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A comparative study of nurses' competencies in integrating religion/spirituality into patient care

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Abstract

Background There is a need of research to evaluate and compare the competencies of nurses in integrating patients' religion and spirituality into nursing practice in various settings, including general and psychiatric hospitals. By understanding the competencies of nurses working in different environments, tailored spiritual care training programs can be developed to meet their specific needs. This study aimed to evaluate and compare the competencies of nurses in integrating patients' religion/spirituality into nursing practice in both a general and a psychiatric hospital.

Methods This cross-sectional descriptive-analytical study was conducted in two hospitals affiliated with Kerman University of Medical Sciences in southeastern Iran. Quota sampling was used to select 200 nurses (100 nurses from each hospital) in 2023. The Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS) was used to evaluate and compare nurses' competencies in integrating the religion/spirituality of patients into their nursing practice.

Results The study revealed that nurses' competencies in integrating patients' religion/spirituality into nursing practice were moderate in both general (122.39 ± 19.40) and psychiatric hospitals (110.82 ± 25.63). Nurses in the general hospital had significantly higher competency scores compared to those in the psychiatric hospital ($t = 3.59$, $p = 0.001$). The type of hospital, work experience, and the involvement of professionals in providing religion/spirituality care were significant predictors of nurses' competencies in integrating patients' religion/spirituality into clinical practice.

Conclusions The moderate levels of competencies among nurses highlight the need for further education and training to effectively integrate patients' religion/spirituality into nursing across various healthcare settings. The type of hospital also influenced their competencies. Therefore, it is crucial for nurses, particularly those working in psychiatric hospitals, to receive training that is tailored to the specific needs, culture, and context of their respective healthcare environments. It is essential to conduct a baseline assessment of nurses' readiness and competencies before implementing appropriate training programs.

Keywords Spiritual care, Religion, Spirituality, Mental health settings, Spiritual care competence, General hospital

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Introduction

In contemporary evidence-based nursing, there is a growing emphasis on spiritual care and integration of patients' religion/spirituality into nursing practice [1]. This integration involves various nursing activities such as considering patients' religious/spiritual beliefs, utilizing standardized assessment tools, identifying their religious/spiritual needs and conflicts, understanding their coping strategies, introducing them to relevant resources, discussing topics like gratitude, forgiveness, presence, mindfulness, hope, and helping patients find meaning and purpose in their lives [2].

Religion and spirituality are widely recognized as important coping strategies and valuable resources that help individuals find meaning and strength in difficult situations [3]. These beliefs also play a significant role in health-related decision-making, patients' perception of health, and their ability to cope with illnesses [4]. Patients prefer healthcare providers to consider and integrate their religious/spiritual beliefs into their care, as well as discuss how these beliefs influence the recovery process [2]. Spiritual care and integration of religion/spirituality of patients into nursing practice are essential components of holistic nursing care, involving the evaluation and personalized planning of an individual's religious/spiritual needs [5].

Nurses should be trained to assess and address the religious and spiritual needs of their patients, respect their beliefs, and provide appropriate support and resources. By integrating these aspects into their practice, nurses can promote holistic care and improve patient outcomes [5]. Numerous studies have demonstrated that integrating patients' religion/spirituality into nursing practice leads to positive outcomes for both patients with physical [6–8] and mental illnesses [9–11]. However, nurses find it challenging to integrate spiritual care into their nursing practice, as they tend to prioritize physical care [12–15]. Barriers to integrating religion/spirituality into nursing practice include limited privacy, time constraints, inadequate training, and concerns about patient discomfort or false beliefs [16]. These barriers are present in both general and psychiatric settings [17]. Nurses in psychiatric settings face unique challenges due to the symptoms of psychiatric disorders such as delusions and anxiety. The lack of consensus about spiritual care in these settings can lead to ethical dilemmas for nurses. They may find it difficult to balance the principles of beneficence (believing that spiritual care can provide comfort) and non-maleficence (believing that religious/spiritual discussions could exacerbate spiritual/religious symptoms) [18].

Furthermore, the competencies and skills required of nurses in psychiatric hospitals differ significantly from those in general hospitals. Nurses' competencies in psychiatric settings may be influenced by occupational and environmental factors [19]. Working in psychiatric hospitals can be stressful for nurses due to various factors such as challenging interactions with multidisciplinary teams, navigating legal frameworks, dealing with impulsiveness and hostility, managing non-voluntary admissions, staying in hospital longer, diagnosing psychosis, difficulty distinguishing drug abuse from other disorders, and addressing the risks of suicide and aggression. Additionally, organizational conditions such as high workload, inadequate staffing levels, inappropriate referrals, role conflicts, lack of supervision, and unsupportive management further contribute to the challenging work environment for psychiatric nurses [20].

The literature review indicates that nurses often lack the necessary competency to integrate the religion/spirituality of patients into their clinical practice and provide spiritual care for patients with physical and mental disorders [21–23]. Iranian researchers have also reported a lack of professional competency among nurses in providing religious/spiritual care [24–26]. Various studies have identified factors such as demographic and professional characteristics of nurses, work-related factors, years of experience, and the hospital's spiritual climate as influencing their competencies in integrating patients' religion/spirituality into practice and delivering spiritual care interventions [27–29]. Moreover, research by Pirkola et al. [30] demonstrated that a higher spiritual condition in healthcare settings led to increased work productivity and performance compared to a lower spiritual climate. Therefore, the spiritual conditions of nurses play a critical role in effectively incorporating the religion/spirituality of patients into their practice [30].

Limited efforts have been made by researchers to assess and compare nurses' competencies in incorporating clients' religion/spirituality into practice across different cultures and settings. To ensure the successful integration of patients' religion/spirituality into nursing practice, it is essential to evaluate nurses' competencies in this area. This study evaluated and compared the competencies of nurses in integrating clients' religion/spirituality into nursing practice, specifically in general and psychiatric hospitals.

Methods

Study design and settings

This descriptive-analytical cross-sectional study was conducted in two hospitals affiliated with Kerman University of Medical Sciences in southeastern Iran: Afzalipour General Hospital and Shahid Beheshti Psychiatric Hospital. Kerman University of Medical Sciences is the largest medical university in southeastern Iran, with three large general hospitals and a psychiatric hospital. These hospitals have more than 1500 beds and serve patients from southeastern Iran. Afzalipour Hospital is known for its

size and advanced facilities, while Shahid Beheshti is the only specialized psychiatric hospital in Kerman province and southeastern Iran.

Population and sampling

The study included 740 nurses from a general hospital (620 nurses) and a psychiatric hospital (120 nurses). The sample size was calculated according to a pervious study [24] and the Cochran formula ($\alpha = 0.05$, $d = 0.06$, $Z = 1.94$), resulting in a target sample size of 200 nurses to account for potential dropout rates. Quota sampling was used to select an equal number of nurses (100 from each hospital). Inclusion criteria required nurses to have a bachelor's degree or higher, at least six months of work experience in the hospitals, and willingness to participate in the study. Participants who did not complete questionnaires and experienced major stressors were excluded from the study.

Study tool

The study utilized a two-part tool for data collection:

1. **Sociodemographic information form:** This form consisted of various items, including age, gender, employment history, position, education level, history of attending training courses related to religious/spiritual care (yes, no), and utilization of professionals for providing spiritual/religious care (yes, no). Nurses were also asked about their level of religiosity and spirituality using Likert-scale responses ranging from high to not at all.
2. **Religious/Spiritual Integrated Practice Assessment Scale (RSIPAS):** The RSIPAS was developed and validated by Oxhandler et al. [1] in the United States. It consists of 40 items divided into four subscales: self-efficacy in integrating clients' religion/spirituality into practice (13 items), attitudes towards integrating clients' religion/spirituality into practice (12 items), perceived feasibility of engaging in religion/spirituality integrated practice (6 items), and behaviors associated with integrating clients' religion/spirituality into practice (nine items). The items were rated on a 5-point Likert scale, ranging from strongly disagree (1) to strongly agree (5). Nine behavior-related items were rated on a scale from never (1) to always (5). The scoring for specific items was reversed. The minimum possible score on this scale was 40, while the maximum score was 200 [1]. To facilitate comparison, scores of 40–93 were considered as low competence, 94–146 as moderate competence, and above 146 as desirable competence.

The RSIPAS was validated by its designers through content validity, construct validity, discriminant validity, and factorial validity. Content validity was determined by consulting multiple experts. The scale's reliability was evaluated using internal consistency, with Cronbach's alpha coefficients of 0.84–0.91 for the domains and 0.95 for the overall scale [1]. In Iran, researchers developed the Persian version of the RSIPAS. Content validity was confirmed qualitatively by ten nursing faculty members. The scale's reliability was assessed using internal consistency, with Cronbach's alpha coefficients of 88.8, 80.9, 76.1, 90.7, and 91.2 for the self-efficacy, attitude, feasibility, related behavior, and overall scale, respectively [24].

Data collection procedure

Data collection took place between April and May 2023 using self-administered, face-to-face response forms to ensure anonymity. Nurses received information about the study's objectives and instructions on form completion before filling them out. It took approximately 18 min to complete the forms. To maximize the response rate, researchers spent significant time collecting data and set a specific date for the delivery of completed forms. All forms were kept anonymous and confidential.

Data analysis

The data were analyzed using SPSS21. Descriptive statistics such as frequency, percentage, mean, and standard deviation were utilized to summarize the data. The Kolmogorov-Smirnov test was used to assess the data normality. Chi square or Fisher's exact test was employed to detect differences in sociodemographic information between nurses in general and psychiatric hospitals. An independent samples t-test was conducted to compare RSIPAS scores based on type of hospital. Additionally, the independent t-test and one-way analysis of variance (ANOVA) were used to compare the RSIPAS score by nurses' sociodemographic information. Multivariate linear regression was used to determine whether demographic variables of the nurses could predict changes in the RSIPAS score. The significance level was considered ≤ 0.05.

Results

Sociodemographic information

All nurses completed forms, resulting in a 100% response rate. The majority of nurses in both the general and psychiatric hospitals were female (88% vs. 82%), aged between 30 and 40 years (61% vs. 46%), held a bachelor's degree (93% vs. 87%), worked as clinical nurses (93% vs. 84%), and had 10–20 years of work experience (49% vs. 57%). Most of them identified themselves as moderately religious (71% vs. 67%) and spiritual (65% vs. 71%). It is worth noting that a significant proportion of nurses (70% vs. 745) did not participate in any religion/spirituality

Table 1 Comparison of the sociodemographic information between nurses in general and psychiatric hospitals

Type of hospital		General hospital		Psychiatric hospital		Statistic test	*P*-value
Variables	**Category**	***n***	**%**	***n***	**%**		
Age groups	< 30	13	13	21	21	4.81*	0.09
	30–40	61	61	46	46		
	> 40	26	26	33	33		
Gender	Male	12	12	18	18	1.41**	0.23
	Female	88	88	82	82		
Level of education	Bachelor's	93	93	87	87	2**	0.15
	Master's	7	7	13	13		
Work position	Nurse	93	93	84	84	4.73**	0.19
	Head nurse	3	3	8	8		
	Supervisor	2	2	6	6		
	Other	2	2	2	2		
Work experience (years)	<10	40	40	36	36	1.7*	0. 42
	10–20	49	49	57	57		
	> 20	11	11	7	7		
Degree of religiosity	High	8	8	14	14	6.75**	0.08
	Moderately	71	71	67	67		
	Slightly	14	14	18	18		
	Not at all	7	7	1	1		
Degree of spirituality	High	13	13	12	12	0.09*	0.95
	Moderately	65	65	71	71		
	Slightly	19	19	17	17		
	Not at all	3	3	0	0		
History of training in religious/spiritual care	Yes	30	30	26	26	0.39	0.52
	No	70	70	74	74		
Involvement of professionals in religious/spiritual care	Yes	10	10	15	15	1.14	0.28
	No	90	90	85	85		

*Chi-square test

**Fisher's exact test

Table 2 Comparison of the competencies in integrating patients' religion/spirituality into nursing practice (RSIPAS) based on type of hospital

Variables	General hospital	Psychiatric hospital		
	M ± SD	**M ± SD**	**Independent t-test**	***P*-value**
Self-efficacy	42.58 ± 8.44	34.43 ± 11.2	5.8	**0.001***
Attitudes	40.29 ± 8	36.05 ± 9.52	3.4	**0.001***
Feasibility	16.24 ± 3	17.09 ± 1.88	−2.39	**0.02***
Behaviors	23.28 ± 7.02	23.25 ± 7.16	0.03	0. 19
Total of RSIPAS	122.39 ± 19.4	110.82 ± 25.63	3.59	**0.001***

*Significant at level of ≤ 0.05

care training and did not rely on specialists to provide spiritual/religious care (90% vs. 85%) (Table 1).

Descriptive and comparative results

The competencies of nurses in integrating patients' religion/spirituality into nursing practice were found to be moderate in both the general hospital (122.39 ± 19.40) and the psychiatric hospital (110.82 ± 25.63). However, the competency score of nurses in the general hospital was significantly higher than that of nurses in the psychiatric hospital ($p = 0.001$), (Table 2).

The results indicated a significant difference in nurses' competencies in integrating religion/spirituality based on factors such as age, work experience, degree of religiosity and spirituality, and the utilization of professionals for providing religious/spiritual care ($p < 0.05$), (Table 3).

Multiple regression analyses

Forward regression showed that the type of hospital, work experience, and the involvement of professionals in providing religious/spiritual care were

Table 3 Comparison of the competencies in integrating patients' religion/spirituality into nursing practice according to the sociodemographic information of the nurses *n* = 200

Variables	Groups	M	SD	Statistic test	*P*-value
Age groups	20–30	108.38	28.84	F = 3.41	**0.03***
	31–40	116.57	21.05		
	> 40	121.38	23.08		
Gender	Male	111.33	25	t=−1.04	0.18
	Female	117.53	23.06		
Level of education	Bachelor's	116.02	23.84	t=−1.04	0.29
	Master's	121.8	18.7		
Work position	Nurse	116.53	24.43	F = 0.08	0.97
	Head nurse and	114.9	17.12		
	Supervisor	118.37	10.47		
	Other	121	6.37		
work experience (years)	<10	111.73	25.02	F = 3.363	**0.02***
	11–20	118.43	21.46		
	> 20	126.38	24		
Degree of religiosity	High	119.4	17.45	F = 3.16	**0.02***
	Moderately	118.64	22.6		
	Slightly	109.27	27.91		
	Not at all	88.66	14.5		
Degree of spirituality	High	122	18.02	F = 3.17	**0.02***
	Moderately	118.57	22.79		
	Slightly	107.37	27.2		
	Not at all	104.62	20.74		
History of training in religion/ spirituality care	Yes	118.27	23.29	t = 1.62	0.10
	No	112.32	23.36		
Involvement of professionals in religious/ spiritual care	Yes	127.84	18.75	t = 2.6	**0.01***
	No	115	23.6		

F One-way analysis of variance, and *t* Independent t-test

*Significant level of ≤ 0.05

Table 4 Multiple regression analysis for factors influencing nurses' competencies in integrating patients' religion/spirituality into practice (*n* = 200)

Variables	B	SE β	Beta	T	*p*	95% CI	
						Lower	Upper
Type of hospital	−12.49	3.13	−0.26	−3.98	**0.001***	−18.66	−6.31
Age groups	−0.46	0.42	−0.12	−1.08	0.28	−1.3	0.37
work experience	1.18	0.46	0.3	2.54	**0.01***	0.26	2.09
Degree of religiosity	−4.96	3.64	−0.13	−1.36	0.17	−12.15	2.22
Degree of spirituality	−1.92	3.88	−0.04	−0.49	0.62	−9.59	5.74
Involvement of professionals in providing religious/ spiritual care	−12.62	4.71	−0.17	−2.67	**0.008***	−21.92	−3.32

The nurses' competency in integrating clients' religion/spirituality into nursing practice was the dependent variable

β is the unstandardized coefficient; SE-b is the standard error. Beta is the standardized coefficient. R 2 = 0.20; Adjusted R2 = 0.16

*$p < 0.05$

significant predictors of nurses' competencies in integrating patients' religion/spirituality into nursing practice (R2 = 0.20; Adjusted R 2 = 0.16). Competency scores were higher in nurses who worked in the general hospital, had a longer employment history, and engaged professionals in providing religious/spiritual care (Table 4).

Discussion

This study aimed to evaluate and compare the competency of nurses in integrating patients' religion/spirituality into nursing practice in both general and psychiatric hospitals. The results revealed that nurses in both hospitals demonstrated moderate competency scores, with nurses in the general hospital scoring higher than nurses do in the psychiatric hospital.

The results of several studies were consistent with our findings, indicating that both general and psychiatric nurses generally demonstrated moderate competency in providing spiritual care [1, 20, 31–36]. Previous studies have shown varying levels of competency among nurses in providing spiritual care, with some reporting low competency among psychiatric nurses [26, 37–39] and mental health counselors [40], while others reporting high competency among nurses in general [24, 41, 42] and psychiatric hospitals [43]. Studies in Muslim countries, such as Saudi Arabia, Jordan, Iran, and Malaysia, have shown a positive perception of spiritual care and a favorable spiritual climate among nurses in different hospitals [27, 44–47].

The study results indicated that the type of hospital significantly influenced nurses' competencies in integrating patients' religion/spirituality into nursing practice. Nurses in the general hospitals exhibited higher competency scores compared to those in psychiatric hospitals. Previous studies have also shown significant differences in nurses' perspectives on spirituality and spiritual nursing care based on the type of hospital they work in [48, 49]. Some studies have reported similar findings to our study, while others have found that psychiatric nurses have a more favorable perspective on spirituality and higher competency in spiritual care compared to nurses in non-psychiatric hospitals [43, 50, 51].

Researchers have suggested that the observed differences in workplace spirituality among nurses may be influenced by their sociodemographic characteristics and diverse aspects of spirituality such as higher power, morality, faith, values, love, and relationships, which make each individual unique [52]. Additionally, differences in leadership styles and organizational cultures in various hospitals can influence the perception of workplace spirituality. Exploring these variations can enhance spiritual care among nurses and provide valuable insights into the nursing field for educational interventions and future studies [27, 30, 53].

Our study found that nurses with a longer work experience showed better competencies in integrating patients' religion/spirituality into practice. Previous studies also support this, indicating that the length of employment history affects nurses' perceptions of spirituality and their ability to provide spiritual care. Exposure to a spiritual climate over time leads to improved provision of spiritual care for patients [27, 34, 53, 54]. However, some studies have found no significant difference in nurses' spiritual competency scores based on the length of employment history [27, 55, 56]. Additionally, sociodemographic characteristics of patients such as age, sex, engagement in religious activities, belief in God/Higher Power, frequency of interactions with mental health providers, and patient preferences were found to influence nurses' competencies in integrating patients' religion/spirituality into nursing practice [57].

According to the study results, the involvement of professionals in providing religious/spiritual care predicted nurses' competencies in integrating patients' religion/spirituality into practice. This finding is consistent with Shamsi et al. [26], who emphasized that nurses who engaged professionals in providing religious/spiritual care demonstrated higher levels of competency in meeting patients' religious/spiritual needs through collaboration with the patients' family members and the multidisciplinary team, which included religious/spiritual care professionals, psychologists, chaplains, and counselors [26].

Our research aligns with existing literature, indicating that nurses have a professional duty to integrate patients' religion/spirituality into nursing practice in general and psychiatric hospitals. It is crucial for nurses to provide holistic care, improve their competencies, and collaborate with religious/spiritual care professionals when needed to address challenges in spiritual care delivery.

It is important to note that our findings may differ from those of other studies due to various factors that were not considered in our study. These factors include differences in the study population, cultural contexts, data collection tools, study settings, sampling methods, sociodemographic information, educational backgrounds of patients and nurses, organizational and contextual factors, institutional spiritual care policies, and in-service continuing educational programs. Understanding these differences highlights the need for strategies aimed at improving nurses' competencies in integrating patients' religion/spirituality into nursing practice, taking into account the specific conditions and cultures prevalent in general and psychiatric hospitals. Further studies in diverse contexts and cultures are needed to explore these differences.

Limitations

Study limitations include the use of quota sampling from two teaching hospitals in southeastern Iran, which may not represent all nurses in psychiatric and general hospitals. The self-administered tool used to assess nurses' competencies may not fully capture the complex nature of integrating patients' religion/spirituality into practice. Future studies should consider diverse cultural contexts and utilize mixed methods approaches with larger sample sizes to provide a more comprehensive assessment of competencies and explore influencing factors.

Conclusions

This study found that nurses' competencies in integrating patients' religion/spirituality into nursing practice varied across different healthcare settings. Nurses in general and psychiatric hospitals showed moderate competencies.

Nurses in the general hospitals had higher levels of perceived competencies compared to nurses in the psychiatric hospitals. These results highlight the importance of workplace and hospital characteristics when integrating patients' religion/spirituality into practice. Nursing education, practice, and management should focus on developing nurses' competencies based on the specific needs, culture, and conditions of their workplaces. Healthcare managers should consider factors that influence nurses' competencies and redesign processes accordingly. Providing training opportunities, organizational support, and reducing workload can help nurses to effectively incorporate patients' religion/spirituality into care. Integrating patients' religion/spirituality into healthcare requires a team approach involving various professionals like doctors, nurses, social workers, chaplains, psychologists, and counselors. Nurses should engage in team learning and collaborate with the multidisciplinary team to deliver holistic care. These competencies should be incorporated into nurses' academic education and reinforced through in-service training, especially in mental health settings.

Abbreviation

RSIPAS Religious/Spiritual Integrated Practice Assessment Scale

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Authors' contributions

JF, AS and ZF contributed to conceiving and designing the research. The data were collected, analyzed, and interpreted by JF, AS and ZF. JF, AS and ZF contributed equally to writing and revising the manuscript and approved the final manuscript.

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Data availability

The data supporting the findings of this study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

The ethics committee of Kerman University of Medical Sciences approved this research with the code of ethics No. IR.KMU.REC.1401.476. All methods were carried out in accordance with relevant guidelines and regulations. First, the researcher presented an introduction letter to the hospital officials, explained the eligible participants the study purpose and method before data collection, and then informed consent was obtained from all nurses. The researcher assured participants to keep their information confidential and allowed them to withdraw the study at any time. Finally, the research results were presented to the relevant settings.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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