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Correlation of nurses' perception of spirituality and spiritual care with spiritual care practices in Indonesia: A cross-sectional survey

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Abstract

Background: Spiritual care is essential to nursing practice, contributing to holistic patient care. However, the relationship between nurses' perceptions of spirituality and spiritual care with their engagement in spiritual care practices remains underexplored, particularly in Indonesia. Understanding this relationship is crucial for enhancing the quality of care provided to patients.
Objective: This study aimed to examine the correlation between nurses' perceptions of spirituality and spiritual care with their spiritual care practices in Indonesia.
Methods: A cross-sectional survey design was employed, involving a total of 300 nurses working in healthcare facilities across Indonesia. Data were collected via an online survey conducted from March to May 2024, using validated questionnaires: the Indonesian adaptation of the Spirituality and Spiritual Care Rating Scale (SSCRS) and the Nurse Spiritual Care Therapeutic Scale (NSCTS). Spearman Rank Correlation was used to assess the relationship between nurses' perceptions of spirituality and their engagement in spiritual care practices.
Results: The study found that nurses held a positive perception of spirituality, with a mean score of 3.85 (SD = 0.41) regarding statements related to spirituality and spiritual care. However, they reported providing spiritual care only occasionally, with an average frequency of 3-6 times over a 72 to 80-hour work period. There was a significant positive correlation (r = 0.235, p <0.001) of nurses' perception of spirituality and spiritual care with their engagement in spiritual care practices.
Conclusion: The study highlights the need for targeted education and training to enhance nurses' competencies in spiritual care practices. Addressing spiritual needs is vital for holistic patient care, and improving nurses' perceptions and practices in this area can significantly benefit patient well-being.

Keywords

Indonesia; nurses; perceptions; spirituality; spiritual care practices; cross-sectional survey; competencies

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Background

Spirituality involves the understanding of life's purpose, the acknowledgment of self-transcendence, and the establishment of connections with oneself and others. Connections are influenced by religious customs, cultural factors, personal experiences, and the belief in a higher power (Deng & Liu, 2020; Martins et al., 2017; Sinaga et al., 2021). Nurses are responsible for providing holistic care that addresses spiritual needs (International Council of Nurses (ICN), 2021; Maryana & Erwan, 2020; Rachmawati & Aristina, 2022; Tunny et al., 2022). Nurses' perceptions of spirituality and spiritual care significantly affect their attitudes and abilities to deliver spiritual care (Mascio et al., 2022; Rachmawati & Aristina, 2022; Tunny et al., 2022).

The spiritual dimension is crucial for nurses who possess a strong understanding of spirituality and spiritual care, as recognizing the spiritual needs of patients can improve their quality of life and satisfaction with care (Abusafia et al., 2021; Maryana & Erwan, 2020; Rachel et al., 2019; Tunny et al., 2022). Among the diverse holistic care theories, one commonality is that humans are viewed as a complete entity. Consequently, the care provided is not centered on physical illness but on the individual as a whole (Doreen, 2017). Bangcola (2021) posits a theory on spiritual care, asserting that all individuals possess holistic needs, including spiritual needs, which play a significant role in the patient's physical and emotional well-being. Additionally, the International Council of Nursing's code of ethics mandates that nurses cultivate an environment that honors the spirituality, diversity, life values, and human rights of individuals, families, and communities (International Council of Nurses (ICN), 2021).

In Indonesia, nurses prioritize the patient's physical well-being and view the patient's spiritual requirements as the

secondary obligation of the nurse, with primary responsibility falling on religious leaders or the spiritual department (Maryana & Erwan, 2020; Nurhanif et al., 2020; Rachmawati & Aristina, 2022). To date, limited research has explored nurses' perspectives on spirituality, spiritual care, and related practices.

Several studies have been conducted in Indonesia to explore nurses' perceptions of spirituality and spiritual care, but these studies highlight significant gaps in both research and practice. A study by Herlianita et al. (2018) examined the perceptions of spirituality and spiritual care among 256 Muslim nurses, revealing moderately high levels of awareness across two dimensions of spirituality and spiritual care. The study emphasized the urgent need for curriculum development and on-the-job training to improve nurses' competence in spiritual care, particularly in Muslim healthcare settings (Herlianita et al., 2018).

In another study by Sinaga et al. (2021), factors associated with spirituality and spiritual care were examined among 204 clinical nurses in private hospitals in Medan and Bandung. The study identified significant associations between spirituality and factors such as department assignment, educational background, and receiving spiritual care lessons during nurse training. While this research highlighted important correlation between variables, it did not explore the broader impact of these factors across different healthcare settings or patient outcomes, nor did it provide longitudinal data to track how perceptions might evolve over time. Additionally, Rachmawati and Aristina (2022) conducted a qualitative study that explored the experiences of associate degree nursing graduates in Yogyakarta providing spiritual care. The study found that nurses recognized the importance of spiritual care, but there are internal and external factors influenced its delivery. Despite acknowledging the value of spiritual care, many nurses did not consider it a primary duty. This study provided valuable qualitative insights but was limited by its small sample size and focus on a specific group of nurses (Rachmawati & Aristina, 2022).

Although the studies described above provide valuable insights, the gaps remain. Many studies have been confined to specific regions or hospitals, limiting their generalizability to a broader population of nurses in Indonesia. Much of the research has focused primarily on Muslim nurses, which does not fully represent the religious diversity of the country. Moreover, the lack of formal spiritual care training identified in multiple studies indicates a need to explore the competencies required for effective spiritual care delivery. Finally, none of these studies have explored the direct impact of spiritual care on patient well-being or outcomes, leaving a critical gap in understanding the practical benefits of spiritual care in nursing practice.

Our study aimed to address these gaps by examining the correlation between nurses' perceptions of spirituality and spiritual care and their spiritual care practices across a broader range of healthcare settings in Indonesia. Unlike previous studies, our research included nurses from various religious and cultural backgrounds, providing a more inclusive understanding of spiritual care in a diverse healthcare environment.

Methods

Study Design

The study utilized a cross-sectional survey design. The target population included all nurses in Indonesia, totaling 524,508 nurses (Ministry of Health, 2023).

Samples/Participants

The participants in the study were nurses working in clinical settings in Indonesia, specifically community and hospital nurses. The inclusion criteria were as follows: (1) Registered nurse; (2) Aged between 20 and 55 years; (3) Actively employed in a healthcare setting; and 4) Proficient in reading and writing in Indonesian. The sample size was determined using the table of Isaac and Michael (1995), with a significance level of 5%, resulting in a minimum requirement of 348 participants. A total of 379 individuals accessed the provided link and indicated their consent to participate in the survey. However, only 300 respondents completed the questionnaire, meeting all analysis requirements, yielding a response rate of 86.21%.

Instruments

The survey employed three questionnaires. The demographic questionnaire, created by the researchers, aimed to gather general information pertinent to the study, including gender, age, religion, education level, length of employment, workplace setting, working unit, province of employment, and the availability of a Standard Operating Procedure (SOP) for spiritual care.

The second instrument used was the Indonesian version of the Spirituality and Spiritual Care Rating Scale (SSCRS), which assesses nurses' perceptions of spirituality and spiritual care across four domains: spiritual beliefs, views on the provision of spiritual care by nurses, beliefs regarding religion and religious expressions, and beliefs about patient-centered care (McSherry & Jamieson, 2011; Rachel et al., 2019). Developed by McSherry et al. (2002), the SSCRS has demonstrated validity in various studies involving nurses in hospital settings (Kaddourah et al., 2018; Mulyono & Chen, 2019; Tan et al., 2018). The survey consists of 17 statements rated on a 5-point Likert scale, with responses ranging from 1 (strongly disagree) to 5 (strongly agree). Four statements (numbers 5, 6, 13, and 16) were scored inversely. The SSCRS score was calculated by determining the mean score for each item, resulting in a total score ranging from 1 to 5, where an overall mean closer to 5 indicates a strong perception of spirituality and spiritual care (McSherry & Jamieson, 2011; Mulyono & Chen, 2019; Rachel et al., 2019). The original questionnaire was in English, and the original authors granted permission for its use and translation. The SSCRS was translated into Indonesian and validated for reliability, with a Cronbach's Alpha of 0.74 (Mulyono & Chen, 2019).

The third questionnaire, the Nurse Spiritual Care Therapeutic Scale (NSCTS), was developed to measure the spiritual care provided by nurses (Mamier et al., 2019). This questionnaire focuses on spiritual care rather than religious therapies, emphasizing broader themes such as the meaning and significance of life and human self-transcendence (Mamier et al., 2019). It consists of 17 statement questions with response options: 1 = never, 2 = 1-2 times (seldom), 3 =

3-6 times (occasionally), 4 = 7–11 times (often), and 5 = more than 12 times (always), allowing respondents to indicate how often they provided spiritual care over the past 72-80 hours. A high score reflects the consistent provision of spiritual care, while a low score indicates a lack of such care (Mamier et al., 2019; Sulistyanto et al., 2021; Taylor et al., 2023). The NSCTS has been validated and used in various studies related to spiritual care practices (Mamier et al., 2019; Sulistyanto et al., 2021; Taylor et al., 2023). This questionnaire was used with the consent of the original authors, and the NSCTS was translated into Indonesian for the study. The validity and reliability of the Indonesian version have been established, achieving a Cronbach's Alpha coefficient of 0.870 (Sulistyanto et al., 2021).

Data Collection

An electronic flyer was created to provide a brief overview of the study, its objectives, participant characteristics, and a link to the questionnaire. The e-flyer was shared across various social media platforms, including WhatsApp, Instagram, Facebook, and Twitter. Although online surveys have methodological limitations, such as the inability to control the population to which the survey is distributed and the potential for self-selection bias among respondents (Andrade, 2020), measures were taken to mitigate these issues. The first page of the survey was designed to screen participants, ensuring that respondents met the required criteria. The survey was immediately terminated if respondents provided answers that did not align with the necessary characteristics. Participants were provided with detailed research information and informed consent before completing the surveys. If individuals chose not to consent, the survey page was automatically closed. Data were collected from March to May 2024.

Data Analysis

Data analysis was conducted using IBM SPSS™ version 29.0.2.0. Descriptive statistics, specifically frequencies, were used for univariate analysis to describe the demographics of nurses in Indonesia and their perceptions and practices regarding spirituality and spiritual care. Spearman Rank Correlation, a non-parametric test, was used to examine the relationships between variables.

Ethical Considerations

Ethical approval was obtained from the Research Ethics Committee (KEP FON) of the Faculty of Nursing at Universitas Pelita Harapan, under approval number 003/KEP-FON/I/2024. Informed consent was obtained from all participants prior to data collection. All participants were assured that their data would be kept confidential and used solely for research purposes.

Results

Table 1 shows that the majority of participants in this study were female, comprising 78% of the total. Among the respondents, 110 individuals, or 36.76%, fell within the age range of 26 to 30 years. The survey indicated that most participants, specifically 68.7%, identified as Christians. Additionally, 73.3% of the respondents were from the Central region of Indonesia, and 88% were employed in hospitals, primarily in inpatient units (31.7%). It is noted that 80% of the healthcare facilities where the respondents work already have Standard Operating Procedures (SOPs) in place for spiritual care activities. The findings also revealed that the majority of participants had fewer than five years of work experience. In terms of educational background, most respondents held an associate degree in nursing (47.3%) or a bachelor's degree in nursing with a registered nurse (RN) status (40.7%).

Table 1 Demographic characteristics of the participants (*N* = 300)

Demographic Characteristics	*n*	%
Gender		
Male	63	21.0
Female	234	78.0
Prefer not to say	3	1.0
Age		
20-25	27	9.00
26-30	110	36.67
31-35	81	27.00
36-40	56	18.67
41-45	12	4.00
46-50	14	4.67
Religion		
Christian	206	68.7
Catholic	26	8.7
Moslem	64	21.3
Hinduism	4	1.3
Level of Education		
Associate Degree	142	47.3
Bachelor's degree	33	11.0
Bachelor's degree + RN	122	40.7
Master's degree	3	1.0
Work Experience		
≤5 years	127	42.33
6-10 years	80	26.67
11-15 years	49	16.33
16-20 years	31	10.33
≥21 years	13	4.33
Health Facilities		
Hospital	264	88.0
Community Health Center	25	8.3
Clinic	11	3.7
Work Unit		
Inpatient Care	95	31.7
Emergency Department	63	21.0
Outpatient	34	11.3
Intensive Care (ICU/NICU/PICU)	41	13.7
Operating room	23	7.7
Hemodialysis Unit	12	4.0
Others	32	10.7
Workplace (Region)9+		
Western Indonesia	73	24.3
Central Indonesia	220	73.3
Eastern Indonesia	7	2.4
Standard Operational Procedure (SOP) for Spiritual Care Provision at Workplace		
Yes	240	80.0
No	60	20.0

The data presented in **Table 2** indicates that the highest mean score was associated with the statement that nurses can provide spiritual care by demonstrating kindness, concern, and hospitality in their caregiving (Mean = 4.42, SD = 0.79). Additionally, nurses can offer spiritual care by respecting

patients' privacy, dignity, religiosity, and cultural beliefs (Mean = 4.29, SD = 0.65). Conversely, the lowest average score was linked to the belief that spirituality does not apply to individuals who identify as atheists or agnostics (Mean = 2.96; SD = 1.07). Overall, the mean score for nurses' perceptions of spirituality and spiritual care was 3.85 (on a scale of 1 to 5), indicating that the respondents generally agreed with statements regarding spirituality and spiritual care.

Table 2 Description of Spirituality and Spiritual Care Rating Scale (SSCRS) (*N* = 300)

Statements	Mean	SD
I believe nurses can provide spiritual care by arranging a visit by the patient's own religious leader if requested.	4.18	0.78
I believe nurses can provide spiritual care by showing kindness, concern, and hospitality while providing care.	4.42	0.79
I believe that spirituality is related to the need to forgive and to be forgiven.	4.10	0.83
I believe spirituality only involves going to a mosque/church/worship place.	3.62	1.05
I believe spirituality has nothing to do with belief or faith in God.	3.79	1.11
I believe spirituality is about finding the meaning of good and bad things in life.	3.76	0.87
I believe that nurses can provide spiritual care by spending time with patients and giving support and reassurance when needed.	3.69	0.94
I believe nurses can provide spiritual care by helping patients find the meaning and purpose of their illness.	3.89	0.74
I believe that spirituality is about having hope in life	4.15	0.71
I believe that spirituality has to do with how one lives in the present moment.	4.07	0.70
I believe nurses can provide spiritual care by listening and being available for patients who want to convey and acknowledge their fears, anxieties, and difficulties.	4.11	0.69
I believe that spirituality is a uniting factor that enables one to be at peace with both the world and oneself.	4.11	0.69
I believe spirituality is not related to art, creativity, and self-expression.	2.97	0.99
I believe nurses can provide spiritual care by respecting patient's privacy, dignity, religiosity, and cultural beliefs.	4.29	0.65
I believe that spirituality does not apply to an atheist or agnostic.	2.96	1.07
I believe spirituality is related to personal friendships and relationships.	3.87	0.78
I believe spirituality includes people's morals.	4.13	0.67
Overall Mean	3.85	0.41

Table 3 Description of Nursing Spiritual Care Therapeutic Scale (*N* = 300)

Statements	Mean	SD
Ask the patient how you could help them with spiritual or religious practices.	2.71	1.24
Help the patient to have a quiet place or time.	3.14	1.23
Actively listen to the patient's story of illness.	3.65	1.23
Assess the patient's spirituality or religious beliefs and practices relevant to health.	3.12	1.36
Listen to patients talk about anything related to spiritual aspects	3.08	1.25
Encourage the patient to discuss how illness impacts his relationship with God or their creator.	2.87	1.29
Encourage the patient to talk about their spiritual coping.	2.94	1.27
Document the spiritual care that you provided in a nursing note.	2.67	1.40
Discuss a patient's spiritual care needs with colleagues (e.g., shift report).	2.90	1.35
Arrange for clergy to visit the patient.	2.55	1.38
Arrange for a religious leader (Cleric/Priest) to visit the patient.	2.45	1.39
Encourage patients to talk about what it means to live in distress (due to illness).	2.69	1.30
Encourage a patient to talk about the spiritual challenges of living with illness (which is experienced).	2.66	1.31
Offer the patient to pray.	3.35	1.32
Offer the patient to read spiritually nourishing text (e.g., the patient's holy scripture).	2.65	1.41
Inform the patient about spiritual resources.	2.66	1.32
Once a task is completed, stay on to show caring to the patient.	3.07	1.38
Overall Mean	2.89	1.06

Table 3 presents an overall mean score of 2.89 (on a scale of 1 to 5), indicating that nurses in this study engaged in spiritual practices occasionally, or 3 to 6 times over a 72-80 hour period of care. The average score for the statement regarding nurses actively listening to patients' illness stories was 3.65, suggesting that nurses frequently practiced active listening while providing spiritual care. In contrast, the statement concerning plans to invite a religious leader (such as a Cleric or Priest) to visit patients received the lowest average rating of 2.45, indicating that nurses rarely make arrangements for such visits.

Table 4 indicates that the majority of participants, who are female, have a poor perception of spirituality and spiritual care. Additionally, the study revealed that spiritual care was infrequently practiced regardless of the participants' demographic characteristics, occurring only 1 to 2 times in the past 72 hours.

Table 5 shows that there was a significant relationship between nurses' perceptions of spirituality, spiritual care, and the practice of spiritual care (p <0.001). The correlation coefficient was 0.235, indicating a low correlation between the two variables. A weak positive correlation was identified among these variables.

Table 4 Demographic Characteristics, Spirituality and Spiritual Care Perception, and Spiritual Care Practices (*N* = 300)

Demographic Characteristics		NSCTS*										SSCRS**			
		Never		Seldom (1-2 times)		Occasionally (3-6 times)		Often (7-11 times)		Always (>12 times)		Poor Perception		Strong Perception	
		n	%	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%
Gender	Male	15	5.00	19	6.33	11	3.67	15	5.00	3	1.00	31	10.33	32	10.67
	Female	44	14.68	90	30.00	61	20.33	29	9.67	10	3.33	132	44.00	102	34.00
	Prefer not to say	1	0.33	1	0.33	0	0.00	0	0.00	1	0.33	3	1.00	0	0.00
Age (years)	≤25	4	1.33	10	3.33	5	1.67	8	2.67	0	0.00	13	4.33	14	4.67
	26-30	21	7.00	33	11.00	28	9.33	19	6.33	9	3.00	62	20.67	48	16.00
	31-35	15	5.00	31	10.33	23	7.67	10	3.33	2	0.67	48	16.00	33	11.00
	36-40	14	4.67	22	7.33	12	4.00	6	2.00	2	0.67	27	9.00	29	9.67
	41-45	1	0.33	7	2.33	2	0.67	1	0.33	1	0.33	8	2.67	4	1.33
	≥46	5	1.67	7	2.33	2	0.67	0	0.00	0	0.00	8	2.67	6	2.00
Religion	Christian	39	13.00	79	26.33	48	16.00	29	9.67	11	3.67	107	35.67	99	33.00
	Catholic	5	1.67	5	1.67	5	1.67	11	3.67	0	0.00	13	4.33	13	4.33
	Moslem	13	4.33	25	8.33	19	6.33	4	1.33	3	1.00	43	14.33	21	7.00
	Hinduism	3	1.00	1	0.33	0	0.00	0	0.00	0	0.00	3	1.00	1	0.33
Level of Education	Associate Degree	23	7.67	49	16.33	36	12.00	25	8.33	9	3.00	80	26.67	62	20.67
	Bachelor's Degree	10	3.33	9	3.00	8	2.67	3	1.00	3	1.00	21	7.00	12	4.00
	Bachelor's Degree + RN	26	8.67	50	16.67	28	9.33	16	5.33	2	0.67	64	21.33	58	19.33
	Master's Degree	1	0.33	2	0.67	0	0.00	0	0.00	0	0.00	1	0.33	2	0.67
Work Experience	≤ 5 years	24	8.00	48	16.00	23	7.67	23	7.67	9	3.00	69	23.00	58	19.33
	6-10 years	19	6.33	20	6.67	28	9.33	12	4.00	1	0.33	49	16.33	31	10.33
	11-15 years	7	2.33	21	7.00	13	4.33	6	2.00	2	0.67	28	9.33	21	7.00
	16-20 years	6	2.00	16	5.33	5	1.67	3	1.00	1	0.33	12	4.00	19	6.33
	≥ 21 years	4	1.33	5	1.67	3	1.00	0	0.00	1	0.33	8	2.67	5	1.67
Health Facilities	Hospital	46	15.33	95	31.67	66	22.00	43	14.33	14	4.67	146	48.67	118	39.33
	Community Health Center	8	2.67	10	3.33	6	2.00	1	0.33	0	0.00	11	3.67	14	4.67
	Clinic	6	2.00	5	1.67	0	0.00	0	0.00	0	0.00	9	3.00	2	0.67
Work Unit	Inpatient Care	15	5.00	37	12.33	29	9.67	11	3.67	3	1.00	52	17.33	43	14.33
	Emergency Department	10	3.33	23	7.67	12	4.00	14	4.67	4	1.33	32	10.67	31	10.33
	Outpatient	10	3.33	14	4.67	7	2.33	2	0.67	1	0.33	16	5.33	18	6.00
	Intensive Care (ICU/NICU/PICU)	8	2.67	13	4.33	11	3.67	8	2.67	1	0.33	24	8.00	17	5.67
	Operating Room	8	2.67	5	1.67	5	1.67	2	0.67	3	1.00	14	4.67	9	3.00
	Hemodialysis Unit	3	1.00	5	1.67	1	0.33	3	1.00	0	0.00	7	2.33	5	1.67
	Others	6	2.00	13	4.33	7	2.33	4	1.33	2	0.67	21	7.00	11	3.67
SOP*** for Spiritual Care Provision at the workplace	Yes	39	13.00	86	28.67	58	19.33	43	14.33	14	4.67	129	43.00	111	37.00
	No	21	7.00	24	8.00	14	4.67	1	0.33	0	0.00	37	12.33	23	7.67

Notes. *NSCTS = Nurses Spiritual Care Therapeutic Scale
**SSCRS = Spirituality and Spiritual Care Rating Scale
***Standard Operational Procedure

Table 5 Correlation between Nurses' Perceptions of Spirituality and Spiritual Care and Spiritual Care Practice (Spearman Correlation)

		Nurses' Perceptions of Spirituality and Spiritual Care	Spiritual Care Practice
Nurses' Perceptions of Spirituality and Spiritual Care	Correlation Coefficient	1.000	0.235**
	Sig. (2-tailed)		<0.001
	N	300	300
Spiritual Care Practice	Correlation Coefficient	0.235**	1.000
	Sig. (2-tailed)	<0.001	
	N	300	300

Discussion

This study revealed a significant correlation between nurses' perceptions of spirituality and spiritual care with their practices in spiritual care, indicating that as nurses' perceptions of spirituality improve, their practice of spiritual care also tends to increase. However, the relationship between these two variables was low, suggesting that additional factors contribute to fulfilling patients' spiritual needs. Factors such as trust, nurses' competence in providing spiritual care, patient and family involvement, work environment, education, clinical experience, and available resources also play a crucial role in spiritual care practices (Bangcola, 2021; Herlianita et al., 2018; Mascio et al., 2022; Nissen et al., 2021; Sinaga et al., 2021; Veloza-Gómez et al., 2017).

The findings align with previous research conducted in Indonesia, which indicated a significant relationship between nurses' perceptions and their provision of spiritual care (Mardiani, 2017). This study found that nurses with a negative view of spirituality were three times more likely to provide insufficient spiritual care compared to their counterparts with a positive perception. Similar results were noted in a study involving 271 nurses at a public hospital in Malaysia, where a substantial number of nurses expressed a positive view of spirituality and demonstrated competence in providing spiritual care (Abusafia et al., 2021).

Interestingly, while nurses generally reported a positive perception of spirituality, the frequency of spiritual care practices was limited, as evidenced by their responses indicating they provided spiritual care only 3 to 6 times during a 72 to 80-hour work period. This observation is consistent with findings from a study conducted in Singapore, which suggested that although nurses held positive perceptions of spirituality and spiritual care, this understanding was not consistently applied in their daily nursing practices (Chew et al., 2016).

Several factors contribute to the limitations in spiritual care practices. One critical aspect is how nurses understand their responsibilities in delivering spiritual care. A qualitative study in an Indonesian hospital revealed that nurses recognized their role in addressing spiritual needs but did not view spiritual care as solely their responsibility (Nurhanif et al., 2020). This aligns with findings from multiple studies indicating that nurses often prioritize physical needs and perceive patients' spiritual needs as the responsibility of religious leaders or spiritual departments (Maryana & Erwan, 2020; Rachmawati & Aristina, 2022).

Moreover, the study highlighted that while nurses possessed a positive perception of spirituality, they struggled with the application of this understanding, particularly regarding patients who identify as agnostic or atheist. The mean score of 2.96 (SD = 1.07) indicates that nurses felt spirituality was less relevant for these patients, showcasing a potential misunderstanding of the broader concept of spirituality. Previous research has shown that nurses often equate spirituality solely with religious practices, concluding that spirituality does not apply to individuals with different belief systems (Adeyemo et al., 2022). Additionally, the frequent confusion between spirituality and religion among nurses has been noted, as they tend to provide spiritual care based on the patient's religious beliefs rather than a more inclusive understanding of spirituality (Chew et al., 2016; Maryana & Erwan, 2020).

Defining spirituality as a dynamic aspect of human existence connected to life experiences, the search for meaning, and self-transcendence underscores that it is a universal concept applicable to all individuals, including atheists and agnostics (Kang, 2018; Rachel et al., 2019). To demonstrate a comprehensive understanding of spirituality, nurses must challenge rigid interpretations that limit their application to religious contexts (McSherry & Jamieson, 2013).

The study also found that the most frequently spiritual care practices included providing care with kindness, compassion, and hospitality (Mean = 4.42, SD = 0.79) and actively listening to patients' stories of illness (Mean = 3.65, SD = 1.23). These findings indicate that nurses recognize the principles and qualities essential for delivering spiritual care. Additionally, the presence and friendliness of nurses toward patients have been positively correlated with spiritual care practices, as shown in qualitative research conducted in Taiwan (Tao et al., 2020).

Nurses' perceptions are crucial in shaping spiritual care practices (Doreen, 2017; Mascio et al., 2022; Tunny et al., 2022). Nurses with positive perceptions are more likely to effectively implement spiritual care practices (McSherry & Jamieson, 2013). Nonetheless, the implementation of these practices is influenced by various factors, including the necessity for nurses to possess the required knowledge and skills to administer spiritual care (Bangcola, 2021; Mascio et al., 2022; Nissen et al., 2021; Veloza-Gómez et al., 2017). Therefore, it is essential to provide targeted training and education on spirituality and spiritual care to enhance nurses' understanding and proficiency in delivering care that aligns with the specific needs of patients and their families (Melhem et al., 2016; Tao et al., 2020). Addressing spiritual needs through effective spiritual care practices is vital for improving patients' overall well-being (Bangcola, 2021; Doreen, 2017).

Implications for Nursing Practice

The findings of this study underscore the necessity for nursing practice to incorporate a more comprehensive understanding of spirituality in patient care. Nurses should be encouraged to recognize the importance of spirituality as a universal aspect of human existence that extends beyond religious affiliations. This understanding can enhance their ability to address the spiritual needs of all patients, including those who identify as agnostic or atheist. By fostering an inclusive approach to spirituality, nurses can create a more supportive environment for their patients, ultimately improving the quality of care. Additionally, the study highlights the need for targeted education and training programs focused on spirituality and spiritual care. Such programs should equip nurses with the knowledge and skills to deliver effective spiritual care. This could involve workshops, seminars, or continuing education courses that address both the theoretical and practical aspects of spiritual care. Furthermore, integrating spiritual care training into nursing curricula could better prepare future nurses to recognize and respond to the spiritual dimensions of patient care.

Moreover, nursing leadership should prioritize the establishment of supportive work environments that facilitate the practice of spiritual care. This includes developing policies and protocols that encourage collaboration among healthcare

professionals, including spiritual leaders and counselors, to address patients' spiritual needs comprehensively. Providing access to resources and support systems can empower nurses to implement spiritual care practices more confidently and effectively.

Finally, the study's findings indicate that nurses' perceptions of spirituality significantly influence their practice of spiritual care. Therefore, it is crucial for nursing organizations to promote a culture that values and respects the spiritual dimension of care. This could involve initiatives to raise awareness among nursing staff about the significance of spirituality in health and well-being, encouraging discussions around spiritual care and providing opportunities for self-reflection on their beliefs and biases. By addressing these factors, nursing practice can evolve to better meet patients' holistic needs, improving patient outcomes and satisfaction.

Strengths and Limitations

This research was constrained by restrictions in the data gathering methodology, specifically the use of online surveys. Despite the ease of distributing an online survey, two drawbacks associated with its use were that the population might not be well distributed and that there was a significant probability of bias (Andrade, 2020). Nevertheless, the findings of this study can be generalized, as the respondents were drawn from 32 of Indonesia's 38 provinces.

Conclusion

This study revealed a significant relationship between nurses' perceptions of spirituality and spiritual care with their implementation of spiritual care practices in Indonesia. Indonesian nurses had a positive perspective and agreement on statements concerning spirituality and spiritual care. However, the findings indicated that additional factors also played a role in shaping spiritual practices. While nurses provided spiritual care on a limited number of occasions during their clinical work, this frequency suggests that such care was delivered only occasionally. Enhancing nurses' understanding of spirituality can improve their care practices. Meeting patients' spiritual needs can lead to better outcomes and a more compassionate healthcare experience in Indonesia. Further research is needed to explore the multifaceted dimensions of spirituality in nursing and its impact on patient care and nurse well-being.

Declaration of Conflicting Interest

The authors declare no conflict of interest.

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Authors' Contributions

All four authors collaborated on developing the idea or topic, the background section, the research framework, the literature review, and the manuscript writing. Afiska Elsa Baguna, Cynthia Yohana Magdasutry Pandeirot, and Juniarta contributed to data collection and analysis, while the discussion section involved all authors. Juniarta and Novita Susilawati Barus primarily managed the publication process. All authors approved the final version of the article.

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Data Availability

The dataset generated during and analyzed during the current study is available from the corresponding author upon reasonable request.

Declaration of Use of AI in Scientific Writing

There is nothing to declare.

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