**Supplementary Table 2.** Illustrative data items, themes, and synthesized finding classified by TDF domain.

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

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| **TDF DOMAIN**Synthesized findings  **Themes encompassed within this domain** Illustrative data items extracted from included studies |
| **TDF DOMAIN: KNOWLEDGE**Synthesized finding: Three types of knowledge were frequently reported: knowing how to identify and assess spiritual/existential distress; knowledge of spiritual care and care practices, which ranged from general knowledge, such as the meaning of spiritual care, to specific elements, such as the timing of spiritual care; and knowledge related to issues of spirituality and death. Knowledge of oneself as a person also aided care. **Theme: Knowledge of spiritual/existential care practices** + knowledge of care practice (Johansson 2011)+ pastoral care knowledge (Pitroff 2013)+ knowledge about timing of spiritual care (e.g., when to begin and stop) (Bailey 2009) - uncertainty about meaning of spiritual care (Bush 2008) - scarce knowledge of spiritual care (Kuuppelomaki 2001) and spiritual interventions (Kisvetrova 2013))**Theme: Knowledge related to spiritual assessment and identification** + intuitive knowing when patient is experiencing spiritual distress (Walker 2017) - not knowing what to ask or how to approach spiritual assessment (Belcher 2005) **Theme: Knowledge regarding spirituality and death** + knowledge about life and death issues, and human existence (Arman 2007) + knowledge of dying process (Zerwekh 1993) - lack of knowledge of different religious practices/beliefs and spirituality (Belcher 2005, Kuuppelomaki 2001) **Theme: Self knowledge**  + knowledge of oneself as a person and how to use one’s lived knowledge (Johansson 2011) |
| **TDF DOMAIN: SKILL**Synthesized finding: Skills in spiritual assessment and identification, and in delivery of spiritual/existential care, acted as facilitators. Specific experience in spiritual care seems to act as facilitator, while general experience (i.e., work experience, nurse experience) was unrelated. Studies that reported training/education showed that training specifically in spiritual/existential care acted as a facilitator, but education qualifications and education level alone was not a facilitator. A randomized, controlled study examining the effect of a workshop on the care of terminally-ill patients (Morita, 2009) found that training had only short-term effects on care practice, which petered out in the longer-term. Opportunities for self-reflection, and watching and learning from others, facilitates the provision of spiritual/existential care. All these skills relied on first having mastered technical nursing skills. **Theme: Skills related to spiritual assessment and identification**+ ability to sense, recognize, observe patient need (Bailey 2009, Carroll 2001, Minton 2018)+ recognizing signs when patient wants to talk (Browall 2014) and to adapt quickly (Tornoe 2015)+ sense of timing, situational understanding, ability to tune in to patient verbal and non-verbal cues (Tornoe 2014) + skill to identify spiritual need/distress from verbal, uncontrolled symptoms (Zerwekh 1993) + skill to identify when distress has physical components (Walker 2017)- inability to pick up patient spiritual needs, and identify spiritual anxiety (Kuuppelomaki 2001)  - mistake patient's spiritual concerns for physical concerns (Keall 2014), expect patient to manifest spiritual needs in a concrete, 'religious' way  and to be literally reported by patient (Nixon 2013)**Theme: Skills in delivery of spiritual/existential care**  + skills in verbal and non-verbal communication (e.g., being present, listening, meaningful conversation, asking the right questions, touch, right  use of body language, holding patient's hand (Bailey 2009, Bush 2008, Keall 2014, Minton 2018, Wittenberg 2017, Zerwekh 1993) + competent in: helping patient let go of attachments and life, anticipating dying process and providing guidance about dying, fostering  reconciliation and integration of life experiences and beliefs, sharing mystical death experiences (Zerwekh 1993) + skill in timing of intervention (Bailey 2009)+ ability to be non-judgemental (Pitroff 2013, Zerwekh 1993)+ skill of openness (Browall 2014) + clinical skills/intuition about how far to go with patient (Keall 2014)+ a professional nurse chooses right time for spiritual conversations (van Meur 2018) - scarce skills and competencies; (Bailey 2009, Keall 2014, Kuuppelomaki 2001) **Theme: Experience**+ experience providing spiritual care (Bailey 2009, Tornoe 2014)+ experience in cancer nursing (Carroll 2001)+ frequent experience of caring for dying (Kociszewski 2004)+ years experience in palliative care nursing (Ronaldson 2012)+ years of experience (Keall 2014)  ≠ work experience in years (Kisvetrova 2018) ≠ years work experience as nurse (Kuuppelomaki 2001, Taylor 1999) or hospice nurse (Johnson 2013) ± work experience (Kisvetrova 2013) + frequency of patient care at the end of life (Kisvetrova 2016)  - no experience providing spiritual care (Nixon 2013)**Theme: Training/education**+ adequacy of spiritual care education and training (Belcher 2005, Highfield 2000, Taylor 1999)+ training in spiritual assessment (Johnson 2013)+ palliative care education (Kisvetrova 2016)+ frequent participation in training seminars dealing with the care of terminally ill patients (Kuuppelomaki 2001) and continuing education in  spiritual care (Pitroff 2013) + extensive reading about care of terminally ill (Kuuppelomaki 2001), Harrington 1995) + then ≠, training in care of patients’ feeling meaninglessness has a significant effect on short-term practice, but returned to baseline after nine  months (Morita 2009)- insufficient/inadequate education and training (Bush 2008, Keall 2014, Harrington 1995, Ronaldson 2012) ≠ qualifications (Ronaldson 2012)≠ education level (Kisvetrova 2018, Taylor 1999)**Theme: Self-reflection**+ self-reflection, reflective practice (Vosit 2010)**Theme: Learning from others**+ watching and learning from chaplains (Bone 2018), or being mentored by chaplains (Pitroff 2013)+ learning from patients (Highfield 2000, Kociszewsk 2004)+ witnessing forgiveness interactions between patient and family (Ferrell 2014)**Theme: Basic nursing skills** + mastered the technical stuff and can take extra step (Kociszewski 2004) |
| **TDF DOMAIN: SOCIAL OR PROFESSIONAL ROLE AND IDENTITY**Synthesized finding: An acceptance that spiritual assessment and care was part of the nurse role acts as a facilitator, and vice versa. Some studies reported sub-components of the spiritual care role and what it includes (such as showing ensuring the family is present at death) and excludes (such as not needing to fix patient feelings). Role conflict (e.g., when discord arises between personal beliefs and patient request) and erosion of patient-nurse boundaries (e.g., when nurse identifies too closely with the patient) discomfit spiritual/existential care, while work commitment aids such care.**Theme: Spiritual care in nursing role content**  + spiritual assessment and care is part of nurse role (Abu-El-Noor 2016, Belcher 2005, Bush 2008, Carroll 2001, Harrington 1995, Kale 2011,  Kociszewski 2004, Kristeller 1999, Kuuppelomaki 2001,Naden 2009,Taylor 1999, van Meur 2018,Walker 2017)+ professional obligation to support patient sources of faith (Tornoe 2014)- spiritual assessment not in nurse role (Belcher 2005, Nixon 1999, Ronaldson2012)- spiritual care is someone else's role (Kisvetrova 2013) e.g., chaplain (Kristeller 1999, Nixon 2013) **Theme: Sub-components of spiritual care role** + showing compassion (Bone 2018)+ part of role is to ensure family presence at death (Zerwekh 1993)+ need to change roles for each unique patient situation (Johansson 2011) + nurses function as emotional containers when patients vent thoughts/feeling (Tornoe 2015)+ accept no need to "do things" to the patient (Walker 2017) but be there (Kociszewski 2004)+ accept it's not nurse's job to fix feelings, just accept how patient feels (Minton 2018)- as nurses want to fix things, hard to accept not always possible (Tornoe 2015)**Theme: Role conflict**- conflict between personal and professional spirituality (Belcher 2005) - conflict between personal beliefs and patient requests (Belcher 2005)- confusion between proselytizing and delivery of spiritual care (Ronaldson 2012)**Theme: Patient-nurse boundaries** - boundaries blurred when patient has children same age (Browall 2014) or nurse identifies with patient (e.g., both have babies) (Tornoe 2015)± need closeness but not too close (Johansson 2011)**Theme: Work commitment**+ love this work (Bailey 2009) |
| **TDF DOMAIN: BELIEF ABOUT CAPABILITIES**Synthesized finding: Feeling confident and comfortable in providing spiritual/existential care was a facilitator, and vice versa. Studies reported that a specific personal facility that aided spiritual/existential care was personal courage to face daunting situations, such as encountering vulnerability in a patient, and to be emotionally intimate with a patient. Maturity and life experiences (such as personal experience of loss) generally facilitated the provision of spiritual/existential care, however, personal experience could interfere with spiritual/existential care, when personal self-disclosure superseded awareness of client needs. Studies generally reported that nurses' resolution of their own existential issues and tending to their own spirituality to be facilitators, but there were exceptions. Nurse religiosity and age had mixed effects, while gender and non-English background had no influence. **Theme: General capabilities**+ comfortable/confident providing spiritual care (Belcher 2005, Keall 2014)+ accept/know limits of expertise and ready to work with other team members (Keall 2014, Pitroff 2013)  - not confident/comfortable (Bone 2018, Belcher 2005, Harrington 1995 , Kale 2011, Ronaldson2012) - experience powerlessness, uncertainty, insufficiency, inadequacy in some situations (Browall 2014, Kuuppelomaki 2001) such as when can't  cure patient (Guedes 2013) , or relieve suffering (Karlsson 2017)**Theme: Courage** + personal courage (Tornoe 2014, Tornoe 2015)+courage to encounter vulnerability, suffering, death in patient (Arman 2007)+courage to enter into sacred space of patient (Minton 2018)+courage to be emotionally intimate (Browall 2014)+ courage as caregiver and human being (Karlsson 2017)+courage to ask difficult questions and hear difficult answers and patient fears (Zerwekh 1993)- lack of courage (Kuuppelomaki 2001)**Theme: Life experiences**+ life experiences (Carrol 200, Pitroff 2013, Tornoe 2014, Tornoe 2015)+ variety of experiences in life (Harrington 1995)**+** maturity (Tornoe 2015) + personal experience of loss and illness(Pitroff 2013) - personal experience of loss can interfere with sc, when personal self-disclosure supersedes awareness of client needs (Pitroff 2013)**Theme: Reflection/acceptance of one's own existential issues**+ reflection on own existence/death (Johansson 2011)+ comfortable with own feelings of death and dying (Kociszewsk 2004)+ come to terms with own vulnerability (Tornoe 2015)+ able to encounter vulnerability, suffering, death in oneself (Arman 2007)≠ beliefs about death, death avoidance, death as better life, death as escape (Kisvetrova 2016)**Theme: Nurse's own spirituality/belief system** + explored/aware of own spirituality/beliefs ((Belcher 2005, Bush 2008, Carroll 2001, Harrington 1995, Kuuppelomaki 2001, Pitroff 2013,  Taylor 1999, Vosit 2010,Walker 2017) - neglect of own spirituality (Ronaldson2012) - spirituality not important to nurse (Harrington 1995) ≠ spirituality (Johnson 2013) + for palliative care nurses, extent to which they consider that spirituality has an impact on their life and their engagement in interactions or  activities that are spiritually related (Ronaldson2012)± own beliefs about death/dying (Karlsson 2017 ≠ for acute care nurses, extent to which they consider that spirituality has an impact on their life and their engagement in interactions or activities  that are spiritually related (Ronaldson2012) ± personal beliefs (Tornoe 2014)**Theme: Participation/identification with faith tradition**+ importance of religious values (Kuuppelomaki 2001, Pitroff 2013)+ participation in faith community (Pitroff 2013) - lack of belief in God (Belcher 2005, Kisvetrova 2013)- nurse religiosity (Kisvetrova 2013, Kuuppelomaki 2001) - absence of religious convictions (Kuuppelomaki 2001)≠ religiosity (Johnson 2013)**Theme: Nurse demographics**+ age (Taylor 1999, Tornoe 2015)≠ age (Johnson 2003, Kisvetrova 2018, Kuuppelomaki 2001, Ronaldson 2012)≠ gender (Ronaldson 2012),≠ English-speaking background (Ronaldson 2012)  |
| **TDF DOMAIN: BELIEFS ABOUT CONSEQUENCES**Synthesized finding: Some studies reported patient wellbeing as a consequence of spiritual/existential care, but other studies reported the reverse. Several studies reported beliefs in the positive consequences of specific nurse actions on patients, such as engaging in conversation or eye contact, but some studies reported negative consequences if patients viewed nurse actions as undesired/unhelpful. Spiritual conversations that are peceived by nurses as taking too much time impede spiritual/existential care. **Theme: Consequences of general spiritual care and assessment on patient**+ spiritual care leads patient health & wellbeing (Bush 2008, Kale 2011)+ spiritual assessment is important for patient (Johnson 2013)+ spiritual care brings patients relaxation, comfort (Abu-El-Noor 2016, Bailey 2009)+ patient sometimes needed a push to embrace life (Tornoe 2014)- dilemma involving giving patient hope versuse being realistic and honest with patient (Browall 2014)- relieving suffering extends time for suffering (Guedes 2013) - spiritual support does not help patient (Nixon 2013)- not accept patient's death as natural (Guedes 2013)**Theme: Consequences of specific nurse actions on patients**+ patient talking may help patient in their search (Harrington 1995)+ beneficial effects of nurse actions on patient e.g., eye contact (Arman 2007) + beliefs about effects of touch, presence, communication (Walker 2017) + prayer is used as it suits patient of all faiths (Kale 2011) + engaging in conversation important to provide patient spiritual/existential care (Tornoe 2015) and quality care (Wittenberg 2017) + sharing silence has consoling effect, and helps patients talk (Tornoe 2014) + alleviating physical pain a prerequisite to spiritual/existential care (Tornoe 2014) - spiritual questions are potentially intrusive (Johnson 2013, Tornoe 2014) and off-putting to patient if done in checklist fashion (Walker 2017)  - spiritualconversations might be stressful for patient or unwanted by patient (van Meur 2018) **Theme: Consequences of care work on nurse**- spiritual conversations take a long time (van Meur 2018) |
| **TDF DOMAIN: REINFORCEMENT**Synthesized finding: Positive personal feelings, meaningful work, and satisfaction at being part of a patient's life, facilitated the provision of spiritual/existential care. However, feeling inadequate, and needing to see good results of care work acted as barriers.**Theme: Positive reinforcers**+ rewarding to be part of patient's life (Minton 2018), feel honoured and privileged to be part of end of life (Pitroff 2013)+ feel honoured when patients choose to confide in them (Tornoe 2015)+ feel good about themselves, doing something useful for patients (Abu-El-Noor 2016)+ giving love means receiving love (Bush 2008)+ derive a sense of fulfilment, confirmation, personal benefit and work satisfaction (Johansson 2011) + witnessing a good, peaceful, harmonious death is rewarding and fulfilling (Tornoe 2015)+ work is deeply meaningful and rewarding (Tornoe 2014)**Theme: Negative re-inforcers**- when nurses need to see good results of their work (Tornoe 2015) - too demanding /draining to do frequently (van Meur 2018)  |
| **TDF DOMAIN: MOTIVATION AND GOALS**Synthesized finding: A variety of goals/intentions influenced nurse spiritual/existential care behavior. These goals varied in their target (whether for patient, relationship, self, or task). Patient-oriented goals varied from general goals of patient care, such as providing the best care for patients, to more specific outcomes for the patient, such as for the patient to feel comfortable and cared for. Almost all of these goals facilitated the provision of spiritual/existential care, except for the goal of helping patient recover from illness, which impeded spiritual/existential care. Relationship goals (i.e., that promote a trusting and secure connection with the patient to help the patient share) and empathy goals (i.e., that enhance understanding/feeling of what the patient is experiencing) facilitated spiritual/existential care. Nurse-oriented goals include conduct goals and self-benefit goals. Conduct goals refer to the demeanor or manner that nurses tried to enact during an encounter, such as attempting to be in the 'here and now', and asking about worries at each visit. Self-benefit goals refer to states of being that nurses desired to achieve, such as striving for completeness or being myself. Most of these types of goals facilitated spiritual/existential care. The prioritisation of spiritual/existential care above other activities facilitated the provision of spiritual/existential care, and vice versa. Goals associated with colleagues included an intention to use the expertise of team members and chaplain if necessary. Underscoring these goals, was a recognition that goals should be achievable to facilitate caring. **Theme: General goals of patient care**+ importance for patient to have a good end to life experience (Bone 2018, Johansson 2011) + aim to provide best care for patients (Johansson 2011)+ aim to treat 'whole person' (Keall 2014) + patient wellbeing (Naden 2009)+ bring peace to patient (Carroll 2001, Tornoe 2015, Yingting 2018)+ help patient make most of final days (Tornoe 2014)+ help patient and improve health (Abu 2016)+ to brace the patient (Minton 2018)+ help patient acquire balance, help alleviate patient suffering (Naden 2009) + preserve patient dignity (Naden 2009) + help patient achieve tranquility (Tornoe 2015) + strive to help patients accept death, settle their practical affairs and achieve reconciliation with their past, their loved ones, and with God (Tornoe 2015)+ encourage family members to talk with each other (Tornoe 2015)+ want patient to feel comfortable and cared for (Kociszewsk 2004) and not alone (Arman 2007)+ aim to get patient to share concerns while respecting autonomy (Tornoe 2014) and to talk (Harrington 1995)+ to respect patients' need to contemplate and have space alone with thoughts (Browall 2014) - to help patient recover from illness (Guedes 2013)  - unwilling to support or respond to spiritual/existential/religious need (Kuuppelomaki 2001, Tornoe 2015) **Theme: Relationship goals**+ aim to create sense of communion and security with patient (Karlsson 2017)+ need to establish trusting relationship with patient (Tornoe 2015)+ aim to fully participate in the encounter and enter patient's personal space (Arman 2007, Minton 2018)+ desire for meaningful conversations with patient (Minton 2018)+ willingness to listen (Zerwekh 1993) and be open and present for whatever patient wanted to share (Wittenberg 2017)**Theme: Empathy goals**+ to respect the way patient sees things (Harrington 1995)+ to put oneself in patient shoes (Browall 2014) + desire to understand and respect patient thoughts, feeling, self-evaluations (Carroll 2001) and spiritual beliefs (Walker 2017) and  wishes/preferences (Naden 2009)**Theme: Self-oriented goals**+ strive for completeness (i.e. feeling they've done all they can and feel satisfied with work) (Johansson 2011) + try to be myself (Harrington 1995)+ want to care for and be responsible for patient (Karlsson 2017)- to stay away from distressed patient for self-protection (Fay 2019)- try to avoid potential anxiety about their own suffering/dying (Tornoe 2015)**Theme: Task priorities**  + prioritise spiritual/existential above other activities (Arman 2007, Bailey 2009, Belcher 2005; Browall 2014, Tornoe 2015)- sometimes unable to tend to spiritual domain because have to deal with technical aspects first (Bone 2018)- other priorities due to workload (van Meur 2018) - need to triage symptoms and address physical suffering first (Keall 2014)**Theme: Goals related to colleagues**+ recognise and utilise expertise of team members (e.g., chaplain) (Pitroff 2013)+ commitment to refer to chaplain if nurse is not spiritual (Zerwekh 1993); **Theme: Goal features**+ limit goals to what is achievable (Zerwekh 1993) |
| **TDF DOMAIN: MEMORY ATTENTION AND DECISION-PROCESSES**Synthesized finding: Spiritual/existential care requires nurses to make conscious effort to focus attention on patients needs while being aware of their own mental condition. Barriers to care occur when other priorities deflect nurse attention, such as completing workload or filling in checklists.**Theme: Conscious focus on patient**+ attention to patient spoken and unspoken signals (Naden 2009, Zerwekh 1993) and to patient distress (Tornoe 2014)+ try to keep in mind that patient needs help, when the patient is being difficult (Browall 2014)+ view the patient as a physical, social, psychological, spiritual, complete human being (Naden 2009);  + stop and think that patient and families are experiencing existential distress (Tornoe 2015) **Theme: Consciousness of self**+ being conscious of oneself and not confusing nurse's own wishes/concerns with patient wishes/concerns (Naden 2009) + constant awareness of difference between self-serving commentary (self-disclosure of personal loss and beliefs) and communication that meets  client needs (Pitroff 2013)+ attempt to be in the 'here and now' (Arman 2007) + need mental shift from "doing for' patient to "being with patient" (Tornoe 2014)± frame of mind affected by personal situations affects dealings with patient (van Meur 2018) **Theme: Attention deflectors** - full attention needed to complete checklists for which they are accountable makes it hard to hear patient spiritual communication (van Meur 2018) - attention focused primarily on physical care, ignore spiritual care (Bush 2008) |
| **TDF DOMAIN: ENVIRONMENTAL CONTEXT AND RESOURCES**Synthesized finding: Several studies referred to staffing issues: low staff: patient ratio was a reported as a barrier to spiritual/existential care; but the availability of spiritual care providers seems to have mixed effects. Several studies referred to aspects of time: lack of time generally, or time with patient, or time for learning, acted as barriers. The care setting and organisational priorities influence spiritual/existential care behaviors. For example, a hospice setting, and organisations that make spiritual care a priority, are reported to facilitate spiritual/existential care more than other settings. Facilities with specially decorated rooms and ward designs that allow privacy aid the provision of spiritual/existential care. The use of care tools seems to have mixed effects. Ethnic culture influenced the type of religious rituals nurses used to help patients, but not not whether they encouraged patients to speak about dying. **Theme: Time-related aspects***Temporal demand*- shortage of time (Belcher 2005, Kale 2011, Keall 2014, Kisvetrova 2013,Kuuppelomaki 2001, Nixon 2013, Ronaldson2012, Tornoe 2015, van  Meur 2018)+ time availability (Browall 2014, Fay 2019)≠ time (Kisvetrova 2016)- low staff-patient ratio (Bailey2009, Kisvetrova 2016, Tornoe 2015)- many who need help at same time (Karlsson 2017)- workload Belcher 2005, Kale 2011, Kisvetrova 2013), Walker 2017)- spend more time administering treatment due to medical advances (Tornoe 2014)*Duration of time that patient is in unit* +The average length of stay of dying patient in the ICU (Guedes 2013, Kisvetrova 2016)- short-term stay (Belcher 2005)- patient referred too late to palliative care (Keall 2014)*Duration of time with individual patient*+ time to be with patient (Bailey2009, Browall 2014, Walker 2017)± limited time with patient (Karlsson 2017) + continuity of care (Keall 2014, van Meur 2018), including involvement with admission (Keall 2014)- unable to spend as much time as like with patient (Bone 2018)*Timing of care* - frequent interruptions (Kuuppelomaki 2001, Tornoe 2015) - unpredictability of suffering (Tornoe 2014) - caring for acute & pall patient simultaneously (Kale 2011) - untimely networking with different religious leaders (Kale 2011) *For learning* - lack of time for self-reflection (Kale 2011)**Theme: Availability of spiritual care providers** + chaplain availability (Kristeller 1999) + where chaplain limited (Minton 2018) ± chaplain unavailable, so I have to do it (Bone 2018) - lack of availability of chaplain (Kuuppelomaki 2001) - lack of after-hours specialist providers (Walker 2017)**Theme: Care setting**+ hospice setting (Belcher 2005, Harrington 1995)+ working in hospice vs intensive, acute or long-term department (Kisvetrova 2018)+ hospice vs long-term care, oncology, geriatrics, home for elderly, home care (Kisvetrova 2013)+ hospice vs oncology setting (Taylor 1999)+ large health centres (Kuuppelomaki 2001)+ home setting (Minton 2018)+ nurses in office settings (Kristeller 1999)+ palliative care vs acute care (Ronaldson2012)- acute care (Harrington 1995)- neuro-surgical setting (Nixon 2013) **Theme: Organisational priorities**+ organisation prioritises/supports spiritual care (Belcher 2005, Walker 2017)+ organisation supports spiritual care (Taylor 1999)+ health centres that focused on raising care standards (Kuuppelomaki 2001)**Theme: Facility/amenities**+ specially decorated rooms enhance calmness, harmony, rest, security (Johansson 2011)+ privacy (Minton 2018, Yingting2018)+ quiet room for eol patient (Yingting 2018)- lack of privacy(Browall 2014, Keall 2014, Kisvetrova 2013), Kuuppelomaki 2001, Ronaldson2012, van Meur 2018)- poor radios can't pick up spiritual programs (Kuuppelomaki 2001)- unit not geared to offer spiritual support (Kisvetrova 2013)**Theme: Care tools**- no tool for spiritual assessment (Belcher 2005)± documentation of spiritual care conversations (Keall 2014)+ documentation of spiritual care (Walker 2017)**Theme: Ethnic culture** ± ethnic culture is related to use of Jesus- vs Hindi-focused religious rituals (Doorenbos 2006) ≠ ethnic culture re urging patient to speak about dying (Doorenbos 2006)  |
| **TDF DOMAIN: SOCIAL INFLUENCE-PATIENT**Synthesized finding: Nurses use the patient's diagnosis and prognosis (whether terminal or short prognosis) as one indication of spiritual/existential need. Nurses also use other cues, such as patient's verbal and non-verbal behavior and emotions. Nurses assess the patient's openness to spiritual/existential help by their willingness to communicate regarding spiritual/existential matters (e.g., the patient asking the nurse about her beliefs). Sometimes, though spiritual needs are difficult to detect and isolate, especially when the patient is unable to communicate. The patient's unique beliefs and worldviews, and their social situation (i.e., family relationships and wider network) are other cues that influence how nurses provide spiritual/existential care. A patient who is too demanding, by having too many needs to meet for example, obstructs the provision of spiritual/existential care. Several studies reported that a trusting nurse-patient relationship and nurse-patient affinity facilitate spiritual/existential care. Whether nurses and patients shared beliefs had mixed effects on care delivery. Holding to the social norm that religion is a private matter for the individual impeded the provision of spiritual/existential care.**Theme: Patient diagnosis/prognosis**+ terminal illness diagnosis (Abu-El-Noor 2016, Belcher 2005)+ short prognosis (Fay 2019, Kociszewsk 2004, Kristeller 1999)- patient in terminal stages (Fay 2019)**Theme: Patient demographics**+ patient proneness to existential distress e.g., young mothers (Fay 2019)≠ patient gender (Kristeller 1999)**Theme: Patient's cues of distress and spiritual needs**± how patient manifests distress (Ferrell 2014) + patient shows signs of spiritual/existential distress (Arman 2007) , Fay 2019, Harrington 1995) + patient behavior and utterances and indicators (Belcher 2005, Carroll 2001, Johnson 2013)  + patient verbal cues regarding spiritual needs (Abu-El-Noor 2016, Bailey 2009 Nixon 2013) e.g., ask to see clergy (Harrington 1995), never-ending requests for medication (Tornoe 2014)+ patient non-verbal behavior cues regarding spiritual needs (Abu-El-Noor 2016, Nixon 2013)+ patient emotion cues regarding spiritual needs (Karlsson 2017, Nixon 2013) + patient's admission notes regarding spiritual needs (Nixon 2013)+ seeing patient in physical suffering (Karlsson 2017)± patient physical and mental condition (Tornoe 2015)± patient acceptance/fear of death (Walker 2017)- when patient distress difficult to detect/isolate (Browall 2014, Carroll 2001; Kuuppelomaki 2001, Nixon 2013)- witnessing significant bodily changes (Johansson 2011) **Theme: Patient openness and ability to communicate needs**+ patient openness (Browall 2014, Keall 2014) + patient chooses when to talk (Carroll 2001)+ patient 'permits' nurse to talk about spiritual/existential questions (Belcher 2005, Tornoe 2015)+ patient ask about nurse beliefs (Ellington 2015)  - patient unable (Kuuppelomaki 2001) or unwilling to express spiritual or religious needs (Kuuppelomaki 2001, Tornoe2015)+ patient ability to communicate verbally & nonverbally (Belcher 2005, Tornoe 2015, Zerwekh 1993)+ gauge patient energy to talk, and willingness to talk (Tornoe 2014)± some patients want to share, others don't (Carroll 2001)- patient has tribal dialect (Kale 2011)- patient blocks provision of spiritual care (Belcher 2005)**Theme: Patient unique needs and beliefs** + adapt to patient needs (Harrington 2006), Tornoe 2014,Yingting 2018)+ spiritual care tailored to patient's belief/meaning system(Walker 2017, Yingting2018)+ patient religiosity (Abu-El-Noor 2016)± nurse perceptions of which activities the patient will accept (Belcher 2005)± each patient is unique so use of spirituality tools only a guideline (Bailey2009)± patient beliefs (Ellington 2015, Harrington 1995), values and culture (Harrington 1995)± spiritual, religious and existential beliefs (Tornoe 2015), e.g., if religious, chaplain called (Carroll 2001)± patient personality (van Meur 2018) - patient are non-believers (Kisvetrova 2013) - nurse ignorance of patient religious convictions (Kuuppelomaki 2001) - patient had traditional indigenous beliefs or tribal dialect, or searches for alternative spiritual explanations (Kale 2011)**Theme: Patient's social situation**± patient-family relationship quality (Ferrell 2014)± patients’ family situation, social network (Tornoe 2015)± family atmosphere around patient (Tornoe 2014) - when patient and family have different acceptance levels of death (Browall 2014)- lack of reconciliation between patient and family (Karlsson 2017)- differences between patient and family religious convictions (Kuuppelomaki 2001)**Theme: Patient too demanding**- unreasonably demanding patient (Browall 2014) or bothersome (van Meur 2018)- challenging patient situation (Belcher 2005)- patient has too many physical, psychological and spiritual needs to meet (Nixon 2013)**Theme: Nurse-patient relationship** + nurse-patient rapport, trustful relationship (Carroll 2001, Fay2019, Keall 2014, Vosit 2010, Walker 2017)+ nurse has deep involvement/engagement with patient (Johansson 2011, Karlsson 2017, Minton 2018)+ patient starts conversation with certain nurses (van Meur 2018)+ nurse experiences affinity with patient (Browall 2014)± depends on nurse-patient relationship (Harrington 1995) and connectedness (Bush 2008)- not all patients want support from nurse (Kuuppelomaki 2001)- no rapport or connection with patient (van Meur 2018)**Theme: Nurse-patient homophily**+ patient-nurse share beliefs Carroll 2001)+ same age (Carroll 2001)≠ patient-nurse different beliefs (Wittenberg 2017)- difference between patient- nurse spirituality (Keall 2014, Ronaldson2012) **Theme: Nurse-perceived norms regarding care of patient** + patient needs more important than nurse needs (Harrington 2006)± how a nurse should relate to patient's spirituality (Taylor 1999)- support can only be provided if patient requests (Kuuppelomaki 2001)- religion is a taboo subject and/or private matter (Kisvetrova 2013, Kuuppelomaki 2001, Tornoe 2015) |
| **TDF DOMAIN: SOCIAL INFLUENCE: OTHER THAN PATIENT** Synthesized finding: Support from colleagues, especially pastoral care and personal social network, and the quality of the relationship with the patient's family were factors that influenced the provision of spiritual/existential care. Holding to the social norm that religion is a private matter for the individual impeded the provision of spiritual/existential care.**Theme: Relationship/collaboration with colleagues**+ support/sharing with colleagues (Bush 2008, Fay 2019, Johansson 2011, Kociszewsk 2004, Tornoe 2014)+ interdisciplinary collaboration (Vosit 2010)+ good relationship with pastoral care (Belcher 2005, Pitroff 2013)± when chaplain with me, I don't feel guilty about having other things to do (Bone 2018)- criticism from peers (Ronaldson 2012)**Theme: Nurse relationship with patients' family**+ bond with family (Minton 2018)+ partnership and trust between nurses and families (Vosit 2010)- challenging family situation (Belcher 2005)- patient family blocks provision of spiritual care, questions nurse beliefs (Belcher 2005)- patient family throw anger/frustration at nurse (Tornoe 2015)**Theme: Relationship with nurse personal social network**+ nurses' connection with family, friends (Bush 2008) |
| **TDF DOMAIN: EMOTIONS**Synthesized finding: Nurses experienced a range of emotions that influenced their practice. While positive emotions facilitate spiritual/existential care, a range of negative emotions (e.g., anxiety, frustration, pain, sadness, fear, emotionally draining) act as barriers to care.**Theme: Positive emotions**+ feels great to share a patient's life (Johansson 2011) **Theme: Negative emotions**± feeling suffering, pain (Walker 2017)- feeling agonised/anxious/weary when patient is young, when patient desires death, patient perceives injustice, patient convinced they're going to live (Browall 2014)- frustration when nurse can't help (Fay 2019), when patient dies (Guedes2013)- painful caring for patient with no chance of living(Guedes 2013)- sadness (Ferrell 2014)- fear that I can't handle what comes out (Keall 2014)- fear of witnessing death (Guedes 2013), that you may make a bad situation worse (Keall 2014)- feel helpless and inadequate when can't console patient (Tornoe 2015)- emotionally draining (Tornoe 2014, Tornoe 2015)- feel helpless and vulnerable (Tornoe 2014) |
| **TDF DOMAIN: BEHAVIORAL SELF-REGULATION**Synthesized finding: Nurses need to prepare emotionally, spiritually and mentally for an encounter with a patient; and during the encounter, they try to regulate their verbal and non-verbal body language to convey care**Theme: Preparation before the encounter:**+ prepare before difficult encounters (Naden 2009) + self-preparation (e.g., praying for wisdom) (Minton 2018)+ personal grounding: deliberate work to replenish personal energy, maintain emotional wellbeing, healthy grieving, put aside personal agendas  (Zerwekh 1993)+ preparedness to conduct spiritual assessment (Johnson 2013) and discuss spiritual needs (Kuuppelomaki 2001)**Theme: Behavior during encounter**+ regulate own body language (Keall 2014) + manners and humbled relational stance of (i.e. humbling self, respecting other; subject-subject stance rather than subject-object distancing  prevalent in healthcare) (Pitroff 2013)+ ask about worries at each visit (Minton 2018)+ be open, honest, caring, respectful, compassionate (Keall 2014) + don't push them or rush them (Minton 2018)+ actions guided by wanting to show genuine desire to care and love patient (Walker 2017)± manage touch and tone during physical care (Tornoe 2014)+ trying to be perceptive and emphasise patient needs (Harrington 1995)+ always follow up actions/conversations (Naden 2009) - want to avoid different nurses asking same patient about concerns (van Meur 2018) |