A qualitative study of nurses' attitudes towards' and accommodations of patients' expressions of religiosity and faith in dementia care

Abstract

Aims: To investigate nurses' attitudes towards and accommodations of patients' expressions of religiosity and faith in dementia care.

Background: Holistic care for people with dementia addresses patients' religiosity and faith. Nurses' accommodations of patients' religiosity have not been studied extensively even though nurses report a lack of experience and knowledge regarding religious care.

Design: This study has a qualitative research design.

Methods: Eight focus group interviews with 16 nurses and 15 care workers in four Norwegian nursing homes were conducted from June 2011 – January 2012. The interview text was analysed using van Manen's hermeneutic-phenomenological approach and Lindseth and Nordberg's structural analysis.

Findings: The following three main themes reflected the nurses' and care workers' attitudes towards and accommodations of patients' expressions of religiosity and faith: i) embarrassment vs. comfort, described in the sub-themes "*feelings of embarrassment*" and "*religiosity as a private matter*"; ii) unknown religious practice vs. known religious practice, described as *"religious practice that was scary"* or *"religious practice that was recognisable"*; and iii) death vs. life, described as *"difficulty talking about death "* or *"focusing on life and the quality of life"*.

Conclusion: Nurses and care workers were uncertain and lacked knowledge of the patients' expressions of religiosity and faith in terms of both their substance and their function. Nurses struggled with ambivalent feelings about patients' religious expressions and with unclear

understanding of the significance of religiosity. These challenges compromised person-centred and holistic care on several occasions.

Key words: dementia, nursing homes, care, religiosity, faith, spirituality, nurses' attitudes, culture.

SUMMARY STATEMENT

Why is this research needed?

- Nurses and care workers face challenges with patients' expressions of religiosity, and nursing research has rarely investigated religious faith expressions among patients with dementia in nursing homes.
- Religiosity and faith in human lives are vital for general quality of life, but they are often omitted from nurses' holistic care, and these issues create challenges in dementia care.
- Nurses and care workers need forums in which they can discuss patients' religiosity to increase their competence and confidence in meeting patients' religious needs.

What are the key findings?

- Nurses and care workers lack knowledge of the significance of religiosity and faith in the lives of nursing home patients with dementia.
- Nurses and care workers in nursing homes are uncertain about how to address religious expression and faith in the lives of patients with dementia.
- Nurses' and care workers' ambivalent feelings on patients' religiosity and faith in dementia nursing compromises holistic care and person-centred care.

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

- Nurses and care workers should discuss with other nurses experiences that are challenging and demanding in addressing religiosity and faith in patients with dementia.

- Training on religion and religious practice should be increased in nursing education so that nurses can develop skills in religious care and customise care to the individual patient.
- Nurses should establish forums in their departments in which they can discuss the significance of religiosity for patients with dementia as well as develop knowledge that can improve religious care.

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INTRODUCTION

Approximately 35.6 million people suffer from dementia worldwide, and 7.7 million new cases are reported every year (WHO 2012). Holistic nursing care for people with dementia in nursing homes must consider patients' spiritual and religious needs when needed (O'Brien 2011). Patients' cognitive interpretation of the relation to their "self" and their previous life is often blurred and can sometimes causing their spiritual and religious expressions to be vague and fragmented (Killick 2004, Lloyd 2004, Vance 2004). Therefore, it is important to explore how nurses observe, interpret and meet the patients' spiritual and religious faith expressions in dementia care settings (Narayanasamy *et al.* 2004).

Background

The relationship between the concepts of spirituality and religiosity are widely debated in the interdisciplinary research on the content of these concepts and how the concepts may relate to each other (Hill *et al.* 2000, Miller & Thoresen 2003, McSherry & Cash 2004, Zinnbauer & Pargament 2005, Clarke 2009, Taylor *et al.* 2014). Spirituality is generally described as more inclusive than religiosity and is the overall concept of which "*religiosity"* is a sub- set (Koenig 2008, Vachon *et al.* 2009). Spirituality is not necessarily related to religious beliefs, and people may define themselves as "*spiritual*" but not religious. Other people have lost their previous faith and some people do not have any stated faith or religious belief. Spirituality is defined by Pargament (2007, p. 32) as the "*Search for the sacred"* and religiosity is defined as the "*search for significance in ways related to the sacred*" (1997, p. 32). Religiosity is defined both by its content and the activities in a person's life (substantive) and / or its function (functional) (Pargament *et al.* 2005). This article describes both perspectives. "Search" refers to peoples' ability to be purposive in their behaviour, and "significance" refers to a set of values that are meaningful and important to a person

(Pargament 1997). These values involve existential questions regarding life and death or psychological conditions such as self-esteem and happiness (Danbolt 2014). Health and material needs are significant for people as are spiritual and religious experiences of God. The "sacred" refers to concepts of God, the divine and transcendent reality, such as the commitment to objectives beyond one's immediate needs (Pargament 2007). Humans can ascribe symbolic value to objects or special events and treat these values with deep respect because of the meaning they represent and the sacred quality of objects (Danbolt 2014).

Religiosity is reported to be a driving force in people's lives (e.g., expressed through art, music, poetry or morality) (Pargament 1997), and it is a vital predictor of the ability to find meaning in life (Park 2005, Park & Paloutzian 2005). Studies show that religion is an important predictor of well-being in older adults and is used as a coping method for various illnesses, especially anxiety and depression (Pargament 1997a, Roff *et al.* 2006, Stanley *et al.* 2011, Bush *et al.* 2012). Religious service attendance contributes to a high quality of life and a feeling of improved health (Bjorklof *et al.* 2013, Chokkanathan 2013, Krause 2013, Nichols 2013, Ysseldyk *et al.* 2013). Religion can be understood in terms of attributes such as rituals, doctrines, symbols, and belief systems as well as practices that are either chosen or passed down through individual and/or cultural heritage (Farran *et al.* 2003, WHOQOL SRPB Group 2006). In some literature religiosity is described as the way in which peoples seek and express their own spirituality (Taylor *et al.* 2014). In the present study, we wanted to focus on nurses' accommodations of patients with dementia who have religiosity and faith expressions because this is often what nurses must adhere to because of the patients' inability to verbally express their own faith and beliefs.

THE STUDY

Aim

The aim of the present study was to investigate nurses' attitudes towards and accommodations of patients' expressions of religiosity and faith in dementia care in nursing homes.

Design

A qualitative research design was applied using a hermeneutic-phenomenological approach. Focus groups are useful for examining peoples' experiences and exploring attitudes and views that may be less accessible in individual interviews by "*revealing dimensions of understanding that often remain untapped*" (Kitzinger 1995, p. 299-230). The joint communication of shared experiences may also help participants reveal their feelings with others who share similar experiences (Kitzinger 1995, Morgan & Scannell 1998, Kidd & Parshall 2000, Freeman 2006).

Sample/ - Participants

Nurses (Registered Nurses, RNs) and care workers (Auxiliary Nurses, LPNs and assistants) from four nursing homes participated in the study. Participants were chosen in a manner that is similar to purposive sampling, and the leaders of the nursing department requested the employees they believed were involved and had experience within this topic to enroll. The inclusion criteria were a) permanent employment and b) employment for at least one year in a dementia care setting. Both nurses and care workers were included. Participants varied in their age and length of work experience, but all had worked in dementia care settings.

Insert Table 1about here. "Participants' characteristics".

Our focus was not to compare the differences between nurses' (RNs) and care workers' (LPNs and assistants) views of this topic. We did not want to compare the participants' age or different age groups because the data were created by joint reflections. Therefore, we denoted the professional groups as "nurses" in the presentation of findings and in the discussion.

Data collection

Two interviews were conducted at each nursing home from June 2011 to January 2012 for a total of eight interviews. The same participants were required in both interviews, but because of shifts, five new participants were included in the follow-up interview. Only one male participated in the study. Each interview lasted 1 ½ - 2 hours. A thematic guide was applied. Questions during the interviews included the following: "*What do you mean by good attitudes in dementia care*? *How do you arrange for the religious care*? *What impact do religious traditions have on general care*?" The discussions were open and characterised by joint reflection. The same facilitator (LSØ, first author) and co- moderator (KK, second author) conducted all eight interviews. The interviews were audio recorded and transcribed verbatim, amounting to 228 pages of text with 1.5-line spacing. Field notes for the group communication were written during the interview and included 50 pages of text. We identified saturation after 8 interviews because few new themes were identified in the follow-up interview.

Ethical considerations

Written and oral information was given to the managers at the nursing homes. Written informed consent was obtained from all participants. Participation was emphasised as voluntary, and participants could withdraw from the study at any time. Information about confidentiality was provided. Names were not linked to either the interview text or audio

files. Study approval was obtained by the Data Protection Official for Research (Norway), which confirmed that the study met the requirements for ethical soundness in relation to standards and codes of ethics and according to the Helsinki Declaration.

Data analysis

Text analysis was based on van Manen's (Van Manen 1997b) hermeneutical-phenomenological analysis because we sought a deeper understanding of the meaning of the nurses' experiences of daily life in nursing homes (Van Manen 1997b, Streubert & Carpenter 2011). Van Manen (1997b) outlines some conditions for the analysis of a text and emphasises that these conditions cannot be strictly followed because they overlap somewhat. These conditions are as follows:

- Study a phenomenon that is of serious interest and importance to the world
- Investigate experiences as they are lived rather than as they are conceptualised
- Reflect on the essential themes that characterise the phenomenon
- Describe the phenomenon through the art of writing and rewriting
- Maintain a strong and oriented pedagogical relationship to the phenomenon
- Balance the research context by considering the parts and the whole.

The interview text was read in its entirety several times. The text was characterised as being descriptive and there were detailed descriptions of the nurses' attitudes and accommodations to patients' religiosity and faith.

We attempted to let the text "speak" to us, and we were inspired by the text in a non-cognitive way, searching for both the apparent and deeper meaning in the text. For example, a section of text stated that the nurses felt *embarrassed* when singing religious songs and that

they felt shame when they sang these songs. In light of the text in its entirety, the "*deeper meaning"* of the text could be that faith and religiosity are a personal matter in the Norwegian society that should not be expressed openly. The text was divided into meaningful units and condensed; throughout we emphasised that the meaning of the text was preserved (Lindseth & Norberg 2004). Our assumptions and pre-understandings were explicated by our openness and reflection. During the reading of the interview text, we reflected on the essential topics to uncover the significance of a certain experience and commonalities between the experiences. We also reflected on the parts of the text that seemed obscure by repeatedly questioning the text (Van Manen 1997b). During this work, we identified themes and clusters of themes that constituted sub-themes and, subsequently, main themes.

Hermeneutical-phenomenological writings

During the study, we attempted to uncover life-world descriptions or isolate thematic statements. We examined both the overall understanding of the text and the understanding of the parts, and we moved backward and forward several times to obtain a comprehensive understanding of the phenomenon the nurses described (van Manen 1997a). We repeatedly considered the native language to ensure the analysis was as close to the content of the text as possible, which is demonstrated in the citations under the presentation of findings. The detailed descriptions in the text helped us to understand the primary meaning of the text based on the literal meaning in the text (Van Manen 1997b), and the secondary meaning was based on possible interpretations of the text (van Manen 1997a).

Validity and reliability/rigor

Credibility was ensured by having the same facilitator (LSØ) and co- moderator (KK) complete all eight interviews. Both were female and had research experience. The facilitator

(LSØ) led the conversation, and the co- moderator (KK) provided input during the interviews. The data showed great diversity with multiple participating departments and age groups as well as variation in the length of professional experience (Thorne 2008). Follow-up interviews were preceded by a summary of the first interview to provide continuity and to obtain comments and corrections from the participants, enhancing trustworthiness (Streubert & Carpenter 2011). All researchers (LSØ, KK, SH, LJD) participated in the analysis of the text and discussed and created sub-themes and themes, increasing the dependability. Preliminary findings were also discussed with other researchers throughout this process.

FINDINGS

Three main themes were described as a movement between contradictions, and these themes highlight the nurses' attitudes towards and /or accommodations of patients' expressions of religiosity and faith. The main themes were i) embarrassment vs. comfort, ii) unknown religious practice vs. known religious practice; and iii) death vs. life. The themes and sub-themes are presented in Table 2.

Insert Table 2 about here. "Themes and sub- themes".

Embarrassment vs. comfort

Feelings of embarrassment

The nurses stated there was a high degree of "silence" regarding the patients' religiosity in the nursing home, which meant that the nurses did not extensively discuss it with each other. The silence was caused by feelings of embarrassment "when considering religion in care". The nurses felt that their feelings were barriers to integrating the patient's religiosity into care. This feeling was particularly evident in situations in which the nurses' sang religious

songs openly in the department together with the patients' and when the nurses were asked to pray with the patients or read a Bible verse. One of the nurses explained that the feeling of embarrassment resulted in religion being "hidden away" when patients were admitted to the nursing home. Another nurse used the phrase "feelings of shame" in her description, as revealed in the following conversation:

> 1E: "It is a bit shameful to sing religious songs. You become a little weird, and I think that's wrong".
>
> 3E: "I think that religious and spiritual care is as important as the care we provide otherwise, but it is a little forgotten".
>
> 2E: "I find it a bit strange when we think of caring for the patients' spiritual and religious needs. Many nurses who have a Christian background do not talk about the subject either, and the nurses are very cautious….". (p7)

The nurses in this study used the concepts of spirituality and religiousness interchangeably and made no distinction between them. In the focus groups, the nurses discussed how the culture in the departments influenced nursing practice and differed from the nursing culture for home-care practice. One nurse who had cared for patients in their homes felt that more openness occurred in conversations about religious issues in patients' homes than in the nursing home. The culture in nursing homes was more influenced by "taking into account" all patients, including those who are not religiously oriented. This approach led nurses to avoid religion because it was associated with embarrassment and shyness around the patients' religious needs.

Religiosity as a private matter

Nurses considered patients' religiosity primarily a private aspect of their lives. Patients' faith was considered individual and reflected each patient's personal beliefs. Nurses claimed that the patient's beliefs affected "the meaning of life" and that it was "a personal standpoint from their heart" that was important to consider. Although the nurses attempted to regain control in difficult situations, there were several unanswered questions that threatened the nurses' comfort and confidence. The nurses wanted to stimulate the patients' experiences of freedom and autonomy, even for religious matters. However, the nurses argued that their own lack of knowledge might confuse patients as they think about their religious values, norms, and beliefs. The nurses were afraid of making mistakes. A difficult dilemma arose when patients did not recognise their own religious background, either because they did not remember it or because the nurses did not remind the patients about it. One conversation revealed this dilemma:

> 5B "It is important not to lead a non-religious patient into the devotion".
>
> 3B "I fully agree with that. We have to respect that not everyone shares the same faith".
>
> 7B "We should not only think about offering them devotion at any point just because they are demented". (p 3)

The nurses were also unsure of the extent to which the patient understood and perceived religious practice. In the focus groups, the nurses discussed their low level of knowledge about other cultures and religious traditions. This lack of knowledge made the nurses distance themselves from patients' religious life. However, the nurses perceived this

distance as positive because it gave them a neutral approach to their patients' different worldviews.

Unknown religious practice vs. known religious practice

Religious practice that was scary

The nurses felt that unfamiliar religious expression from the patient could be experienced as scary. A lack of knowledge about the variation in the patients' expressions of religiosity prevented the nurses from realising what was genuine and what was confusion or psychosis related to dementia. In such situations, the nurses found that they easily lost control of the situation, and they did not know how to respond. Nurses were also challenged by patients' stories about religious experiences and had to consider whether they were fantasy or reality, especially when the patient interrupted the stories. Sometimes, the nurses attempted to normalise the situation when it seemed overwhelming by providing distractions (e.g., changing the topic or interrupting a chain of events), as described in the following:

> 3D: “We have a patient who can’t express himself verbally. He suddenly began to speak in tongues. It was scary, and we did not know what to do. Finally, someone came and suggested that we could sing a well-known hymn named ‘Blott en dag’, and then he stopped, and there was a kind of relief because the situation was difficult to handle. I do not know what we should have done. Should we let him continue? He was physically upset”.
>
> 5D: “It's clear that it was good to sing that song then”.
>
> 3D: “Are you sure? It was obvious that he needed to speak in tongues. Did we care for it?”
>
> 5D: “I should almost believe that”.

4D: “Yes, I think you did. Was he in the room alone?”

3D: “Yes”.

4D: “Then, I think that I would have sat there and listened to it”.

3D: “I do not know if it would have been correct".

4D: “I would have sat there and waited until he was finished and just let it be”. (p 7)

Uncertainties in the patients’ behaviour contributed to the nurses’ desire to change the patients’ focus to something the nurses could recognise and control. The nurses reflected on whether it was right or wrong to interrupt the patient's religious expression and supported each other in addition to identifying their own insecurities. The nurses discussed what types of religious expressions were normal or abnormal and acknowledged that the distinctions were unclear. Unfamiliar and sometimes frightening experiences caused the nurses to distance themselves from the patients instead of supporting them. Therefore, the nurses felt that familiar religious expressions created confidence and reassurance and that it was important to maintain composure upon exposure to unfamiliar religious experiences in patient care.

Religious practice that was recognisable

Some experiences of uncertainty made the nurses to attempt to reclaim their own confidence and to reassure themselves. Several of the nurses did not share the same faith as the patients and felt they knew too little about the importance of faith in the patients' lives. Nurses referred to “faith” as a Christian value and to familiar religious acts as part of the Norwegian Church tradition. The nurses expressed uncertainty in situations in which the nurses themselves had to contribute to the religious practice, but their uncertainty decreased in situations characterised by cultural events in which they did not have to disclose their own

beliefs. Nurses facilitated devotions, listened to sermons, looked for symbols inside the patients' rooms, and applied this knowledge to conversations with the patients. One conversation revealed these actions:

> A3: "We try to meet them where they are".
>
> A2: "We look at the television to listen to devotionals. When the priest comes, we sing hymns and psalms, and it's something most people enjoy. It is to show respect when it is a public holiday, for example, and talk about that". (p2)

Although the church's tradition was established in nursing homes, some of the nurses felt that their own experience was limited and that they needed the assistance of a priest. Nurses thought that it was difficult to determine whether it was their responsibility or the priest's responsibility to meet the patients' religious needs. The priest was seen as a solution to the nurses' sense of insecurity.

Death vs. life

Difficulty talking about death

The nurses did not want to talk about death with the patients, although the patients expressed that life did not make sense anymore and that they wanted to die in a dignified way. The nurses often considered the patients' desire to die as an expression of despair or depression. In such cases, the nurses felt it was appropriate to deflect the patients' feelings instead of discussing them further. At other times, the nurses assumed that patients were not able to complete conversations about death and gave little attention to the patients' expressions. At times, the patients remained in a prolonged grief process when a fellow patient died; the nurses thought it was important to prevent this process. For this reason, nurses sometimes

deliberately avoided the subject, even when they were also struggling with it. One conversation about death revealed the nurses' uncertainty:

> 2D "There are many patients who say, *'I can die, there is no meaning'*."
>
> 3D "Yes, we hear that. *'I wish I could die'*."
>
> 1D "We have a patient who cries sometimes, just for a little while, and then it's over. We do not know the cause, but it could be frustration or despair ...". (p23)

The nurses did not always know how to answer the patients when they talked about death because it was difficult to confirm the patients' expressed desire to die or to deny such statements. Both perspectives could be perceived as wrong for the patient. Only a few patients discussed their faith with respect to what death might involve. These dilemmas made the nurses move the patients' focus from death and meaninglessness to something positive that gave life meaning.

Focusing on life and the quality of life

Because dementia caused many lost- experiences for the patients, the nurses wanted to focus on their quality of life. The nurses realised that the patients' religiosity was related to maintaining important values and that quality of life was one of them. The nurses understood the concept of quality of life in terms of the experiences that patients mentally and/or spiritually care about (4d) (e.g., sensory experiences, including meals that create wellbeing). The content of such a conversation was described in one of the focus groups:

> 3C: "We try to get a good conversation at the breakfast table and attempt to stay calm around the meal. We sit down with patients, taking a slice of bread and a cup of

coffee, and then we can talk about everything, really. We begin with the weather and end up in something else. Maybe we talk about the old days too - it's very nice".

2C: "It is important to give attention to what they remember, and then we might enter religion or the spiritual if it is something they are upset about or want to talk about". (p 10)

Nurses' shifting of topics in these conversations from "death to life" was based on the idea that these informal discussions were positive experiences for the patients and gave them a sense of accomplishment. Several of the nurses in the focus groups stated that their own approach to the question of "life and death" was connected to their own life experience, expertise, and personal security in the nursing role. With increased skills, they experienced greater confidence in conversations about death, as well as the ability to lead discussions in a positive direction.

DISCUSSION

The present study reveals that nurses struggled with ambivalent feelings about patients' religiosity and that they had an unclear understanding of the significance of religiosity in patients' lives. The nurses' attitudes to patients' religiosity were characterised by uncertainty, which was mostly grounded in a lack of knowledge as well as the belief that the patient's religiosity was a private matter. The discussion below is structured on the basis of these main findings.

The nurses felt that their ambivalence about religiosity was a barrier to supporting the patients.

Prejudice prevented nurses from relating to patients' expressions of religious faith, especially in situations that were unknown, extraordinary, and frightening. The nurses responded by being evasive about the patients' religious activities and expressions, but they recognised that they were providing inadequate care. The nursing culture was not adapted for patients' religious faith expressions, and the nurses' were unable to escape from the prevailing culture. A study by Nordberg *et al*. (2006) found that nurses showed positive attitudes, especially with regard to ethical and aesthetic questions in dementia care, without even explicitly referring to religious issues. Such positive attitudes may promote person-centred care (Norbergh *et al.* 2006, Kada *et al.* 2009, Moyle *et al.* 2011), and contribute to patients' psychological well-being (Norbergh *et al.* 2006). Kada (2009) found that negative attitudes, if present, were more prominent among the oldest nurses with the longest working experience. The findings in the present study seem to highlight another aspect of the nurse-patient relationship: nurses' life experience promots their knowledge and confidence in conversations with the patients about religious matters, which is based on these nurses' positive attitudes.

The findings also reveal that nursing care is characterised by many dilemmas that are caused by a pronounced cultural "script", which is based on the culture that involves unspoken norms and values. These norms may sometimes hinder the nurses' scope of action. Moyle *et al*. (2011) argue that person-centred care is one way of promoting open and inclusive attitudes that may challenge the cultural barriers faced by nurses. Generally, an overall impression is that the nurses in this study were not prepared to perform person-centred care that integrated patients' religiosity and faith, even though they wished they

could. Previous research and the findings in this study reveal the need for further research in nursing science that can explore the cultural and environmental aspects that contribute to promoting excellent care to satisfy patients' religious needs in dementia care units.

Nurses felt they possessed an unclear understanding of the significance of religion in the patients' lives.

The nurses addressed religiosity in terms of the doctrinal frameworks based on a cultural heritage but felt that it was not part of current society. Therefore, they had difficulty relating to patients' religiosity. Research reveals that patients' private prayer and church attendance reduces depression (Branco 2000) and improves life satisfaction and self-esteem (Scandrett & Mitchell 2009). Pargament (1997) claimed that human expressions of religiosity are about the "search for significance". Nurses perceived that participation in religious activities was engaging for the patients, but they did not fully discuss the way in which the activities helped the patients on a psychological level. A lack of clarity prevented the nurses from fully discussing religiosity as a source of meaning with some of the patients, which is central to religious belief (Park 2005, Schnell 2011). The patients' "search" for God as "sacred" was only addressed in a superficial way, and the nurses seemed to lack proper words to describe faith (Pargament 1997, 2007). Instead, the nurses interrupted sacred moments for some of the patients. Their lack of understanding may explain the nurses' unwillingness to join the patients in events that were outside of their comfort zone and their tendency to turn the events towards a path that they could recognise and manage. The nurses' avoidance of the individual approach to patients' lives in the present study reflects another major challenge in person-centred care. Another aspect is that nursing research seems to "retrieve" the knowledge of other sciences on peoples' religiosity in general terms. There is a need to develop knowledge

that is adapted to practical nursing care situations in the context of dementia care units in particular.

Nurses felt great uncertainty about patients' religious expressions, mostly due to their lack of knowledge.

The nurses believed that the patients' faith was essentially a private matter that contributed to uncertainty about their role in supporting the patient. The nurses' perceptions of faith as private may also have prevented the nurses in being open to both the patient's religiosity and their own (Livingstone *et al.* 2012). The nurses also struggled with distinguishing between patients' genuine expressions of religious needs and expressions that were motivated by the patients' confusion. This uncertainty led nurses to avoid discussions of existential topics, such as death and meaninglessness. The consequences of altering the patient's focus from death to life led the nurses to openly and more deliberately ignore the patients' requests to reflect on death. A more positive interpretation of the nurses' actions is that the nurses embraced holistic care but gave less space to person-centred care, mostly because of their own uncertainties (Vaismoradi *et al.* 2011). Livingston *et al*. (2012) found that nurses consider conversations about death uncomfortable, which is mostly because they were afraid of saying too much or too little or because these conversations reminded them of their own losses in life.

The nurses' uncertainty led to a preference for open collective events instead of individual exercises of faith due to the dilemmas nurses faced. The patients did not have the opportunity to express their individual religious beliefs, although research has shown that religious activities remain important to elders in the final years of life and contributed to an improved quality of life (Scandrett & Mitchell 2009). This study found that the nurses

genuinely attempted to address the patients' religiosity from the perspective of both holistic care and person-centred care, but several obstacles were difficult to address and overcome. In addition, this study shows that we need more nursing research that examines how religiosity can be a resource in the lives of people with dementia in addition to developing knowledge that can improve the patients' experiences of quality of life in nursing homes (Ysseldyk *et al.* 2013).

Study limitations

All of the study participants were from Norway except two participants. The findings can nevertheless be applied to other contexts, especially in similar Nordic cultures. Additionally, nurses from other contexts can easily relate to the findings because these findings reveal general issues in dementia nursing. Another limitation may be that we have based our understanding of religiosity on Pargament's (1997, 2007) definition. The nurses in this study had a more traditional understanding of religion, reflecting, to a limited extent, the patients' subjective experiences of religion and faith.

CONCLUSION

The nurses lacked understanding of religiosity in the patients' lives, both in terms of its substance and its function. The findings revealed a gap between the theoretical knowledge on the significance of religion and the nurses' accommodations of patients' religiosity and faith. Holistic care and person-centred care were compromised on several occasions due to the nurses' ambivalence towards patients' religious expressions. Joint discussions in focus groups revealed the need for nurses to expand their knowledge on this topic to allow practice to be evidence-based rather than based on random solutions. The findings have implications regarding nurses' efforts to address those aspects of religious care that they experiences

challenging. The present study reports on the implications for nursing research in terms of developing knowledge on religious care aimed at improving nurses' practical skills when caring for the religiosity and faith of people with dementia.

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Table 1. Participant characteristics.

Nursing home	**Units (n)**	**Participants, interview 1 and 2 (n)**			**Nurses (n)**	**Care Workers (n)**	**Age, years**			**Working experience, years**		
		Interview 1	Interview2	New*			<30	30-50	>50	<5	5-10	>10
A	4	8	6	0	5	3		4	4	1	3	4
B	5	6	4	2	6	2	2	4	2	1	3	4
C	4	6	4	0	2	4		1	5			6
D	3	6	6	3	3	6	2	2	5	2	4	3
		26	20	5	16	15	4	11	16	4	10	17
Total		**31** total participants*.										

31 total participants*: 1) Interview 1: Twenty-six participants attended “Interview 1”.

2) Interview 2: Fifteen of the participants from “Interview 1” attended “Interview 2”.

3) *New = Five new participants attended “Interview 2”.

Table 2. Themes and sub-themes.

Themes	**Sub-themes**
Embarrassment vs. comfort	Feelings of embarrassment
	Religiosity as a private matter
Unknown religious practice vs. known religious practice	Religious practice that was scary
	Religious practice that was recognisable
Death vs. life	Difficulty talking about death
	Focusing on life and the quality of life