Prayer and the Registered Nurse (PRN): Nurses' reports of ease and dis-ease with patient-initiated prayer request

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Prayer and the Registered Nurse (PRN): nurses' reports of ease and dis-ease with patient-initiated prayer request

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Abstract

Aims. To explore nurse comfort with patient-initiated prayer request scenarios.

Background. Spiritual care is fundamental to patient care evidenced by Joint Commission requirement of a spiritual assessment on a patient's hospital admission. Prayer is an assessment component. Patients may seek solace and support by requesting prayer from the bedside nurse, the nurse may lack confidence in responding. Absent in the literature are reports specific to nurses' comfort when patients initiate prayer requests.

Design. Cross-sectional mixed methods study.

Methods. Data were collected in early 2014 from 134 nurses in the USA via an online survey using QuestionPro. The qualitative results reported here were collated by scenario and analysed using thematic analysis.

Results/findings. The scenario responses revealed patterns of ease and dis-ease in response to patient requests for prayer. The pattern of ease of prayer with patients revealed three themes: open to voice of calm or silence; physical or spiritual; can I call the chaplain. For these nurses, prayer is a natural component of nursing care, as the majority of responses to all scenarios demonstrated an overwhelming ease in response and capacity to pray with patients on request. The pattern of dis-ease of prayer with patients distinguished two themes: cautious hesitancy and whose God. These nurses experienced dis-ease with the patient's request no matter the situation.

Conclusion. Educators and administrators must nurture opportunities for students and nurses to learn about and engage in the reflective preparation needed to respond to patient prayer requests.

Keywords: nurses, nursing administration, nursing education, patient care, prayer, religion, spiritual assessment, spirituality, thematic analysis

Why is this research needed?

- Spiritual care is a required component of the hospital intake assessment; patient use of prayer is recognized as part of this assessment.
- Nurses spend the greatest amount of time with patients and may experience patient prayer requests; understanding nurses' capacity to respond to these requests is essential in the patient-centred care environment.

What are the key research findings?

- Nurse participants' narrative responses revealed patterns of ease and dis-ease in response to requests for prayer by patients.
- The majority of nurse participants reported ease in responding to patient-initiated prayer requests; however, variations in patient acuity or religion/ethnicity appeared to elicit feelings of dis-ease among many nurses.

How should the findings be used to influence policy/practice/research/education?

- Administrators should provide intentional institutional support and educational curriculum devoted to the reflective preparation needed to authentically respond, for example, have the capacity to act.
- Education should incorporate into the curriculum the art of reflective preparation, where students learn to ponder their personal spiritual beliefs alongside a patient's spiritual practices.

Introduction

Spiritual care is a fundamental aspect of patient care evidenced by the inclusion of a patient spiritual assessment in the Joint Commission (JC) (2008) standards. Further, the JC includes patient use of prayer in the spiritual assessment. Individuals express connectedness to a higher power through prayer (Narayanasamy 2006), relying on spiritual practices as a means of coping (Ikedo *et al.* 2007). As a coping mechanism during times of health crises, prayer is a source of solace and inner strength (Kelly 2004) and is associated with healing (Koenig 1997).

Spiritual care is integral to nursing (Burkhart & Schmidt 2012). As a component of the nurse-client relationship, praying with a patient highlights the inspiriting role of the nurse (Carson 1989, O'Brien 2003) through which the patient experiences hope, worth and purpose.

The American Association of Colleges of Nursing (2008) includes spiritual care in patient-centred care in baccalaureate education; the American Nurses Association (2010) identifies assessment of spirituality as a core competency for assessment, planning and health teaching/promotion. International Council of Nurses Code of Ethics (2012) emphasizes respecting an individual's spirituality; however, besides literature from the United Kingdom (UK) and North America, little is known regarding who in the healthcare team is equipped to provide spiritual care (Paal *et al.* 2014).

In the USA, hospitalized patients' spiritual care has historically been relegated to the hospital chaplain, yet little more than 50% of hospitals provide chaplaincy services (Pesut *et al.* 2012). Given the lack of these services and the need to remain compliant with JC, hospital staff nurses in the USA complete the initial spiritual assessments. Moreover, nurses are the healthcare professional that spends the most time with patients and may be sought for prayer in the absence of in-house chaplains (Mallory 2003, Paice *et al.* 2007). Although nurses may lack confidence and knowledge addressing spiritual health needs, nurses initiate prayer with patients and are influenced by their personal beliefs and religious affiliation (Taylor *et al.* 2014). And, while nurse initiated prayer is unethical (Puchalski & Ferrell 2010, French & Narayanasamy 2011), the likelihood remains that a patient may elicit a prayer request.

A systematic literature review of the effect of prayer on patient health represented outcomes from the USA, UK, Israel and Korea (Simão *et al.* 2016); however, absent in the USA and international literature are reports specific to nurses' comfort with prayer requests. This article reports the qualitative findings of a mixed-method study, where nurses from a USA health care organization provided written responses to four simulated patient-initiated prayer request scenarios.

Background

Conceptual considerations

The Inpatient Spiritual Care Implementation Model (Puchalski *et al.* 2009) identifies nurses among the clinicians involved in spiritual screening, which includes spiritual assessment during patient admission. This communication with patients and families is crucial in acknowledging the patient as a whole person (Puchalski & Ferrell 2010). Moreover, the Spiritual Care Framework (SCF) (Puchalski *et al.* 2009) suggests reflective preparation as a link between the personal dimensions of spirituality, that is, call to service, meaning and purpose, transcendence, connectedness, transformation and the JC Humanitarian Skills of compassion, empathy, dignity, respect and support. This

framework emphasizes the 'capacity for action', or being fully present, as the key to alleviating suffering; a patient request for prayer directly calls on the nurse's capacity for action.

Numerous definitions of spirituality, spiritual care and prayer exist in the literature (Narayanasamy 1999, Narayanasamy *et al.* 2004, Burkhart & Hogan 2008, Borneman *et al.* 2010, French & Narayanasamy 2011, Burkhart & Schmidt 2012, Bennett & Thompson 2015). Central to these definitions is the commonality of spirituality to all people, the 'essence of one's humanity' (Puchalski & Ferrell 2010, p. 25) in reference to the seminal writings of Frankl (1963). The SCF places emphasis on the previously mentioned dimensions of spirituality in a relational context, such that patients and providers are engaged in a process of collaboration, evaluation and follow-up (Puchalski & Ferrell 2010). Spirituality in the nurse-patient relationship is one of mutuality. The nurse recognizes the individuality of patient interaction and with true presence creates the capacity to transcend and transform the experience (Burkhart & Hogan 2008).

Prayer can be prescriptive and confined to the formal liturgical settings of a given faith community (Ai *et al.* 2008), but it is often broadly defined as communication between an individual and a higher power (Spilka & Ladd 2013). This study uses the latter definition and aligns with the dimensions of spirituality and JC humanitarian skills in the SCF. Key to the SCF is reflective preparation, which identifies the nurse's ability to respond to a patient prayer request with compassionate presence. Reflective preparation requires of the nurse a familiarity with the practices of contemplation (Yang & Mao 2007), discussion with peers about the spiritual components of patient care (McSherry & Jamieson 2011) and an awareness of personal spirituality and self-care based on internal and external resources (Koren & Papamiditriou 2013).

Spiritual care holds a prominent place in the historical context of the nursing profession (Carson 1989) and in a current healthcare focus on patient-centred care (Puchalski & Ferrell 2010). Literature review about nurse participation in the delivery of spiritual care includes quantitative and qualitative exploration of spiritual assessment and interventions (Narayanasmay & Owens 2001, Grant 2004, Tanyi *et al.* 2009, Carron & Cumbie 2011, Lind *et al.* 2011, Sacco *et al.* 2011, Deal & Grassley 2012, Pittroff 2013, vanLeeuwen *et al.* 2013). Patient preferences are emphasized in Taylor's (2003) query of families and patients about their expectations of nurses related to spiritual care: nursing actions of respect, kindness, listening, prayer and physical presence were identified. Previously, Bauer and Barron (1995) reported patients prefer nurses showing respect and caring over specific religious interventions – offering prayer received a low ranking. Their findings are similar to Sellers (2001); nurses can enhance spirituality by understanding the unique human experience of each person through the establishment of a caring human relationship characterized by the art of being present, listening, respecting and giving of self.

A nurse's capacity for empathic presence is particularly crucial given that the implementation of a spiritual assessment offers an opening for patient prayer request during times marked by clergy unavailability. However, spiritual assessment and associated interventions may not meet the patient's needs when the nurse has not nurtured his or her spirituality (Yang & Mao 2007). If nurses have not engaged in ongoing reflective preparation (Puchalski & Ferrell 2010, Koren & Papamiditriou 2013), their lack of comfort may impede their ability to be present for the patient. As nurses' comfort with patient-initiated prayer has not been reported, an exploration of this gap in knowledge is relevant regarding implications for nursing education and clinical practice (Taylor 2003, Narayanasamy & Narayanasamy 2008).

The study

Aim

The aim of this study was to explore Registered Nurse comfort with patient-initiated prayer request via scenarios. Enhanced understanding is essential to identify specific implications and potential interventions for nursing education and clinical practice related to spiritual care.

Design

This article reports the qualitative findings of a mixed-method study. Qualitative descriptive methodology as described by Sandelowski (2010) was used to further understand the phenomenon of comfort with patient-initiated prayer requests from the perspective of the bedside nurse (Vaismoradi *et al.* 2013). Practicing nurses in this study described their likely reactions to four different, simulated, patient-initiated prayer request scenarios (Table 1).

Participants

The nurse participants were recruited from one hospital in Western South Dakota, USA, with all registered staff nurses (RN) eligible to participate. The facility's Chief Nurse

Table 1 PRN survey scenarios and response rate.

Scenario	Response rate
Scenario 1: During a night shift you discover one of your patients sitting by her window staring out into the night sky. There is instrumental music softly playing in the background and she is clutching her rosary and her Bible. You ask if there is anything you can do for her and she responds "Please sit with me and pray for me." How would you respond?	$n = 114$
Scenario 2: You are an emergency room RN working the day shift in the Emergency Department. The patient exam room has 4 other ED staff stabilizing your patient who is a 56 year old male. With the physician and other staff present your patient looks directly at you and says, "It would mean so much to me if you would offer a prayer for me now." How would you respond?	$n = 111$
Scenario 3: You are employed in a hospital where there are patients of diverse ethnic and religious backgrounds. A patient who practices a religious belief different from yours asks you to pray *for* her. How would you respond?	$n = 111$
Scenario 4: You are employed in a hospital where there are patients of diverse ethnic and religious backgrounds. A patient who practices a religious belief different from yours asks you to pray *with* her. How would you respond?	$n = 110$

Executive invited nurses to participate in the study via an electronic staff newsletter. Due to the mixed-method study design the number of nurses responding to the invitation determined sample size. Nurses could elect to answer or not answer specific scenarios which may have skewed the results; however, great variation, rich texts and several common themes were present in the narratives (Table 3).

Data collection

Data collection occurred over a three week period in early 2014 via an online survey link using QuestionPro. Nurse participants were asked to complete the Prayer and the Registered Nurse (PRN) survey, which consisted of demographic data, previous experience with patient prayer, nine Likert style items related to comfort in prayer with patients and family members and four patient care scenarios. Scenarios 1-3 were designed to capture the nurse's response to pray for the patient; scenario 4 was the same as 3 but the word 'for' was changed to 'with'. Due to the online survey format, validation or clarification of the written responses was not obtained (Table 1).

Data management and analysis

At completion of data collection, the narrative responses were collated from QuestionPro into an SPSS (Version 22) database to ensure responses could be connected with a respondent ID number. Two qualitative researchers (LH and CA) conducted the thematic analysis. Following Braun and Clarke (2006) thematic analysis process, the researchers immersed themselves in the texts, independently reading and rereading the collated narratives. This 'repeated reading' is active, as the researchers grasp new meanings and discern between prior and new knowledge (Diekelmann & Ironside 1998, Braun & Clarke 2006, p. 87). LH and CA independently coded key words or phrases and then collectively shared their results with JL, including thoughts, impressions and insights. The team discussed discrepancies until they reached agreement. After identification of the initial themes and patterns, LH conducted a deeper analysis, where further cultivation, description and integration of the data occurred to explicate the essence of the phenomenon of nurse comfort with patient-initiated prayer requests (Sandelowski & Leeman 2012, Vaismoradi *et al.* 2013). Prior to analysing the texts, the researchers considered their own preconceived notions and biases about this topic. As practicing registered nurses, JL, CA and LH have experienced patient requests for prayer; however, each researchers' viewpoint of this phenomenon differs, including personal perceptions about the possible research results.

Ethical considerations

Institutional Review Board (IRB) approval was obtained covering online recruitment and delivery of the survey which included the patient request for prayer scenarios. An IRB approved incentive of a gift card drawing was optional for each participant. Participant anonymity was emphasized, as no identifying information was present in the narrative responses.

Rigour

The researchers maintained dependability and trustworthiness by sharing and debating their coding and interpretations via conference calls and the verbatim examples provided from the narratives (Lincoln & Guba 1985). These findings are transferable as noted in the descriptions of the setting and the disclosure of the scenario exemplars. Credibility is evident in the data analyses, where the researchers identified common themes and patterns between and among the texts (Thomas & Magilvy 2011). Dependability, transferability and credibility are the foundation for confirmability (Koch & Harrington 1998) and noted in the reexamination and revision of the interpretations, strengthening the findings.

Findings

Average age for the 134 nurse respondents was 42·3 years and the majority identified as White, female and Christian, mirroring USA national statistics specific to age (Health Resources and Services Administration (HRSA), Bureau of Health Professions, National Center for Workforce Analysis (2013) and religion (Pew Research Center 2015). These respondents all worked for the same health system in the Northern Plains, which may account for the less diversified workforce compared with national USA statistics (HRSA 2013). The nurses reported an average practice tenure of 14·3 years. Areas of practice from highest to lowest were step-down, medical-surgical, neonatal intensive care, hospice, paediatrics, labour and delivery and adult intensive care. Forty-two indicated 'other' as a practice arena (Table 2).

The thematic analysis of the participants' narrative responses revealed patterns of ease and dis-ease in response to requests for prayer by patients. Three themes were identified in the pattern of ease of prayer with patients: open to voice of calm or silence; physical or spiritual; can I call the chaplain. The pattern of dis-ease of prayer with patients distinguished two themes: cautious hesitancy and whose God (Table 3).

Table 2 Sample demographics.

Demographics	*N* = 134*
Gender	
Female	129
Male	5
Religion	
Protestant	52
Catholic	34
Non-traditional	16
Other	19
Education	
Associate	38
Bachelor's	61
Master's	13
Race	
White	118
American Indian	2
Black	1
Other	3
Clinical area	
Medical surgical	17
Stepdown	10
Hospice	11
Pediatrics	8
Labor and deliver	7
NICU	16
Other	42

*Total numbers in each area may not total 134; as not all participants answered the demographic questions.

Table 3 Patterns and themes linked to nurse respondents.

Pattern	Theme	Nurse respondent(s)
Ease of prayer with patients		19
	Open to the voice of calm or silence	30, 50, 60, 66, 115
	Physical or spiritual?	11, 12, 28, 44, 53, 59, 73, 83, 112, 122
	Can I call the chaplain?	26, 51, 72, 78, 110
Dis-ease of prayer with patients	Cautious hesitancy	2, 24, 40, 80
	Whose God?	49, 75, 96, 101, 112

The ease of prayer with patients

C. S. Lewis reflected that the ability to pray is 'natural to the believer' and 'is the nature of Christian life' (Houston 2006, p. 5). The naturalness of prayer appeared to be a component of many participants' normal nursing routine, as the majority of the responses to the four prayer scenarios demonstrated an overwhelming ease in their ability to pray with patients when it was requested. For many, concerns of religious orientation, acuity of patient situation or differentiations of praying with versus for did not matter – they ingenuously agreed to pray. Common responses were: 'Certainly', 'I would be happy to do so', 'I would say yes' and 'I would pray with her'.

Several of the replies offered a brief insight into their approach with such a request. Nurse 19 wrote:

I would let her know that I would be honoured to pray with her. I would inquire if there is anything in particular she would like me

to pray about or needed to talk about with God. Does she want me to pray silently or out loud, together or me alone? I would proceed praying based on her wishes

Open to voice of calm or silence

Patients may experience intrusive thoughts and fears as they recover in the hospital. Some nurses may be less comfortable in the spiritual act of praying for a patient, yet understand the importance of the request and elect to demonstrate reverence and respect in sharing silent moments with patients: 'I would sit with her for a moment but not vocalize prayer'. Is it possible this reflects someone who is unable to speak or is unable to find the words to pray? Or is this someone who suddenly finds the futility of words and an inability to express the holiness of the moment? Some narratives captured the moment when words would not come; when they were perhaps left breathless. . .even fearful. . .and felt most comfortable initiating the voice of silence writing, '(I would). . .ask if she had a prayer she wanted to say aloud or if she just wanted the support of silent prayer'. These silent moments are reflective of Krishnamurti's (1992) descriptions of silence. 'Because of silence, you hear. Because of silence, you act. And action is life' (Krishnamurti 1992, p. 66). The active nature of silence provides solace and can reaffirm the personhood of patients.

During these moments of silence, some indicated needing to not only sit quietly, but also to provide physical contact through holding the person's hand: 'I would take the patient's hand, bow my head and pray silently waiting for her to initiate a verbal prayer'. Nurse 115 shared the importance of asking permission before initiating touch, 'I would sit with the patient, ask if it was acceptable to hold her hand and then encourage her to lead the prayer so as to ensure the prayer included those intentions closest to the patient's heart'. Human touch combined with shared silent moments demonstrates authentic presence and transcends the need for the spoken word.

Physical or spiritual?

Nursing education teaches students the importance of assessment and provides many opportunities for students to plan and prioritize patient needs and tasks. Yet, are students intentionally placed in situated experiences, where they must choose between competing physical and spiritual demands? Does the patient's request for prayer supersede the urgency of the physical concerns? How do nurses determine which need is priority – physical or spiritual?

Scenario 2 shed light on this conundrum of priorities. For the majority this scenario seemed not to impact their willingness to honour the patient's request: 'I would offer up a short prayer asking for the caregivers to provide necessary care for the well-being of this patient'. 'I would ask him if there's something specific he would like me to say or say the Lord's Prayer'. A select few not only complied with the request, but carried it further, asking other members of the team to join in the prayer. 'I would ask that everyone in the room who feels accordingly to take a moment and pray with the patient'. 'I would offer a prayer and ask the others if they would like to join us'. Nurses 11, 12, 28 and 59 appeared comfortable in their ability to meet the patient's spiritual needs without compromising his urgent physical concerns.

However, for some of the nurses this scenario seemed to trigger an internal role conflict, whose training includes seeing the patient as a holistic being, comprising more than the sum of their parts, while at the same time prioritizing needs. Nurse 122 exemplified this conflict: 'If I was not in the middle of an important life-saving task, I would offer a short prayer for the patient then tell him that I needed to continue caring for his physical needs at that time. I would tell him that I will call for the chaplain to come see him asap'. Nurse 73 wrote: 'I would assure that the physiological needs of the patient were being met and then I would take his hand and pray for him'.

Urgency with the physical, while seeing the importance of the spiritual was palpable in Nurse 53's response: 'I would love to say a prayer for you but would it be alright if I came back later when there is more time so we can really take our time with it?'

Nurse 83 vehemently indicated that his/her responsibility was as a nurse first, intimating that prayer did not necessarily fall into that category, writing:

ED situations call for ABCD's prioritization. It sounds as if this patient isn't doing very well and is in a critical stage of care. Stabilizing this patient sounds like priority number one. My responsibility to this patient is to carry out my duties as a nurse first and foremost. Which means working with the four other people and physician, only after the patient is stabilized can I began to address the patients personal request. Is the patient requesting prayer because he feels he is in danger of dying? Or is prayer a means to lower blood pressure and improve the patient's ability to cope and endure this scary event? If so, then with the physician's approval, I could maybe as a nurse do my job while at the same time praying with the client? However, I'd prefer to leave this job to the chaplain, I do not know many prayers to be honest and would feel unprepared to do this patient justice on this front

In this narrative the internal struggle is evident. As a team member, if the nurse stops to pray he/she will not be contributing towards stabilizing this patient. Concerns for understanding why the patient is requesting prayer are apparent, yet this nurse feels the request is personal and not in the nurse's job description. This participant appears driven to assist the patient physically and might consider offering a prayer, but only with the approval of the physician.

Nurse 44 echoed the need for approval revealing: '(I would) ask the physician if that would be ok, (and) if so, say a very quick prayer', signifying that if the provider said no, the prayer request would go unanswered. Yet, contradictory to seeking prior approval Nurse 112 wrote, 'I would tell him of course I would. You can't let other people around you dissuade you from doing what's right', indicating that in the past this nurse may have experienced disapproval from others for responding to a prayer request.

Can I call the chaplain?

Urban tertiary facilities have access to chaplain services 24 hours per day, seven days per week, so it was not unusual to see that many of the respondents indicated that they would offer the services of the chaplain to the patient. Several respondents agreed to the prayer request and then also asked or informed the patient they would contact the chaplain or the patient's pastor. 'I would ask (the) patient if they would also like a Chaplain or the pastor from their perish (*sic*) called and I would sit with (the) patient and pray'. 'I will be more than happy to sit with you while you pray but I will call our hospital chaplain as well to come and sit and pray with you' (Nurses 78, 110).

The offer to 'call the chaplain' was also evident when the nurses were situated in a context of novelty, where the certainty to proceed was pre-empted when a patient with a differing ethnic/religious background initiated the prayer request. Despite the uncertainty, several participants willingly prayed with and for the patient; sometimes offering a generic or silent prayer, asking the patient to lead the prayer, or sitting with the patient, being attentive to the need for the nurse's authentic presence. Does nursing attempt to shoulder too much responsibility when attempting to answer prayer requests and should perhaps delegate this responsibility more? 'I don't know your religion, but I will certain(ly) do what I can'. 'I would tell her that I am not familiar with her religion but I am willing to follow her in prayer. I would also consult the chaplain'. 'I would be more than happy to call the hospital chaplain for you'. 'Refer to the chaplain who is probably more familiar with their belief system' (Nurses 26, 51, 72, 110).

These narratives indicated the absence of an established protocol for contacting a hospital chaplain, as the trigger to the referral was related to several factors, that is, discomfort and lack of familiarity with patient's religious beliefs and time constraints. Additionally, are there potential ethical concerns when nurses engage in prayer with persons' whose belief systems are different? Is it the healthcare institution's responsibility to establish protocols for when it is appropriate to pray with patients?

The *dis-ease* of prayer with patients

Pray with me. For the majority of the nurses in this study, this simple phrase was very easy to answer – yes, I will. However, not all of the participants responded 'yes' immediately or they added contingencies; such as, let me check on my other patients, let me tell the manager where I am. Still others identified discomfort or *dis-ease* in the patient's request, no matter what the situation. It was apparent that the request for prayer produced a certain level of cautious hesitancy as these nurses attempted to cope with the request.

Cautious hesitancy

Sitting silently while the patient prayed was a common intervention employed by those responding with cautious hesitancy to prayer requests. Nurses 2 and 80 wrote: 'I would feel uncomfortable actually saying the prayer for the patient but would pray silently for the patient, call the chaplain or if the patient was dying I would say the prayer'. 'I would tell her I do not pray but I would sit with her if she would like'.

Many nurses acknowledged the need for assistance and displayed cautious hesitancy in the following responses (Nurses 24, 40). 'I would politely decline and ask if I can get the chaplain or have another person sit with her'. 'I would either sit with the patient while she prayed or ask another staff member to pray with her'.

Nurses, whether personally religious or not, understand the importance of attending to their patient's spiritual needs. The nurses reporting *dis-ease* with prayer in this study demonstrated that they would either muster up the courage to pray with the patient or find an alternative source.

Whose God?

When nurses receive a prayer request, they must also be cognizant not to proselytize and meet the patient where he/she is in his/her belief system. For the nurses in this study it was rare to see a refusal to pray for a person who may not be Christian. Yet, concerns regarding the patient's beliefs were ignited when the nurses were asked to pray for/with

an ethnically/religiously diverse patient, sparking a need to identify if the client believed in the 'true God', writing (Nurses 101, 96, 49): 'I would offer to have their clergy come in. I am not to worship any false Gods, Only the One true God'. 'Let her know I am Christian and willing to pray for her if she is comfortable with this'. 'I would let her know that I believe in God in heaven and would be happy to pray to my God for her'. 'I may ask how she prays - but I am not sure of the best way to pray with her. I would not be forcing my beliefs on her, but I would appeal to the only One (emphasis by Nurse 75) I know who hears prayer'.

Nurse 112, self-identified as Christian, expressed concern about compromising his /her personal belief system. The participant appeared to be grappling with respecting alternative belief systems while remaining true to his/her personal religion writing:

> I don't know if I could. I am very spiritual as a Christian. I would only pray to my God. I would hold her hand for comfort and say a prayer in silence to God. I would never disrespect someone for their choice of religion, but I would not compromise my beliefs for someone with different opinions. I would try to get someone more qualified involved, because I believe people have a right to their own religious beliefs and wouldn't want them to go without. Now – if it was a religion that had to do with praying to Satan – NO. I would not be involved with that at all.

These data suggest a nurse's belief system may influence the ability to be unconditionally present with the patient. True, compassionate presence has no conditions and incorporates 'deep listening', where the nurse is in-tuned for what is spoken and unspoken, bearing witness to the moment (Ferrell & Baird 2012, p. 259).

Discussion

Nursing embodies what it means to be present with others during life's pivotal moments. Being present means to participate; yet for many nurses being present is an act of self-forgetfulness, a moment to be completely devoted to the matter-at-hand (Gadamer 2004). This devotion is often patient oriented, entailing skilful comportment and perception, where the nurse seeks what is salient, what matters (Benner 1994) and can be witnessed in the nurse's assessment, the administration of medications or treatments or during patient rounds. In these tangible moments patients may identify needs, such as a request for prayer, where, as noted in the findings nurses responded with ease or dis-ease.

With the advent and increased incorporation of checklists into the computerized charting systems in health care is spiritual care complete once the nurse has filed and submitted the spiritual assessment? This study identifies that nurses feel compelled to support their patient's requests for prayer, acknowledging their duty to provide spiritual care (French & Narayanasamy 2011), yet differ in their perceptions and ability to provide prayer practices congruent with the patient's preferred belief system and their own (Kim-Godwin 2013). It is evident that patient-initiated requests for prayer can create great angst and indecision for nurses; they need to know their response is not uncommon and that offering to sit and/or pray silently is a helpful intervention (Kim-Godwin 2013).

Hubbartt and Kautz (2012) identified the importance of authentic relationship and trust in the provision of spiritual care by bedside nurses. This nurse–patient connection is foundational for the nurse's capacity for action or inaction in patient-initiated prayer. A host of factors precipitate nurse inaction, such as fears of offending the patient, feeling incompetent and a lack of time (Hubbartt & Kautz 2012). This study demonstrates the impact of patient acuity and physician approval of a nurse's capacity for inaction in response to a patient's prayer request. Bennett and Thompson (2015) assert that although spiritual care is a principle component of nursing, often nurses do not feel equipped to fulfil this need.

As demographics in the USA continue to shift and become more ethnically/religiously diverse, nurses will encounter more patients reporting non-Christian belief systems. This study noted that for many nurses, prayer requests from an ethnically/religiously diverse patient did not impede their capacity for action; they simply responded, 'Yes'. However, several grappled with concerns related to praying to the correct 'God'. French and Narayanasamy's (2011) review of ethical prayer indicated that nurses should not feel compelled to pray with patients with dissimilar belief systems. Taylor (2003) recommended nurses centre their prayer efforts in recognizing what is similar vs. the dissimilar. These similarities, such as praying to a higher power called God, recognition of the needs for comfort, forgiveness and compassion, can guide nurses in authentically responding to patient's spiritual requests.

Limitations

The study sample is limited to one institution in the USA. Demographic diversity, while limited, reflect the region. Moreover, the computer-generated anonymous survey preempted member checking to verify themes; yet, the online delivery did not impede participant responses rich with description. Finally, scenarios 3 and 4 appeared to create a barrier for several of the nurse respondents; they did not

recognize the change in the words pray *for* or pray *with* as the difference between the two scenarios.

Conclusion

Nurses who are at ease with patient prayer serve as crucial role models (Koren & Papamiditriou 2013) for nurses reporting dis-ease. Moreover, both ease and dis-ease among nurses must be nurtured through intentional institutional support and educational curriculum devoted to the reflective preparation needed to authentically respond, that is, have the capacity to act. Reflective preparation is pertinent to nurses around the world for whom time is both critical to, and opportune for authentic response in clinical settings (Caldeira & Timmins 2015). The time required to deliver quality patient care is also a time of patient engagement, ripe with opportunity for addressing spiritual care needs (Caldeira & Timmins 2015) and, thus, entering more holistically into the patient relationship. The SCF serves as a potential model for nurse educators and nurse administrators to use in guiding students and staff in the art of reflective preparation needed for authentic response. Through reflection, students and staff ponder their personal spiritual beliefs alongside a patient's spiritual practices, creating a sense of 'altruism to provide compassionate presence' (Puchalski *et al.* 2009, p. 70) with their patients, enhancing their capacity to act. Strengthening the capacity to act is an imperative ultimately serving both nurses and patients.

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Author contributions

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- substantial contributions to conception and design, acquisition of data or analysis and interpretation of data;
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