. Cancer Nurs. 2018 Jul 1;41(4):E39–45.
20. Chen CS, Chan SW-C, Chan MF, Yap SF, Wang W, Kowitlawakul Y. Nurses' Perceptions of Psychosocial Care and Barriers to Its Provision: A Qualitative Study. J Nurs Res. 2017 Aug 10;25(6):411–8.
21. Kenny A, Allenby A. Barriers to nurses providing psychosocial care in the Australian rural context. Nurs Health Sci. 2013 Jun;15(2):194–200.
22. Selman LE, Brighton LJ, Sinclair S, Karvinen I, Egan R, Speck P, et al. Patients' and caregivers' needs, experiences, preferences and research priorities in spiritual care: A focus group study across nine countries. Palliat Med. 2018;32(1):216–30.
23. Ebenau A, Groot M, Visser A, van Laarhoven HWM, van Leeuwen R, Garssen B. Spiritual care by nurses in curative oncology: a mixed-method study on patients' perspectives and experiences. Scand J Caring Sci. 2019;33(3):760–1.
24. Riahi S, Goudarzi F, Hasanvand S, Abdollahzadeh H, Ebrahimzadeh F, Dadvari Z. Assessing the Effect of Spiritual Intelligence Training on Spiritual Care Competency in Critical Care Nurses. J Med Life. 2018;11(4):346–54.
25. Van Leeuwen R, Tiesinga LJ, Middel B, Post D, Jochemsen H. The effectiveness of an educational programme for nursing students on developing competence in the provision of spiritual care. J Clin Nurs. 2008 Oct;17(20):2768–81.
26. Robinson MR, Thiel MM, Shirkey K, Zurakowski D, Meyer EC. Efficacy of Training Interprofessional Spiritual Care Generalists. J Palliat Med. 2016 Aug 1;19(8):814–21.
27. Hodge DR. Administering a two-stage spiritual assessment in healthcare settings: a

necessary component of ethical and effective care. J Nurs Manag. 2015 Jan;23(1):27–38.
28. Draper P. An integrative review of spiritual assessment: implications for nursing management. J Nurs Manag. 2012 Dec;20(8):970–80.
29. Caldeira S, Hall J. Spiritual leadership and spiritual care in neonatology. J Nurs Manag. 2012;20(8):1069–75.
30. Jahandar P, Zagheri Tafreshi M, Rassouli M, Atashzadeh-Shoorideh F, Kavousi A. Nurses' perspective on spiritual leadership: A qualitative study based on Fry's spiritual leadership model. Electron Physician. 2017 Nov 25;9(11):5721–31.
31. Ersek M, Wilson SA. The challenges and opportunities in providing end-of-life care in nursing homes. J Palliat Med. 2003;6(1):45–57.
32. World Health Organization. Improving infection prevention and control at the health facility [Internet]. 2018 [cited 2020 Feb 13]. Available from: https://www.who.int/infection-prevention/tools/core-components/facility-manual.pdf
33. Cooper T. Educational theory into practice: development of an infection control link nurse programme The theory-practice gap and infection control. Nurse Educ Pr. 2001;1(1):35–41.
34. Sopirala MM, Yahle-Dunbar L, Smyer J, Wellington L, Dickman J, Zikri N, et al. Infection control link nurse program: An interdisciplinary approach in targeting health care-acquired infection. Am J Infect Control. 2014;42(4):353–9.
35. Seto WH, Yuen SWS, Cheung CWY, Ching PTY, Cowling BJ, Pittet D. Hand hygiene promotion and the participation of infection control link nurses: An effective innovation to overcome campaign fatigue. Am J Infect Control. 2013 Dec;41(12):1281–3.
36. Zadvinskis IM, Salsbury SL. Effects of a multifaceted minimal-lift environment for nursing staff: pilot results. West J Nurs Res. 2010 Feb;32(1):47–63.
37. Alamgir H, Drebit S, Li HG, Kidd C, Tam H, Fast C. Peer coaching and mentoring: A new model of educational intervention for safe patient handling in health care. Am J Ind Med. 2011 Aug;54(8):609–17.
38. Flanagan D, Moore E, Baker S, Wright D, Lynch P. Diabetes care in hospital - The impact of a dedicated inpatient care team. Diabet Med. 2008 Feb;25(2):147–51.
39. Heals D. Development and implementation of a palliative care link-nurse programme in care homes. Int J Palliat Nurs. 2008;14(12):604–9.
40. Cusveller B, Damsma-Bakker A, Streefkerk T, Van Leeuwen R. Implementing 'Link Nurses' as Spiritual Care Support in a General Hospital: Report of Quantitative and Qualitative results. Manuscript Submitted for Publication 2019;
41. Van Leeuwen R, Cusveller B. Nursing competencies for spiritual care. Vol. 48, Journal of Advanced Nursing. 2004. p. 234–46.

42. Williams L, Cooper T, Bradford L, Cooledge B, Elner F, Fisher D, et al. An evaluation of an infection prevention link nurse programme in community hospitals and development of an implementation model. J Infect Prev. 2019 Jan 1;20(1):37–45.
43. Kahlke RM, Hon BA. Generic Qualitative Approaches : Pitfalls and Benefits of Methodological Mixology. Int J Qual Methods. 2014;13(37):37–52.
44. Boeije H. Analysis in Qualitative Research. 1st ed. London: Ltd., SAGE Publications; 2010.
45. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. Int J Qual Heal Care. 2007;19(6):349–57.
46. Association WM. WMA Declaration of Helsinki – Ethical Principles for Medical Research Involving Human Subjects – WMA – [Internet]. [cited 2019 Oct 10]. Available from: https://www.wma.net/policies-post/wma-declaration-of-helsinki-ethical-principles-for-medical-research-involving-human-subjects/
47. Committee for Human Medicinal Products. Guideline for good clinical practice E6(R2) [Internet]. 2006 [cited 2019 Nov 3]. Available from: https://www.ema.europa.eu/en/documents/scientific-guideline/ich-e-6-r2-guideline-good-clinical-practice-step-5_en.pdf
48. Uitvoeringswet Algemene verordening gegevensbescherming - BWBR0040940 [Internet]. 2019 [cited 2019 Nov 3]. Available from: https://wetten.overheid.nl/BWBR0040940/2019-02-19
49. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006;3(2):77–101.
50. Clarke, V., Braun, V., Terry G& HN. Handbook of research methods in health and social sciences. First edit. Springer Singapore; 2019.
51. Holland K, Middleton L, Uys L. Professional confidence: A concept analysis. Scand J Occup Ther. 2012 Mar 5;19(2):214–24.
52. Brown B, O'Mara L, Hunsberger M, Love B, Black M, Carpio B, et al. Professional confidence in baccalaureate nursing students. Nurse Educ Pract. 2003 Sep 1;3(3):163–70.
53. Crooks D, Carpio B, Brown B, Black M, O'Mara L, Noesgaard C. Development of professional confidence by post diploma baccalaureate nursing students. Nurse Educ Pract. 2005 Nov 1;5(6):360–7.
54. Cotterell P, Lynch C, Peters D. Bridging the gap: can a link nurse initiative influence palliative care in an acute hospital? Int J Palliat Nurs. 2007;13(3):102–8.
55. Perry-woodford Z, Whayman K. Education in practice: a colorectal link-nurse programme. Br J Nurs. 2005;14(16):862–7.

56. Lloyd-Smith E, Curtin J, Gilbart W, Romney MG. Qualitative evaluation and economic estimates of an infection control champions program. Am J Infect Control. 2014;42(12):1303–7.
57. Froggatt KA, Hoult L. Developing palliative care practice in nursing and residential care homes: The role of the clinical nurse specialist. J Clin Nurs. 2002;11(6):802–8.
58. Grigg L, Parkar F. Improving the effectiveness of the link system in an acute trust. Nurs Times. 2004;100(7):32–4.
59. Hasson F, Kernohan WG, Waldron M, Whittaker E, McLaughlin D. The palliative care link nurse role in nursing homes: Barriers and facilitators. J Adv Nurs. 2008;64(3):233–42.
60. Allen E, Williams A, Jennings D, Stomski N, Goucke R, Toye C, et al. Revisiting the Pain Resource Nurse Role in Sustaining Evidence-Based Practice Changes for Pain Assessment and Management. Worldviews Evidence-Based Nurs. 2018;15(5):368–76.
61. Dekker M, Van Mansfeld R, Vandenbroucke-Grauls C, De Bruijne M, Jongerden I. Infection control link nurse programs in Dutch acute care hospitals; A mixed-methods study. Antimicrob Resist Infect Control. 2020;9(1):1–10.
62. Hasson F, Kernohan WG, Waldron M, Whittaker E, McLaughlin D. The palliative care link nurse role in nursing homes: Barriers and facilitators. J Adv Nurs. 2008 Nov;64(3):233–42.
63. Horton R. Linking the Chain. Nurs Times. 1988;84(26):44–6.
64. Sturges J, Hanrahan K. Comparing telephone and face-to-face qualitative interviewing: a research note. Qual Res. 2004;4(1):107–18.
65. Farooq MB. Qualitative telephone interviews: Strategies for success. Hamilton, New Sealand; 2015.

TABLE

Table 1

Demographic Characteristics of Participants (N = 8)

All participants (N=8)	N
Age (years)	
20-29	3
40-49	3
50-59	2
Gender	
Female	8
Male	0
Education	
Vocational-educated nurse	8
Religious background	
Protestant	7
None	1
Years working in the hospital	
0-9	3
10-19	1
20-29	3
30-39	1
Months in the role of LNSC	
4-9	1
10-19	1
20-29	6

FIGURE

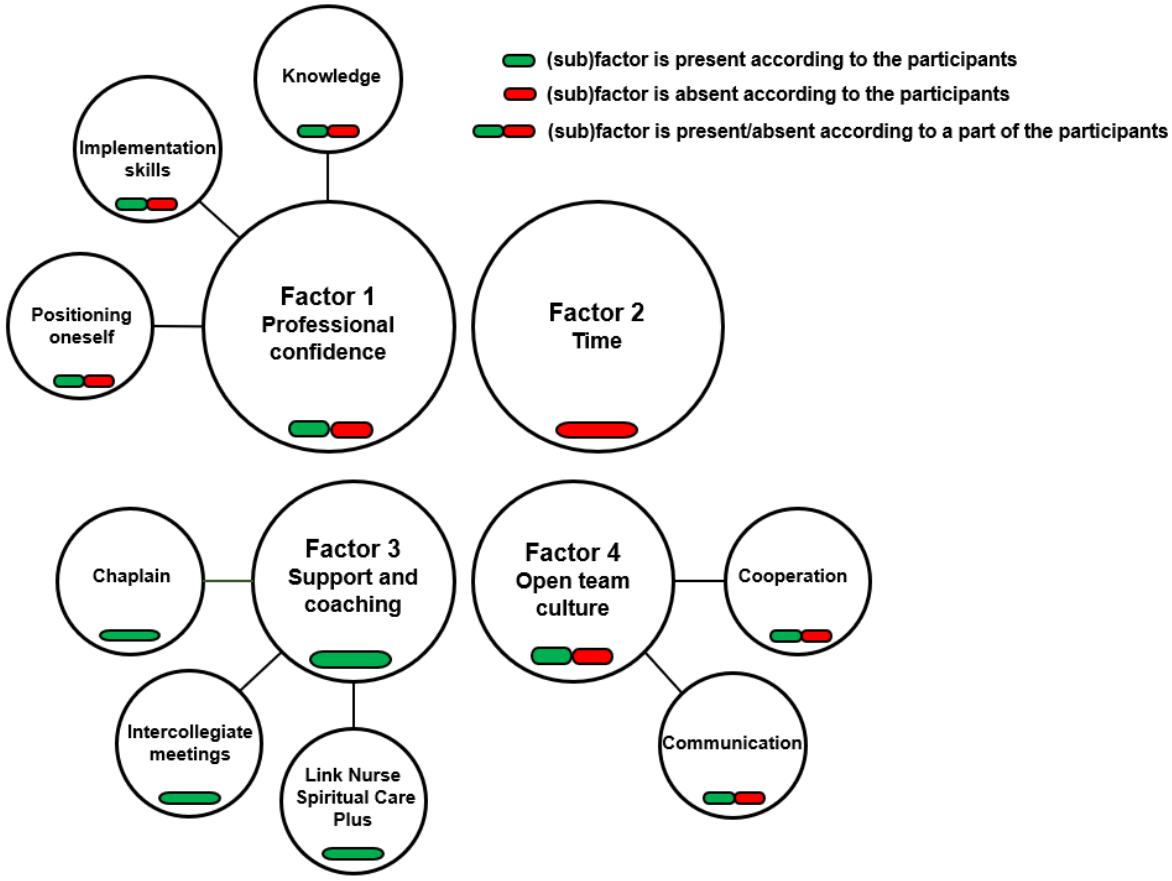

Figure 1

Map of factors and subfactors influencing LNSCs' ability to competently perform their role. Colors indicate the presence/absence of these factors in this study and thus the facilitators and barriers experienced by the participants.