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The Effect of Nurses' Perception Levels of Spirituality and Spiritual Care on Patient Care During the COVID-19 Pandemic Process: A Cross-Sectional Study

COVID-19 Pandemi Sürecinde Hemşirelerin Maneviyat ve Manevi Bakımı Algılama Düzeylerinin Hasta Bakımı Üzerine Etkisi: Kesitsel Bir Çalışma

Adile NEŞE[a], Tuba GEÇDİ[b]

[a]Gaziantep University Vocational School of Health Services, Department of Internal Medicine Nursing, Gaziantep, Türkiye
[b]Kahramanmaraş Sütçü İmam University Faculty of Health Sciences, Department of Psychiatric Nursing, Kahramanmaraş, Türkiye

This study was presented as a summary orally in 7th International Conference on COVID-19 Studies in September 5-6, 2022, Ankara, Türkiye.

ABSTRACT Objective: The present study was conducted to determine the effect of nurses' perceptions of spirituality and spiritual care on patient care during the coronavirus disease-2019 (COVID-19) pandemic process. **Material and Methods:** The research is in the type of a cross-sectional study, and nurses working in COVID-19 clinics in a city hospital in Türkiye between the dates of July and August 2021, who agreed to participate in the study online, were included in the study. As data collection tools in the study, a personal information form containing the demographic characteristics of the participants and The Spirituality and Spiritual Care Rating Scale were used. **Results:** 63.0% of the nurses who knew spiritual care applied it to their patients, 58.8% of the nurses who could not practice spiritual care for their patients stated that this issue was due to the lack of healthcare professionals, 94.6% of the nurses protected themselves during the pandemic can apply spiritual care, 87.0% stated that training on spirituality and spiritual care practices was important. A statistically significant correlation was found between the nurses' status of applying the spiritual care practices and the Spirituality and Spiritual Care Rating Scale's total score average, the spiritual care subscale's and the personalized care subscale's mean scores, and the mean score of the nurses who practiced spiritual care for their patients was found to be high ($p<0.05$). **Conclusion:** Eliminating the knowledge needs of nurses about spirituality and spiritual care practices and solving the problems that prevent the practice can help increase the level of patient care.

Keywords: COVID-19; spirituality; spiritual care; nurse; patient care

ÖZET Amaç: Bu çalışma, koronavirüs hastalığı-2019 [coronavirus disease-2019 (COVID-19)] pandemi sürecinde hemşirelerin maneviyat ve manevi bakımı algılama düzeylerinin hasta bakımına etkisini belirlemek amacıyla yapılmıştır. **Gereç ve Yöntemler:** Araştırma kesitsel tipte olup, Temmuz-Ağustos 2021 tarihleri arasında Türkiye'de bir şehir hastanesinde COVID-19 kliniklerinde çalışan ve çevrim içi olarak araştırmaya katılmayı kabul eden hemşireler çalışmaya dâhil edilmiştir. Araştırmada veri toplama aracı olarak, katılımcıların demografik özelliklerini içeren kişisel bilgi formu ve Maneviyat ve Manevi Bakım Derecelendirme Ölçeği kullanılmıştır. **Bulgular:** Manevi bakım ile ilgili bilgiye sahip olan hemşirelerin %63,0'ının hastasına manevi bakım uyguladığını, hastasına manevi bakım uygulaması yapamayan hemşirelerin %58,8'i bunun nedeninin personel yetersizliğinden kaynaklandığını, %94,6'sı pandemi sürecinde hemşirenin kendisini koruyarak manevi bakım uygulayabileceğini, %87,0'ı maneviyat ve manevi bakım uygulaması ile ilgili eğitimin önemli olduğunu belirtmiştir. Hemşirelerin manevi bakım uygulama durumu ile Maneviyat ve Manevi Bakım Dereceleme Ölçeği toplam puan ortalaması ile manevi bakım alt boyutu ve bireysel bakım alt boyut puan ortalaması arasında istatistiksel olarak anlamalı ilişki bulunmuştur ve hastasına manevi bakım uygulama yapan hemşirelerin Maneviyat ve Manevi Bakım Dereceleme Ölçeği toplam puan ortalaması yüksek bulunmuştur ($p<0,05$). **Sonuç:** Hemşirelerin maneviyat ve manevi bakım uygulamalarına ilişkin bilgi gereksinimlerinin giderilmesi ve uygulamaya engel olan sorunların çözülmesi hasta bakım düzeyinin artmasına yardımcı olabilir.

Anahtar Kelimeler: COVID-19; maneviyat; manevi bakım; hemşire; hasta bakımı

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Correspondence: Adile NEŞE
Gaziantep University Vocational School of Health Services, Department of Internal Medicine Nursing, Gaziantep, Türkiye
E-mail: acaparusagi@hotmail.com

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An emerging coronavirus is the source of the contagious illness coronavirus disease-2019 (COVID-19). The COVID-19 virus first appeared in China in November 2019.[1] The COVID-19 epidemic, which the World Health Organization (WHO) recognizes as a "pandemic," has been a significant threat to global health. All healthcare professionals have been at the frontline of this arduous battle and have continued to provide COVID-19 patients the treatment they require throughout this process, while all nations across the world continue to fight the epidemic. In the struggle against COVID-19, healthcare professionals are crucial. Healthcare providers have given and will continue to give the essential treatment for the suspected or confirmed COVID-19 patients throughout the pandemic phase, frequently in difficult situations.[2] The holistic approach is the most thorough method usually employed by nurses who assess patients in all facets of healthcare services. According to the holistic perspective, every individual is a whole entity with physical, mental, emotional, sociocultural, and spiritual characteristics, each of these dimensions is interconnected and dependent upon the others.[3,4] The provision of health treatment to people using a holistic approach has given the spiritual aspect of people's lives equal weight to the other aspects.[5]

Despite being a fundamental component of what makes us multidimensional beings, the term "spirituality" the same thing can carry diverse meanings for various individuals and evoke a range of emotions.[6] Nursing care must include spiritual care, which is a crucial aspect of psychosocial care. The nurses' viewpoints, volunteering, and sensitivity to spiritual care play a role in it in addition to their own spiritual needs and feelings of hope for life.[7] Empathy, active listening, being alert to the patient's physical, emotional, and spiritual needs, knowing the patient's spiritual history, beliefs, and the meaning attributed to the disease, and helping them carry out their religious practices are all parts of nurses' spiritual care practices.[8,9] Practices in spiritual care, in particular, assist patients going through a crisis to have a positive view of themselves and raise their self-esteem.[3] Additionally, it improves the patient's physical and emotional well-being.[10]

The spiritual care techniques used by nurses are useful in many ways. Among them, the nurse's thought process, spiritual requirements, perception of care, and own hope for life, as well as volunteering and topic sensitivity, are particularly important for good nursing care. The patient's receptivity to communication, the units in which the nurses work, the working environment, and other healthcare providers' interactions with them all have an impact on spiritual care.[11] The current study's objectives are to increase awareness and comprehension of the issue while identifying the effects of the way view of spirituality and their approach to spiritual care on patient care.

MATERIAL AND METHODS

STUDY DESIGN AND SETTING

The current research took place on July 10 and August 10, 2021, in a city hospital in Türkiye. It is a cross-sectional study. Our study, the Declaration of Helsinki was made by the principles. Participants in the research were nurses who were employed at COVID-19 clinics. 92 nurses who voluntarily participated in the study and worked in the COVID-19 clinics were included in it without utilizing the sample selection process. Online data were gathered for the study using the "individual knowledge form" of the researchers and the "Spirituality and Spiritual Care Rating Scale" (SSCRS). The ability to care for COVID-19 patients, nursing licensure, desire to engage in the trial, and at least two weeks of experience working in a COVID-19 clinic were requirements for inclusion. Being a healthcare professional other than a nurse and withdrawing from the research for any reason were exclusion criteria.

DATA COLLECTION TOOLS

Individual knowledge form: The survey created by the researchers comprises 17 questions including the socio-demographic. The attributes of nurses and their perspectives regarding spiritual care.

SSCRS: The SSCRS, a five-point Likert-type scale developed by McSherry et al. in 2002, measures one's feeling of spirituality and level of spiritual care. Cronbach's alpha for the scale is 0.64.[12] When Ergül and Temel examined the scale's reliability and valid-

ity in our country, they found that Cronbach's alpha coefficient, a measure of internal consistency, was 0.76. The scale includes the subscales of spirituality, spiritual care, religiosity, and personalized care, and it has a total of 17 items. The scale can have a minimum score of 17 and a maximum score of 85. Items are scored on a scale of 1 for "strongly disagree" and 5 for "strongly agree." An improved impression of spirituality or the provision of quality spiritual care is implied by higher ratings on the scale.[5] The study found that the scale's Cronbach's alpha value was 0.70.

STATISTICAL EVALUATION

In a computerized setting, the SPSS 25.0 software package (IBM, USA) was used for data coding and assessment. The research data were found to have a normal distribution after scrutiny. According to Tabachnick and Fidell, if the "skewness" and "kurtosis" values of the data acquired from a scale are among ±1.5, it suggests that the data reflect a normal distribution.[13] Standard deviation and mean were utilized to describe continuous variables, whereas percentages and numbers were used to summarize categorical variables. The one-factor and two-factor analysis of variances (ANOVA) were used to evaluate the variables among independent groups, and the ANOVA was utilized to examine the interactions between the two categories. The post-hoc comparison test was also used to ascertain the differences among the groups. The accuracy of the scale was evaluated using the Cronbach's alpha coefficient. The significance threshold was found as p=0.05, or the 95% confidence interval.

ETHICAL PERMISSION

The project received permission confirmed by the Gaziantep University Clinical Research Ethics Committee (date: June 30, 2021; no: 144). A signed agreement was given by the hospital where the study was carried out. Before the research began, informed consent forms from the study's participants were gathered online.

RESULTS

The study's nursing participants had an average age of 33.63±6.7 years. When the initial traits of the nurses were scrutinized, it was determined that 80.4% of them were women, 73.9% of them were married, 69.6% of them had undergraduate education, 31.5% of them had been working for 6-10 years, and 57.6% of them were working during the day shifts (Table 1). When the nurses' knowledge about spirituality and spiritual care and their status of applying spiritual care practices were examined, it was discovered that 63.0% of them knew about spirituality and spiritual care, 51.75% of those who knew spiritual care obtained the information by reading articles, 69.6% of them stated that the training on spiritual care was insufficient, 53.3% of them stated that they did not read any publications on spirituality and spiritual care, 63.0% of them applied spiritual care to their patients, 43.1% of the nurses who applied spiritual care to their patients listened to the patient for short periods at regular intervals, and 25.9% of them practiced relieving the patient by communicating with the patient (Table 2). 58.8% of the nurses who could not apply spiritual care practices for their patients were due to the lack of personnel, 94.6% of them stated that the nurse could apply spiritual care by protecting themselves during the pandemic, 58.7% of them paid attention to the spiritual care needs of the patients in the clinics where they worked, 87.0% of them stated that the training on spirituality and spiritual care practices are important, and 41.3% of them stated that the concept of spirituality was expressed as "relieving the patient spiritually" (Table 2).

The correlation among the sub-score averages of the SSCRS and the age, gender, marital status, level of education, years of experience, and working shift of the nurses employed by the COVID-19 clinics during the pandemic is shown in Table 1. The SSCRS total score average and the mean score of the subscale of religiosity were found to be significantly different ($p<0.05$), as were the gender and level of education of the nurses. The post-hoc test used to assess if there was a statistically important link existed among the educational level of the nurses and the SSCRS found that there was. It was found that the group with a high school education was the source of this statistically significant link.

The mean SSCRS score of the nurses working the day shift was found to be high ($p<0.05$), and there

TABLE 1: The relationship between nurses' descriptive characteristics and the mean scores of the SSCRS and subscale (n=92).

Variable				Subscale Total Score			SSCRS
				Spiritual care	Spirituality	Individual care	Total score
Average age (X̄±SD)/year=33.63±6.7		Number (n)	Percent (%)	X̄±SD	X̄±SD	X̄±SD	X̄±SD
Gender	Female	74	80.4	29.64±3.09	10.06±1.92	14.70±2.17	57.89±4.91
	Male	18	19.6	31.50±4.76	11.44±3.92	15.33±2.78	61.77±10.81
Significance test		t/p*		-2.027/0.094	**-2.153/0.001***	-1.042/0.531	**-2.290/0.000***
Age groups	20-29	28	30.4	30.67±4.13	10.46±3.33	15.25±2.35	59.89±8.81
	30-39	42	45.7	29.69±3.56	10.23±1.92	14.92±2.29	58.26±5.70
	40 and over	22	23.9	29.77±2.54	10.36±2.25	14.09±2.18	57.81±4.75
	Significance test	F/p*		0.718/0.491	0.070/0.932	1.659/0.196	0.738/0.481
Marital status	Married	68	73.9	30.26±3.39	10.57±2.55	15.32±2.17	59.58±6.75
	Single	24	26.1	29.29±3.89	9.66±2.16	13.41±2.10	56.00±5.46
Significance test		t/p*		1.162/0.490	1.551/0.515	3.723/0.662	2.344/0.976
Educational level	High school	6	6.5	30.72±4.09	13.16±6.04	16.16±3.06	65.83±15.38
	Associate degree	12	13.0	29.75±2.80	10.75±1.54	15.00±1.41	58.83±4.72
	Licence	56	60.9	29.62±3.17	10.32±2.08	14.42±2.47	57.80±5.90
	Graduate school	18	19.6	30.05±4.03	9.16±1.50	15.50±1.72	58.77±4.02
Significance test		F/p*		1.513/0.217	**4.514/0.005***	1.816/0.150	**2.839/0.043***
Working year	1-5 year	18	19.6	30.16±3.51	9.38±2.09	14.72±1.93	57.50±4.99
	6-10 year	29	31.5	30.93±3.98	11.17±3.12	15.42±2.40	61.44±8.83
	11-15 year	25	27.2	28.92±3.51	9.88±1.71	14.36±2.28	56.52±4.82
	16 year and over	20	21.7	29.90±2.63	10.55±2.58	14.20±2.23	58.30±4.72
Significance test		F/p*		1.491/0.223	2.409/0.072	2.422/0.071	**2.985/0.035***
Working shift	Night	39	42.4	29.66±3.53	9.82±1.69	15.02±2.24	57.84±5.37
	Daytime	53	57.6	30.26±3.54	10.71±2.88	14.67±2.35	59.24±7.37
Significance test		t/p*		-0.800/0.419	**-1.731/0.036***	0.711/0.714	-1.004/0.501

*p<0.05; t: Independent groups t-test; F: One-way analysis of variance test; SSCRS: Spirituality and Spiritual Care Rating Scale; SD: Standard deviation.

TABLE 2: The relationship between nurses' spirituality and spiritual care practices and the SSCRS and subscale scores mean (n=92).

				Subscale Total Score			SSCRS
Knowledge of the nurses on spirituality and spiritual care		**Number (n)**	**Percent (%)**	**Spiritual care X̄±SD**	**Spirituality X̄±SD**	**Individual care X̄±SD**	**Total score X̄±SD**
Have you received training on piritual care?	Yes	58	63.0	29.81±3.54	10.27±1.88	15.15±1.98	58.48±5.62
	No	34	37.0	30.35±3.54	10.44±3.28	14.26±2.70	58.94±8.09
Significance test	**t/p***		-0.709/707	**-0.307/0.009***	**1.811/0.018***	-0.320/0.150	
If yes, where did you get the training?	During my education	20	34.5	30.00±4.65	10.10±1.83	15.05±2.16	58.55±6.68
	In the institution I work at	8	13.8	29.00±3.62	9.37±1.50	14.62±2.87	56.25±5.54
	From the articles I've read	30	51.7	29.96±2.65	10.67±1.95	15.38±1.58	59.12±4.82
Significance test	**F/p***		0.261/0.771	1.736/0.185	0.520/0.597	0.837/0.438	
Is the information given to healthcare professionals	Yes	28	30.4	29.60±3.60	9.82±2.31	14.92±2.56	58.10±6.55
with spiritual care sufficient?	No	64	69.6	30.18±3.51	10.56±2.53	14.78±2.20	58.89±6.66
Significance test	**t/p***		-0.723/0.682	-1.323/0.889	0.281/0.403	-0.521/0.979	
Status of reading any publications related	Yes	43	46.7	29.72±3.19	10.09±1.98	15.13±2.01	58.32±5.20
to spirituality	No	49	53.3	30.26±3.82	10.55±2.85	14.55±2.51	58.93±7.67
Significance test	**t/p***		-0.735/0.325	-0.888/130	1.226/0.147	-0.442/0.216	
Have you applied spiritual care to your patient?	Yes	58	63.0	30.41±2.79	10.24±2.09	15.03±1.94	59.20±4.69
	No	34	37.0	29.32±4.49	10.50±3.05	14.47±2.80	57.70±8.98
Significance test	**t/p***		**1.436/0.016***	-0.480/0.101	**1.135/0.009***	**1.053/0.016***	
What kind of spiritual care practices	Listening to the patient for short periods at regular intervals	25	43.1	29.68±3.24	9.76±1.85	14.84±2.28	58.32±4.41
did you do to the patient?	Communicating and comforting the patient	15	25.9	30.46±2.58	10.20±2.04	14.66±1.34	58.46±3.77
	Making phone calls with relatives when necessary	6	10.3	31.66±1.50	10.00±1.41	14.66±1.50	58.83±3.86
	To provide the necessary material when he wants to worship	5	8.6	31.20±1.78	10.80±1.30	16.00±1.22	61.20±3.56
	To act smiling and concerned while giving care	7	12.1	31.28±2.62	11.85±3.33	16.14±2.26	62.85±7.31
Significance test	**F/p***			1.006/0.413	1.534/0.206	1.136/0.350	1.688/0.167
The reason why spiritual care could not be	Lack of information	3	8.8	29.66±4.93	10.66±3.05	15.66±0.57	60.00±1.00
applied to the patient	Staff shortage	20	58.8	30.15±4.49	10.65±3.75	13.95±2.94	58.15±10.22
	Lack of opportunity	7	20.6	28.00±4.61	9.00±1.00	13.85±2.85	53.85±7.31
	Job centered work	4	11.8	30.25±2.87	10.25±1.89	16.50±1.91	59.50±7.54
Significance test	**F/p***			0.435/0.730	0.482/0.697	1.266/0.304	0.548/0.654
Should spiritual care be given to the patient	Should be done by taking protective measures	87	94.6	30.02±3.47	10.32±2.38	14.74±2.27	58.58±6.29
during the pandemic period?	I don't think it's right during the pandemic process	5	5.4	29.80±5.01	10.60±4.21	16.20±2.58	59.80±11.81
Significance test	**t/p***			0.136/0.588	-0.242/0.070	-1.378/0.894	-0.398/0.164
Do you think that the spiritual needs of the patient	Yes	54	58.7	30.01±3.23	10.48±2.05	14.62±2.06	58.70±5.26
are taken care of in the clinic you work in?	No	38	41.3	30.00±3.97	10.13±3.00	15.10±2.60	58.57±8.22
Significance test	**t/p***			0.025/0.507	0.664/0.163	-0.975/0.249	0.089/0.216
Do you think spiritual education is important?	Yes	80	87.0	30.12±3.59	10.45±2.56	14.96±2.24	59.05±6.71
	No	12	13.0	29.25±3.10	9.58±1.72	13.91±2.57	56.00±5.34
Significance test	**t/p***			0.798/0.850	1.130/0.376	1.416/0.560	1.502/0.987
What does the concept of spirituality mean to you?	Relieve the patient psychologically	38	41.3	29.84±3.29	10.13±2.26	14.71±1.84	58.28±4.64
	Removing fears such as death anxiety	22	23.9	29.77±5.33	10.45±3.41	14.72±3.11	58.36±11.06
	To support psychologically	32	34.8	30.37±2.05	10.50±1.98	15.03±2.20	59.28±4.33
Significance test	**F/p***			0.259/0.773	0.220/0.803	0.191/0.826	0.220/0.803

*p<0.05; t: Independent groups t-test; F: One-way analysis of variance test; SSCRS: Spirituality and Spiritual Care Rating Scale; SD: Standard deviation.

TABLE 3: Distribution of SSCRS and subscale scores (n=92).

Subscale total score	n	Minimum	Maximum	X̄±SD
Spiritual care	92	21	40	30.01±3.53
Spirituality	92	6	16	10.20±2.09
Individual care	92	10	20	14.82±2.30
Total SSCRS	92	44	85	58.65±6.60

SSCRS: Spirituality and Spiritual Care Rating Scale; SD: Standard deviation.

was a statistically important link among the nurses' working shifts and the subscale of religiosity's mean score on the spirituality and spiritual care scale. The average SSCRS total score and the nurses' years of experience were shown to be significantly correlated ($p<0.05$). The post-hoc test was used to examine if there was an important connection among the nurses' years of experience and the SSCRS revealed that the group with 6-10 years of experience was responsible for this significance.

A statistically significant link among the nurses' spiritual care training and the mean scores of the SSCRS's religiosity and individualized care subscales was discovered when the knowledge of the nurses regarding spirituality and spiritual care was assessed ($p<0.05$). The SSCRS total point average, the average score on the spiritual care subscale, and the average score on the personalized care subscale were all found to be statistically correlated, and the mean score of the nurses who used spiritual care practices for their patients was found to be high ($p<0.05$). The mean SSCRS score of the nurses who used the spiritual care practice of "being friendly and warm while caring for the patients" was found to be high but there was no important link among the nurses' spiritual care practices and the SSCRS total score and its subscales' mean scores ($p>0.05$). When the mean scores of the SSCRS and its subscales were examined, the mean scores of the spirituality and spiritual care subscales were 30.01±3.53, the religiosity subscale was 10.20±2.09, the individualized care subscale was 14.82±2.30, and the total score average of the SSCRS was found to be 58.65±6.60 (Table 3).

DISCUSSION

One of the most important components of nursing care is spiritual care, and nurses should treat patients holistically.[14] The WHO also stressed the need to include spiritual care in nursing practices to provide holistic care.[15] To provide patients with spiritual care that is informed by their understanding of their spiritual beliefs and needs, nursing professionals are responsible for increasing their knowledge of spirituality, incorporating it into nursing care processes, and improving their interactions with patients and their families.[16] The goal of the current study was to ascertain how patient care throughout the pandemic phase at the COVID-19 clinics was impacted by the nurses' perceived levels of spirituality and spiritual care. The SSCRS total mean score and the age or marital status of the nurses in the study were shown to be statistically unrelated. Studies that are similar to this one in the literature provide support for the findings of the current study regarding age and marital status.[17-19]

According to the current study, nurses' views of spiritual care and levels of spirituality varied depending on their gender. Comparable studies in the literature have found that women see spirituality and spiritual care more favorably than males do.[20-22] In the current study, male nurses had higher mean scores on the religiosity subscale and the SSCRS, and it was concluded that this difference was statistically significant. The hypothesis that gender disparities in attitudes toward spirituality and spiritual care exist can be used to explain this result.

The current study found that nurses' educational backgrounds had an impact on how seriously they took spirituality and spiritual care.

According to other studies; the mean spirituality scores of nurses increase as their educational degrees do.[23-25] Even while it is predicted that those with a high school or associate degree will be more aware of and informed about the subject, the SSCRS mean

score and the religiosity subscale mean score were greater, and the difference between them was determined to be significant. The low involvement of nurses with high school and associate degree education, as well as cultural and belief variations, particularly depending on the educational levels of participants, are suggested to be the causes of this discrepancy in the study.

The results of this study unveiled a statistically significant link among the nurses' perspectives on spirituality, spiritual care, and their years of professional experience ($p<0.05$). Notably, nurses with 6 to 10 years of experience demonstrated a more pronounced SSCRS mean score. Healthcare professionals with 6 to 10 years of experience had the strongest views of moral support, according to previous research.[26] In earlier studies of a similar kind, it was discovered that years of experience and spiritual care were substantially connected.[17,24,27] However, multiple studies demonstrated that the level of spirituality and spiritual care is unaffected by professional experience.[23,28,29]

According to the study, 63.0% of the participants who took part in the study received training in spiritual care, 51.7% of them did so by reading articles, 69.6% of those who did so felt that the training was insufficient, and 87.0% thought that the training in spirituality was crucial. A statistically important connection ($p<0.05$) was established among the mean score of the subscale of religiosity and individualized care and the overall score of the SSCRS for the nurses who had received training in spiritual care. Comparable research with student nurses found that those students who took part in a thorough spirituality and spiritual care program were better capable of giving spiritual care than other students.[30] Another study including nurses found that those who had undergone spiritual care training had made developments in their spiritual care practices.[31] Studies that are similar to the current research in the literature support its conclusions.

Spiritual wants are defined as needs that lessen a person's spiritual deprivation and strengthen his or her spirituality. Spiritual care techniques in particular help patients who are in crisis to view themselves favorably and boost their self-esteem. Because of this, it is essential for nurses to understand patients' spiritual needs as a part of holistic care and to give each patient the right care by taking into account their spirituality.[27] The great majority of the study's nurses said that they gave their patients spiritual care. It was found that there was a statistically important link among the nurses' use of spiritual care practices and the SSCRS mean score, as well as the mean scores of the spiritual care and individualized care subscales; it was also found that the nurses who used spiritual care practices with their patients had higher SSCRS mean score ($p=0.05$). In different research with nurses, it was found that a large percentage of nurses (50.7%) used spiritual care methods with their patients.[17]

The participants of this study claimed that they assisted the patients' desire to worship, communicated with them and comforted them, conducted interviews with the patients' relatives, listened to the patient's spiritual care practices, and were interested and cheerful while giving care. Similar to this, it has been stated in studies in the literature that techniques like listening to patients and communicating with them, being friendly and caring, providing a comfortable environment for patients to worship in, and allowing them to meet with their relatives when necessary are effective in meeting their needs for spiritual care.[23,26,27,29] Our study's findings investigation are consistent with those found in the literature.

There are multiple reasons why nurses may find it challenging to fulfill patients' spiritual needs. This situation demonstrates that nurses are unprepared to provide several factors that contribute to the supply of spiritual care, including a lack of clear guidelines on their role in doing so, a lack of time to do so, and a lack of knowledge and training on spirituality.[32] One of the major barriers to providing spiritual care is the difficulty of defining it. Participants in the nursing research asserted that workplace traditions, staffing shortages, and knowledge gaps inhibited them from offering spiritual care. Due to a shortage of staff and a tremendous workload, it was demonstrated in a similar study that nurses were unable to offer spiritual care to patients.[33] According to similar research, nurses' inability to provide spiritual care to their pa-

tients was caused by a lack of time, personnel, education, and opportunities.[29] Another research of a similar kind with a high participation rate (112 nurses and 195 doctors) indicated that 71% of nurses and 73% of doctors could not implement spirituality and spiritual care activities because they did not have enough time for them.[34] The information found in the literature may be compared to what was discovered in the present study.

Considering that the maximum achievable score attained on the SSCRS is 85 and that the average total score of the nurses in the research was found to be 58.65±6.60, it can be concluded that the nurses' impression of spirituality and spiritual care is at a high level. In similar studies, the mean scores of SSCRS were found to be 53.76±4.58, 60.97±7.92, 57.62±12.00, and 57.70±10.04, respectively.[16,33,35] It is believed that the variations in the SSCRS's mean scores reported in the literature might be attributed to both personal factors and the potential disparities in nursing schools' spirituality and spiritual care curricula.

LIMITATIONS

The study has there are a few limitations of acknowledge. Firstly, the study is cross-sectional, which means we cannot infer causality between the variables. Secondly, the data was exclusively conducted from nurses working in the COVID-19 clinics, and it was conducted in a single center. Hence, its applicability to all nurses cannot be extended. Future research are recommended with a larger population, as well as comparative studies across various disciplines and hospitals.

CONCLUSION

The findings from the study demonstrated that even while the nurses' average SSCRS total score was high, the training they had received was insufficient, and they needed further training. The study's participant nurses received their information regarding the application of spiritual care from several sources. It has been shown that spiritual care practices were insufficient owing to factors such as a lack of time, staff, opportunity, and work-based healthcare services, despite the nurses' intention to address the spiritual needs and requirements of the patients and to implement spiritual care. It is imperative to take action to make it simpler for nurses to integrate spiritual care knowledge and practices into nursing practices, to increase the effectiveness of assessment systems, and to provide them with the education required to provide spiritual care. It is advised to teach spirituality, the concepts of spiritual care, and its practices both during the processes of nursing education and as supportive training after graduation to improve working environments and reveal ways to improve nurses' mental well-being in terms of supporting spiritual care practices.

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Conflict of Interest

No conflicts of interest between the authors and / or family members of the scientific and medical committee members or members of the potential conflicts of interest, counseling, expertise, working conditions, share holding and similar situations in any firm.

Authorship Contributions

Idea/Concept: *Adile Neşe, Tuğba Geçdi;* ***Design:*** *Adile Neşe, Tuğba Geçdi;* ***Control/Supervision:*** *Adile Neşe;* ***Data Collection and/or Processing:*** *Tuğba Geçdi;* ***Analysis and/or Interpretation:*** *Adile Neşe;* ***Literature Review:*** *Adile Neşe, Tuğba Geçdi;* ***Writing the Article:*** *Adile Neşe, Tuğba Geçdi;* ***Critical Review:*** *Adile Neşe, Tuğba Geçdi;* ***References and Fundings:*** *Adile Neşe, Tuğba Geçdi;* ***Materials:*** *Adile Neşe, Tuğba Geçdi.*

REFERENCES

1. Zhu N, Zhang D, Wang W, Li X, Yang B, Song J, et al; China Novel Coronavirus Investigating and Research Team. A Novel Coronavirus from Patients with Pneumonia in China, 2019. N Engl J Med. 2020;382(8):727-33. [Crossref] [PubMed] [PMC]
2. Lai J, Ma S, Wang Y, Cai Z, Hu J, Wei N, et al. Factors Associated With Mental Health Outcomes Among Health Care Workers Exposed to Coronavirus Disease 2019. JAMA Netw Open. 2020;3(3):e203976. [Crossref] [PubMed] [PMC]
3. Baldacchino DR. Nursing competencies for spiritual care. J Clin Nurs. 2006;15(7):885-96. [Crossref] [PubMed]
4. Daştan NB, Buzlu S. Meme kanseri hastalarında maneviyatın etkileri ve manevi bakım [Treatments and care of spirituality in patients with breast cancer]. Maltepe Üniversitesi Hemşirelik Bilim ve Sanatı Dergisi. 2010;3(1):73-9. [Link]
5. Ergül Ş, Temel AB. Maneviyat ve manevi bakım dereceleme ölçeğinin Türkçe formunun geçerlilik ve güvenilirliği [Validity and reliability of "the spirituality and spiritual care rating scale" Turkish version]. Ege Üniversitesi Hemşirelik Yüksek Okulu Dergisi. 2007;23(1):75-87. [Link]
6. Dossey BM, Keegan L. Holistic Nursing: A Handbook for Practice. 6th ed. Burlington, MA: Jones & Bartlett; 2013.
7. McSherry W, Jamieson S. An online survey of nurses' perceptions of spirituality and spiritual care. J Clin Nurs. 2011;20(11-12):1757-67. [Crossref] [PubMed]
8. Aştı N, Pektekin A, Adana F. Cerrahi hemşirelik bakımının manevi boyutu [The spiritual dimension of surgical nursing care]. İstanbul Üniversitesi Florence Nightingale. Hemşirelik Dergisi. 2005;13(54):27-34. [Link]
9. Çetinkaya B, Altundağ S, Azak A. Spiritüel bakım ve hemşirelik [Spiritual care and nursing]. Adnan Menderes Üniversitesi Tıp Fakültesi Dergisi. 2007;8(1):47-50. [Link]
10. Wong KF, Yau SY. Nurses' experiences in spirituality and spiritual care in Hong Kong. Appl Nurs Res. 2010;23(4):242-4. [Crossref] [PubMed]
11. Narayanasamy A, Owens J. A critical incident study of nurses' responses to the spiritual needs of their patients. J Adv Nurs. 2001;33(4):446-55. [Crossref] [PubMed]
12. McSherry W, Draper P, Kendrick D. The construct validity of a rating scale designed to assess spirituality and spiritual care. Int J Nurs Stud. 2002;39(7):723-34. [Crossref] [PubMed]
13. Tabachnick BG, Fidell LS. Using Multivariate Statistics. 6th ed. Boston: Pearson; 2013.
14. Ramezani M, Ahmadi F, Mohammadi E, Kazemnejad A. Spiritual care in nursing: a concept analysis. Int Nurs Rev. 2014;61(2):211-9. [Crossref] [PubMed]
15. Erenoğlu R, Can R. Hemşirelik bölümü öğrencilerinin manevi destek algıları ve etkileyen faktörler [Spiritual support perceptions and the affecting factors of students among nursing school]. JAREN. 2019;5(1):23-30. [Link]
16. Babamohamadi H, Ahmadpanah MS, Ghorbani R. Attitudes toward spirituality and spiritual care among Iranian nurses and nursing students: a cross-sectional study. J Relig Health. 2018;57(4):1304-14. [Crossref] [PubMed]
17. Kavak F, Mankan T, Polat H, Sarıtaş SÇ, Sarıtaş S. Hemşirelerin manevi bakıma ilişkin görüşleri [Nurses comments on the maintenance of spiritual care]. İnönü Üniversitesi Sağlık Bilimleri Dergisi. 2014;3(1):21-4. [Link]
18. Yılmaz DU, Yılmaz D, Karaman D, Çalışkan S. Hemşirelerin manevi destek algıları ve ilişkili faktörler [Perception and related factors for nurses in spiritual support]. JAREN. 2019;5(3):188-93. [Link]
19. Azarsa T, Davoodi A, Khorami Markani A, Gahramanian A, Vargaeei A. Spiritual wellbeing, attitude toward spiritual care and its relationship with spiritual care competence among critical care nurses. J Caring Sci. 2015;4(4):309-20. [Crossref] [PubMed] [PMC]
20. Çetintaş İ, Dirik FZ, İlhan E, Kostak MA. Hemşirelik öğrencilerinin maneviyat ve manevi bakım ile ilgili algıları [In the perceptions on spirituality and spiritual care of nursing students]. Eurasian Journal of Health Sciences. 2021;4(1):38-46. [Link]
21. Daghan S. Nursing students' perceptions of spirituality and spiritual care; an example of Turkey. J Relig Health. 2018;57(1):420-30. [Crossref] [PubMed]
22. İnce Çelik S, Akhan LU. Öğrenci hemşirelerin maneviyat ve manevi bakıma ilişkin algıları [Nursing students' perceptions about spirituality and spiritual care]. Hemşirelikte Eğitim ve Araştırma Dergisi. 2016;13(3):202-8. [Link]
23. Yılmaz M, Okyay N. Hemşirelerin maneviyat ve manevi bakıma ilişkin görüşleri [Views related to spiritual care and spirituality of nurses]. Hemşirelikte Araştırma Geliştirme Dergisi. 2009;11(3):41-52. [Link]
24. Ozbasaran F, Ergul S, Temel AB, Aslan GG, Coban A. Turkish nurses' perceptions of spirituality and spiritual care. J Clin Nurs. 2011;20(21-22):3102-10. [Crossref] [PubMed]
25. Wong KF, Lee LY, Lee JK. Hong Kong enrolled nurses' perceptions of spirituality and spiritual care. Int Nurs Rev. 2008;55(3):333-40. [Crossref] [PubMed]
26. Esendir İşbilen N, Kaplan H. Sağlık çalışanlarının maneviyat ve manevi destek algısı: İstanbul örneği [Perception of spirituality and spiritual support among health care professionals: the example of İstanbul]. Ekev Akademi Dergisi. 2018;22(73):317-32. [Crossref]
27. Ercan F, Körpe G, Demir S. Bir üniversite hastanesinde yataklı servislerde çalışan hemşirelerin maneviyat ve manevi bakıma ilişkin algıları [Spirituality and spiritual care related perceptions of nurses working at the inpatient services of a university hospital]. Gazi Medical Journal. 2018;29(1):17-22. [Crossref]
28. Gönenç İM, Akkuzu G, Altın RD, Möroy P. Hemşirelerin ve ebelerin manevi bakıma ilişkin görüşleri [Views of nurses and midwives on spiritual care]. Gümüşhane Üniversitesi Sağlık Bilimleri Dergisi. 2016;5(3):34-8. [Link]
29. Eğlence R, Şimşek N. Hemşirelerin maneviyat ve manevi bakım hakkındaki bilgilerinin değerlendirilmesi [To determine the knowledge level about spiritual care and spirituality of nurses]. Acıbadem Üniversitesi Sağlık Bilimleri Dergisi. 2014;5(1):48-53. [Link]
30. Ross L, van Leeuwen R, Baldacchino D, Giske T, McSherry W, Narayanasamy A, et al. Student nurses perceptions of spirituality and competence in delivering spiritual care: a European pilot study. Nurse Educ Today. 2014;34(5):697-702. [Crossref] [PubMed]
31. Mamier I, Taylor EJ, Winslow BW. Nurse spiritual care: prevalence and correlates. West J Nurs Res. 2019;41(4):537-54. [Crossref] [PubMed]
32. Rushton L. What are the barriers to spiritual care in a hospital setting? Br J Nurs. 2014;23(7):370-4. [Crossref] [PubMed]
33. Bakir E, Samancioglu S, Kilic SP. Spiritual experiences of muslim critical care nurses. J Relig Health. 2017;56(6):2118-28. [Crossref] [PubMed]
34. Balboni MJ, Sullivan A, Enzinger AC, Epstein-Peterson ZD, Tseng YD, Mitchell C, et al. Nurse and physician barriers to spiritual care provision at the end of life. J Pain Symptom Manage. 2014;48(3):400-10. [Crossref] [PubMed] [PMC]
35. Çelik AS, Özdemir F, Durmaz H, Pasinlioğlu T. Hemşirelerin maneviyat ve manevi bakımı algılama düzeyleri ve etkileyen bazı faktörlerin belirlenmesi [Determining the perception level of nurses regarding spirituality and spiritual care and the factors that affect their perception level]. Hacettepe Üniversitesi Hemşirelik Fakültesi Dergisi. 2014;1(3):1-12. [Link]