Conference Name: London International Conference on Research in Life-Science & Healthcare, 19-20 June 2024
Conference Dates: 19-Jun- 2024 to 20-Jun- 2024
Conference Venue: The Tomlinson Centre, Queensbridge Road, London, UK
Appears in: LIFE: International Journal of Health and Life-Sciences (ISSN 2454-5872)
Publication year: 2024

Garcia & Martinez, 2024

Volume 2024, pp. 105-125.

DOI- https://doi.org/10.20319/icrlsh.2024.105125

This paper can be cited as: Garcia, A. L., Martinez, M.C.O, (2024). Nurses' Spiritual Well-Being and Extent of Practice of Spiritual Care. London International Conference on Research in Life-Science & Healthcare, 19-20 June 2024. Proceedings of Healthcare and Biological Sciences Research Association (HBSRA), 2024, 105-125.

NURSES' SPIRITUAL WELL-BEING AND EXTENT OF PRACTICE OF SPIRITUAL CARE

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Abstract

This descriptive correlational study aimed to determine the level of awareness towards spiritual well-being and the extent of the practice of spiritual care of nurses who care for non-covid and COVID-19-infected adult patients at a tertiary hospital in Metro Manila. Data were gathered using two standardized questionnaires namely: The Spiritual Well-Being Scale (SWBS) created in 1982 by Craig W. Ellison and Raymond F. Paloutzian, and the Nurse Spiritual Care Therapeutics Scale (NSCTS) by Mamier and Tylor in 2015. Weighted Mean and Spearman's Rho were used for the statistical treatment. Results of the study showed that the nurse respondents have a very high level of awareness towards spiritual well-being as to religious well-being (RWB) and existential well-being (EWB); they have a moderate extent of the practice in terms of spiritual care; there is a moderate significant relationship between the nurses' level of awareness towards spiritual well-

being in terms of religious well-being (RWB), existential well-being (EWB), overall spiritual well-being and their extent of practice of spiritual care. This implied that there is a relationship between the two variables accordingly but not to the highest degree; that is, the very high level of awareness towards spiritual well-being of nurses just moderately affected their extent of practice of spiritual care. Therefore, the researcher recommended more provision of spiritual care from the nurses for their patients.

Keywords:
Nurses Spiritual Wellbeing, Practice of Spiritual Care, Spiritual Care, Spiritual Wellbeing

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1. Introduction

During the COVID-19 pandemic, healthcare workers, especially nurses in all parts of the world, have been overwhelmed as they work on the frontline to help the patients infected by COVID-19 (Althobaity and Alshammari, 2020). Nurses risk their lives to save people who have COVID-19; people who present severe distress associated with the disease that affects different aspects of their wholeness, including physical, emotional, mental, social, and spiritual components (Mthembu, 2017). They still assume critical functions as they provide holistic care (physical, psychological, social, and spiritual) for all these patients (Althobaity et al, 2019). However, the consequences of the COVID-19 pandemic had a major impact on everyone's activities, routines, livelihoods, mental health, and well-being (World Health Organization, 2020). Nurses sometimes forget to include spiritual care as they are tired of fulfilling the physical, psychological, and even social needs of the patients.

The researcher as a nurse and a catechist herself wondered why such a thing happened, as she as a nurse herself loved to provide spiritual care to her patients. It was one of the researcher's best attributes, offering prayers or praying with the patients and staying at the patient's bedside for a time, especially when the patient needs company and having difficult times are some of her best qualities. Explicit communication, compassion, active listening, and support for the patient make her and her patient feel special. However, during the COVID-19 pandemic, the researcher noticed that nurses' time of care lessened as they admitted more infected patients and became assigned to COVID-19-positive areas or wards. The researcher has observed that nurses can still provide

physical, psychological, and social care to patients even with increasing admission but not spiritual care. It was always left behind, as nurses would say, they will do it after finishing all their tasks in the area; but too tired to perform when the time comes.

Some of the researcher's coworkers even verbalized that they were afraid to approach the patient and ask about their religion, their spiritual needs, or offer prayer or any spiritual emblem. They feel embarrassed to ask and be recognized as discriminatory; so, they just simply question their patients as to what they would want their nurses to do for them. In some situations, some nurses also expressed that most of the patients seek to improve their physical health problems and do not pay much attention to their religious needs or ask for help in this regard; as a result, these nurses do not care about it. Similar to these observations are the studies of Abbasi et al (2016) and Gardideh et al (2015) which showed that spiritual care is not well provided and that the religious needs of patients are not appropriately met. These conditions motivated the researcher to pursue this study. She wanted to identify the challenges of nurses in rendering spiritual care; as well as determine their level of awareness about spiritual well-being and their extent of practice of spiritual care.

2. Method

This study utilized the descriptive-correlational design to determine the level of awareness towards spiritual well-being and the extent of the practice of spiritual care of nurses who care for non-covid and COVID-19-infected adult patients at a tertiary hospital in Metro Manila. Data were gathered using two standardized questionnaires namely: The Spiritual Well-Being Scale (SWBS) created in 1982 by Craig W. Ellison and Raymond F. Paloutzian, and the Nurse Spiritual Care Therapeutics Scale (NSCTS) by Mamier and Tylor in 2015. Weighted Mean and Spearman's Rho were used for the statistical treatment. Ethical and legal aspects were considered during the data collection.

3. Results and Discussion

A. Nurses' Level of Awareness Towards Spiritual Well-Being

1. Religious Well-Being (RWB)

Table 1 shows the nurses' level of awareness towards spiritual well-being as to religious well-being (RWB), with 5.31 as its overall mean score interpreted as a very high level of awareness. The highest item is number 3 about nurses believing that God loves them and cares about them, with a mean score of 5.71 interpreted as a very high level of awareness. The lowest

item is number 6 about nurses feeling unsettled about their future with 4.74 as its mean score interpreted as a very high level of awareness.

The findings of the overall very high level of awareness in Table 1 imply that the nurse respondents were greatly aware and were found to have greater strength and comfort in their faith (feeling more at peace, more productive, and more purposeful, and derived more comfort and strength from their faith); that they believed that they would be fine despite the tremendous consequences of this COVID-19 pandemic which rendered major impact on their activities, routines, livelihoods, mental health, and well-being). This also means that they find greater satisfaction from their faith by being religiously well while doing/saying their personal prayer or knowing that they have a great relationship with a higher being (that is God). One example of this is when nurses' faith leads them to stay beside their patients to pray or to read bible verses to give them comfort, ease their pain, or simply just to let them know their genuine interest in helping the patients. These situations made the nurses feel great and enlightened; that despite the difficulties on their part as well as those of the patients, they managed to put their faith above everything else; and also managed to give strength/comfort to the patients and their families. This finding can be supported by the fact that most of the nurse respondents are Roman Catholic (77.9%). It is a Catholic's way to turn away from despair and seek comfort in their faith and the community. As Catholic nurses, their faith becomes their bond in having a sense of purpose in the workplace which leads to a greater sense of camaraderie with coworkers. This made them know one another and stand for each other to encourage and support each other in difficult times which reminds them that they do not journey alone.

Table 1: Nurses' Level of Awareness towards Spiritual Well-Being as to Religious Well-being (RWB)

Items	Weighted Mean	Rank	Interpretation
1. I don't find much satisfaction in private prayer with God.	5.60	2	Very High Level of Awareness
2. I don't know who I am, where I came from, or where I'm going.	5.44	5	Very High Level of Awareness
3. I believe that God loves me and cares about me.	5.71	1	Very High Level of Awareness
4. I feel that life is a positive experience.	5.36	6.5	Very High Level of Awareness
5. I believe that God is impersonal and not interested in my daily situations.	5.57	3	Very High Level of Awareness
6. I feel unsettled about my future.	4.74	10	Very High Level of Awareness

7.	I have a personally meaningful relationship with God.	5.36	6.5	Very High Level of Awareness
8.	I feel very fulfilled and satisfied with life.	4.90	9	Very High Level of Awareness
9.	I don't get much personal strength and support from my God	5.49	4	Very High Level of Awareness
10.	I feel a sense of well-being about the direction my life is headed in.	4.94	8	Very High Level of Awareness
	Over-all Mean Score	***5.31***		***Very High Level of Awareness***

LEGEND:

WEIGHTED MEAN RANGE	INTERPRETATION
4.50 – 6.00	Very High Level of Awareness (76-100% aware)
3.00 – 4.49	High Level of Awareness (51-75% aware)
1.50 – 2.99	Low Level of Awareness (26-50% aware)
1.00 – 1.49	Very Low Level of Awareness (1-25% aware)

The philosophy of the hospital also supports the findings above; that is to be a premier institution in medical services, medical and paramedical education, training, research, and medical services, dedicated to life and to God's glory. This made the nurse respondents believe more in their faith, that they serve for God's glory. This made them more purposeful in doing their job even if there were so many barriers in their way. Their faith or religious belief them with a greater sense of well-being. With this kind of awareness, these nurse respondents will have a sense of structure (one that can help in the character building of a person). It also gives them the opportunity to connect with other people / or socialize with the same or similar faith/beliefs that can have a positive impact on their mental health. This finding is confirmed by the work of Vishkin et al (2016) who said that religion constantly trains people to reassess emotional events. Therefore, their sense of well-being will present better mental health and adapt more successfully to stress.

In addition, as support for the finding above is the works of Smith et al (2013) which said that the spiritual well-being of a person (like the very high level of awareness towards RWB of nurses) was seen to exert a protective influence on behavior (that these nurses can reassess their emotional events) therefore present better mental health. Smith et al (2013) found out that this spiritual well-being generates a powerful influence toward positive developmental health outcomes through strengthening personal attributes of peace and life satisfaction and enhancing bidirectional proximal processes (relations and spiritual practices) within the family and within the spiritual family.

In terms of the highest item, about nurses believing that God loves them and cares about them, nurses chose this as their top pick because they believe that the love of God purifies the heart

of a person, transforms them to become self-sacrificing as they reflect more on the attributes and qualities of God. This is a good trait for nurses, that they care without asking for reward just like what God is doing for all people. It is like risking their own life to save others. This is supported by the Caring Theory by Watson, that within the theory, of ten carative factors of love-heart-centered-caring/compassion represent the core of caring (Watson, 2012). This focuses or circulates around how nurses care for their patients and how that caring progresses into better plans to promote health and wellness, prevent illness and restore health; and develop nurse's own actualization (this is because Jean Watson contends that caring regenerates life energies and potentiates nurse's capabilities; wherein the benefits are immeasurable and promote self-actualization on both a personal and professional level).

In terms of the lowest item although interpreted also as a very high level of awareness, about nurses feeling unsettled about their future, nurses chose this as their least pick because nurses believe that they cannot be confused or unsettled, especially about their future. This is because they always think of their patients and how they can have a major impact on improving patient experiences while they care for them; as a person who spends a lot of time with patients, nurses are the conduits of patients' recovery. As the Theory of Caring Watson says, "upholding these caring values in a nurse's daily practice helps transcend the nurse from a state where nursing is perceived as "just a job," to that of a gratifying profession (Watson, 2012).

2. Existential Well-Being (EWB)

Table 2: Nurses' Level of Awareness towards Spiritual Well-Being as to Existential Well-being (EWB)

Items	Weighted Mean	Rank	Interpretation
1. I believe that God is concerned about my problems.	5.42	4	Very High Level of Awareness
2. I don't enjoy much about life.	5.39	6	Very High Level of Awareness
3. I don't have a personally satisfying relationship with God.	5.56	1	Very High Level of Awareness
4. I feel good about my future.	4.91	8.5	Very High Level of Awareness
5. My relationship with God helps me not to feel lonely.	5.35	7	Very High Level of Awareness
6. I feel that life is full of conflict and unhappiness.	4.90	10	Very High Level of Awareness
7. I feel most complete when I'm in close communication with God	4.91	8.5	Very High Level of Awareness

8. Life doesn't have much meaning.	5.51	2	Very High Level of Awareness
9. My relation with God contributes to my sense of well-being.	5.40	5	Very High Level of Awareness
10. I believe there is some real purpose for my life.	5.47	3	Very High Level of Awareness
Over-all Mean Score	***5.28***		***Very High Level of Awareness***

Table 2 displays the nurses' level of awareness towards spiritual well-being as to existential well-being (EWB), with 5.28 as its overall mean score interpreted as a very high level of awareness. The highest item is number 3 about nurses not having a personally satisfying relationship with God, with a mean score of 5.56 interpreted as a very high level of awareness. The lowest item is number 6 about nurses feeling that life is full of conflict and unhappiness, with 4.90 as its mean score, interpreted also as a very high level of awareness.

The finding of a very high level of awareness towards existential well-being in Table 2 depicts that the nurse respondents were greatly aware of maintaining a strong sense that life is meaningful and worth living and, indeed, they have to grow/mature from these experiences despite the presence of constraints and difficulties especially at work. This happens because people (like the nurses) when faced with a significant threat to life (pandemic) tend to reflect more intensely upon existential issues, such as the meaning and purpose of one's life. These nurses realized that "they were present", or they became nurses to become instruments of the hospital to serve patients and their families affected/infected by the pandemic; that they have to be strong to fight amidst the hardships/risks of being a frontline nurse to be able to help these patients. This kind of awareness made these nurses incline themselves to seek meaning in their lives, grow, and transcend beyond their self. One example of this is when one of the nurse alumni of the Pamantasan ng Lungsod ng Maynila College of Nursing (PLM-CN) managed/handled efficiently/effectively when the Neonatal Intensive Care Unit (NICU) of Philippine General Hospital (PGH) accidentally went into fire. She could have run (save herself) and left the babies behind, but she did not. She carried them one by one, going down the building to save all the babies. She realized that risking her life for these babies meant more life spared. Like her, the nurse respondents of this study explored how the event in their life in these trying times of the COVID–19 pandemic fits with everyone's worldviews; therefore, they make meanings out of it and determine its significance. Nurses'

interpretation of what is happening around them (like the overwhelming admissions and cases of affected/infected COVID-19 patients) makes them assume possibilities and interpret their experiences in a unique way. Some thought of it as a blessing in disguise, that they were made to work with these patients to help them recover; to lead them to a greater sense of life's purpose. Others would think that it is a punishment that they have to endure being at risk with these affected/infected COVID-19 patients. To support this finding is the work of Udo et al (2013) which said that people are constantly in the process of interpreting the world, thus, their understanding of the world changes along with situations and context. Additional support is the statement by Chandramohan and Bhagwan (2015) that searching for meaning helps a person cope with suffering and the stressful events of daily living.

In terms of the highest item about nurses not having a personally satisfying relationship with God (this item is reverse coded which means nurses feel they have a personally satisfying relationship with God) that is why it is their highest choice and interpreted as a very high level of awareness. This happens because nurses are always confronted with the adversities of how to handle various types of patients in a day (moody, angry, sentimental, joyful, sad, excited, afraid, fearful patients); as such, nurses need the comfort of knowing that God is with them while they care for their patients. This allows them to work in a positive way especially now that nurses are facing different challenges because of the Covid-19 pandemic. The feeling of having God as their guide and support made them stronger to face the realities of life and the danger of becoming a nurse at risk during the pandemic. This finding is supported by the works of Burkhardt and Nagai-Jacobson (2016) which reported that spirituality (according to de Jager Meezenbroek et al (2012) is referred to as ''one's striving for an experience of connection with oneself, connectedness with others, and nature and connectedness with the transcendent'') is the essence of being human, and is recognized, by many health care professionals, as a central component in health and healing (Hawthorne and Gordon, 2020). In addition, the finding is confirmed by the study of Atashzadeh-Shoorideh et al (2017) which revealed that spirituality affects nurses' behavior in a positive way and promoting spirituality in nurses, results in patients and their families receiving better healthcare on the part of nurses.

In addition, as support for the finding above is the works of Roman et al (2020) which stated that the relationship with the transcendent or sacred has a strong influence on a people's beliefs, attitudes, emotions, and behavior; those populations, communities, families, and

individuals have always found solace through their religious or philosophical beliefs during times of personal adversity and widespread anxiety or disaster (like in this study, the nurses have found solace or relief from believing that God is with them, especially that they are in the face of adversaries due to Covid-19 pandemic).

In terms of the lowest item, although interpreted also as a very high level of awareness, about nurses feeling that life is full of conflict and unhappiness, nurses chose this as their lowest because they believe that they cannot think of their life as full of conflict and unhappiness (depletion of one's emotional and physical resources due to work stress), for this will ripple into how they will care of their patients. In support of this is the works of Dunn (2012) which considers that the role of spirituality in nurses, who are part of people providing care, is very important; and believes that a nurse with an inadequate level of spirituality like feeling of conflict and unhappiness, cannot take care of patients in an appropriate way.

B. Nurses' Extent of Practice in Terms of Spiritual Care

Table 3: Nurses' Extent of Practice in terms of Spiritual Care

Items	Weighted Mean	Rank	Interpretation
1. Asked a patient about how you could support his or her spiritual or religious practices	2.65	11	Moderate Extent of Practice
2. Helped a patient have quiet time or space	3.83	2	High Extent of Practice
3. Listened actively to patient's story of illness	4.09	1	High Extent of Practice
4. Assessed a patient's spiritual or religious beliefs and/or practices that are pertinent to health	3.22	5	Moderate Extent of Practice
5. Listened to patient talk about spiritual concerns	3.38	4	Moderate Extent of Practice
6. Encouraged patient to talk about how illness affects relating to God—or his or her transcendent reality	2.99	7	Moderate Extent of Practice
7. Encouraged patient to talk about his or her spiritual coping	3.09	6	Moderate Extent of Practice
8. Documented spiritual care you provided in a patient chart	2.41	13.5	Low Extent of Practice
9. Discussed a patient's spiritual care needs with colleagues (e.g., shift report)	2.41	13.5	Low Extent of Practice
10. Arranged for a chaplain to visit a patient	2.34	17	Low Extent of Practice
11. Arranged for patient's clergy/spiritual mentor to visit	2.13	17	Low Extent of Practice
12. Encouraged a patient to talk about what gives his or her life meaning amid illness	2.88	9	Moderate Extent of Practice
13. Encouraged a patient to talk about the spiritual challenges of living with illness	2.85	10	Moderate Extent of Practice

14. Offered to pray with a patient	2.92	8	Moderate Extent of Practice
15. Offered to read a spiritually nurturing passage (e.g., patient's holy scripture)	2.39	15	Low Extent of Practice
16. Told a patient about spiritual resources	2.51	12	Moderate Extent of Practice
17. After completing a task, remained present just to show caring	3.55	3	High Extent of Practice
Over-all Mean Score	***2.92***		***Moderate Extent of Practice***

LEGEND:

WEIGHTED MEAN RANGE	INTERPRETATION
4.20 – 5.00	Very High Extent of Practice (81-100% extent of practice)
3.40 – 4.19	High Extent of Practice (61-80% extent of practice)
2.60 - 3.39	Moderate Extent of Practice (41-60% extent of practice)
1.80 – 2.59	Low Extent of Practice (21-40% extent of practice)
1.00 - 1.79	Very Low Extent of Practice (1-20% extent of practice)

Table 3 illustrates the nurses' extent of the practice in terms of spiritual care, with 2.92 as its overall mean score, interpreted as the moderate extent of the practice. The highest item is number 3, about nurses listening actively to patient's stories of illness, with a mean score of 4.09, interpreted as a high extent of practice. The lowest item is number 11 about nurses arranging for patient's clergy / spiritual mentor to visit, with 2.13 as its mean score, interpreted as a low extent of the practice.

The moderate extent of practice in rendering spiritual care to patients implies that the nurse-respondents were able to provide their patients spiritual care however, there are times that they cannot simply do it. This can be traced from the fact that: 1) nurses are filled with tasks that overwhelm them especially now that the world is suffering from the COVID-19 pandemic. Their role is now and has been always concentrated on giving physical or psychosocial care that is directly related to the treatment of the illness or health problems of their patients. These situations made the nurses become constrained in terms of their ability to deliver spiritual care. They were tasked to focus more on the cure (physical, psychological, and social impact) for the affected patients and their families due to the consequences of the pandemic; in addition to this is the fast turnover of patients and increasing admissions in their hospital being a covid facility; to support this is the study by Rushton (2014) which emphasized that the willingness to perform routine work due to a large number of patients and lack of time have made the spiritual needs of patients become neglected 2) mostly the nurse-respondents are in their advance beginner's year (based on the Theory of Clinical Competency by Patricia Benner) in the hospital (57.1% belonged to the 1- 3 years of experience) that they are newly graduate nurses in their first job, having knowledge and

the know-how but not enough in-depth experience. As Ozdemir (2019) said, advanced beginner nurses cannot see the "big picture" involving nursing care in all dimensions. For them, it is a stressor to manage patients with complex conditions, heavy workloads, and sudden increases in responsibility; and 3) most of the nurse-respondents have reached only a Bachelor's Degree in Nursing (90.0%) and have not been into continuing studies that would help them build their knowledge, attitude, and skills in terms of spiritual care. This is supported by O'Shea et al (2011) who noted that nursing education has provided few opportunities for the inclusion of spirituality and spiritual care, which leaves the nurse unprepared to meet the challenges of providing therapeutic spiritual care for patients and their families.

Support to all these findings is the works of Chandramohan and Bhagwan (2015) which explained that barriers to providing spiritual care included a lack of time, uncertainty of how to provide spiritual care using spiritual care interventions, and a lack of knowledge regarding diverse religious faiths. The authors explained that these are the areas warranting attention in clinical nursing practice and nursing education.

In terms of the highest item about nurses listening actively to patients' stories of illness as part of their spiritual care, nurses chose this as their top pick because in mental health practice, listening to the patient's story is one of their tools in assessing the patients. It provides the health professional or the nurse, with a wealth of evidence that can be used to help the patient on a journey of recovery. According to the principles of hermeneutics, in which things acquire meaning by being put into language, the very telling of a story gives it a deeper and clearer meaning for the teller, especially if the telling is assisted by skilled listening. Nurses love to hear their patients talk about themselves and this would give them the opportunity to know them and become acquainted with what they prefer for their treatment regimens and the like. From here, nurses can simply plan and develop interventions that are patient-centered. This finding is favored by the study of Chen et al (2018) and Ripamonti et al (2018) which reported that spiritual care consists of nursing methods or activities that depend on the creation of company or care, listening, or religious activities that correspond to patients' beliefs to help them to achieve better physical, mental, social, and spiritual health and comfort. In the study of Chen et al (2018) spiritual care is used to ease patients' difficulties at the spiritual level and help them find the meaning of life, self-actualization, hope, creativity, faith, trust, peace, comfort, prayer, and the ability to love and forgive amid suffering and disease.

As to the lowest item about nurses arranging for a patient's clergy spiritual mentor to visit, it was their lowest pick and interpreted as a low extent of practice because nurses are full of workload that sometimes it is hard for them to arrange or schedule visits from patient's clergy/spiritual mentor due to lack of time. Also, in a private hospital like the research locale, the chaplain/spiritual mentor is only one and it caters to all the patients in the hospital that sometimes it is very unlikely that their schedules are always available for all. This is why it is hard to get a schedule for a visit, or sometimes the nurse is put on the waiting list for their patient/s to be visited by the chaplain. On some occasions, the patients are afraid to be visited by the chaplain (they think that this is done only for patients in their terminal stage); that is why nurses have a hard time scheduling an appointment. This is affirmed by the works of Rushton (2014) which stated that a variety of reasons contribute to the challenges in rendering spiritual care to patients by the nurses, which includes time pressures and fear around the reaction of the patient to their attempts to aid with spiritual care (Keall eta l., 2014).

C. Significant Relationship Between the Nurses' Level of Awareness Towards Spiritual Well-Being and Their Extent of Practice of Spiritual Care

Table 4: Relationship between the Nurses' Level of Awareness towards Spiritual Well-Being and their Extent of Practice of Spiritual Care

Nurses' Level of Awareness Towards Spiritual Well-Being and Their Extent of Practice of Spiritual Care	N	Spearman's Rho (rs)	Sig. (2-tailed)	Decision	Interpretation
Religious Well-Being (RWB) and Spiritual Care	77	0.420	0.000	Reject Ho	Moderate Significant Relationship
Existential Well-Being (EWB) and Spiritual Care	77	0.386	0.001	Reject Ho	Moderate Significant Relationship
Spiritual Well-Being (RWB + EWB) and Spiritual Care	77	0.420	0.000	Reject Ho	Moderate Significant Relationship

LEGEND:

< 0.35 is generally considered to represent low or weak correlations, 0.36 to 0.67 modest or moderate correlations, and 0.68 to 1.0 strong or high correlations with r coefficients > 0.90 very high correlations.

Table 4 presents the relationship between the nurses' level of awareness towards spiritual well-being and their extent of practice of spiritual care.

Data on the table shows that there is a positive moderate significant relationship between the nurse respondents' level of awareness towards spiritual well-being in terms of RWB and their extent of the practice of spiritual care as determined by rs of 0.420 and the p-value of 0.000; there is a positive moderate significant relationship between the nurse respondents level of awareness towards spiritual well-being in terms of EWB and their extent of the practice of spiritual care as determine by rs of 0.386 and the p-value of 0.001; and a positive moderate significant relationship between the nurse respondents level of awareness towards spiritual well-being as a whole and their extent of practice of spiritual care as determine by rs of 0.420 and the p-value of 0.000.

The findings of a positive moderate significant relationship between spiritual well-being in terms of RWB, EWB, and the whole SWB, and their extent of practice of spiritual care means that even with a very high level of awareness toward spiritual well-being, nurses cannot achieve a very high extent of practice, only moderate extent. This is due to the fact that the nurse respondents of this study have encountered challenges in rendering spiritual care, the reason for the moderate extent of the practice. The top 3 among them are: 1) nurses lacking time to provide spiritual care; 2) nurses having anxiety about providing appropriate, non-discriminatory spiritual care; 3.5) nurses lacking clear guidelines for their role in providing spiritual care; and lacking training and education on spirituality for pre- and post-registration nurses, respectively. This finding negates the results of the study by Azarsa et al (2015) which revealed that spiritual care competence had a positive relationship with spiritual well-being and spiritual care perspective, or the significant relationship observed between spiritual health and spiritual care found by the study of Zare and Jahandideh (2014).

According to the findings above, there are moderately significant relationships between the two variables:

1) RWB (satisfaction derived by the nurse-respondents from the measure of their relationship with God or from the relationship they have when they pray, visit churches, or wear a spiritual emblem) and the extent of the practice of spiritual care. Supported by the studies of Chatrung et al (2014) and Cruz et al (2016), religion or religious belief can provide individuals with a greater sense of well-being. Also, in the study of Melhem et al (2016), it was reported that the participating nurses' perceptions of "attributes for spiritual care" indicated that 87% of nurses believe that spiritual care has some characteristics which are considered basic prerequisites to providing this type of care. The finding of the study by Melhem et al (2016) suggested that study participants acknowledged

that establishing a rapport and building trust relationships with patients helped the nurse to engage in providing spiritual care and facilitated addressing patients' spiritual needs. This is like the present study wherein the relationship mentioned above between RWB and the extent of the practice of spiritual care explains that when nurses are satisfied with their relationship with God, they can communicate and be related to the higher being through prayers and other spiritual activities. They are able to practice spiritual care; that is if there are no barriers or hindrances in rendering it. Without these challenges, praying or talking to patients about verses in the Bible, and doing things to uplift their spiritual being makes the nurse feel satisfied so they are able to appreciate this kind of care and will continue to practice it for their patients. However, if there are hindrances, therefore, the spiritual care will be in vain.

2) EWB (nurse-respondent's present state of subjective well-being across existential domains, such as meaning, purpose, and satisfaction in life, and feelings of comfort regarding death and suffering) and extent of the practice of spiritual care). This relationship explains that when nurses are faced with danger / or are threatened, they contemplate the meaning of life or death. With this, they have come to share the same feelings with their patients, thus, making them believe that their life is meaningful and worthy. By doing this, their patients will develop a sense of trust that one can cope with the difficulties of life; both will be able to appreciate this kind of care and will continue to practice it; that is if there are no barriers or hindrances in rendering it. However, if there are hindrances (like most of the nurses are in their productive years (55.8% ages 31 to 40 years old), single (67.5%), and mostly staff nurses (36.4%), they will work and work to fulfill their dreams/ambition for promotion especially for financial reasons, not minding if some aspects of holistic care are being neglected on the way). Therefore, spiritual care will be put in vain.

3) Overall SWB (the degree to which the nurse-respondents perceive or derive a sense of well-being from spiritual attitudes and strivings) and the extent of the practice of spiritual care. This relationship explains that when nurses have a very high level of awareness of what spiritual well-being is all about (sense of well-being from spiritual attitudes and strivings), they will be able to appreciate this kind of care and will continue to practice it; that is if there are no barriers or hindrances in rendering it. However, these nurses cannot effectively assume their roles in rendering spiritual care when there are time constraints, anxiety, and a lack of clear guidelines in providing spiritual care. An example of this is when nurses know what kind of spiritual care the patient needs. The nurse and the patient have communicated, prayers will alleviate the feeling of uneasiness of

the patient. They have scheduled when this will transpire and how they will do it. However, on that day of their schedule, there were more patients admitted to the ward/hospital that needed to be attended. There are not enough nurses to handle the cases, so the prayer schedule should be canceled. Day by day, the same situations arise. Other nurses would like to take over, but they do not have the knowledge/experience of rendering spiritual care; much less a guideline to follow. This prevents the nurses from rendering spiritual care for their patients. Soon after the overwhelming increase, the nurse can render the care, nevertheless, it is not what is expected to be rendered as what was planned.

D. Challenges Encountered by the Nurse-Respondents in Rendering Spiritual Care to the Patients

Table 5: Challenges Encountered by the Nurse-Respondents in Rendering Spiritual Care to the Patients

Challenges	Frequency	Ranking
1. Spiritual care skills deficit'	35	5
2. Anxiety about providing appropriate, non-discriminatory spiritual care	48	2
3. Lack of clear guidelines for the nurse's role in providing spiritual care	44	3.5
4. Nurses' lack of time to provide spiritual care	53	1
5. Lack of training and education on spirituality for pre- and post-registration nurses	44	3.5
6. Conceptual confusion	34	6
7. Role confusion	29	8
8. Clinician discomfort	26	9
9. Lack of trust	32	7
10. Resource constraints	23	10

Table 5 presents the challenges encountered by the nurse respondents in rendering spiritual care to their patients. Data shows that: item 4 about nurses lacking time to provide spiritual care, ranked first (top 1) with 53 out of 77 responses; item 2 about nurses having anxiety about providing appropriate, non-discriminatory spiritual care, ranked second (top 2) with 48 out of 77 responses; items 3 and 5 about nurses lacking clear guidelines for their role in providing spiritual care; and lacking training and education on spirituality for pre- and post-registration nurses, respectively, ranked next (top 3.5) with 44 out of 77 responses.

The finding above is matching to that of the findings by Rushton (2014) which reported that the main barrier to spiritual care is the difficulty in defining spirituality [similar to item 2 about nurses having anxiety about providing appropriate, non-discriminatory spiritual care, ranked second (top 2) in this present study]; the lack of clear guidelines for the nurse's role in providing spiritual care (nurses lacking clear guidelines for their role in providing spiritual care, ranked 3.5 in this present study); nurses' lack of time to provide spiritual care [nurses lacking time to provide spiritual care, ranked first (top 1) in this present study]; and a lack of training and education on spirituality for pre- and post-registration nurses (lacking training and education on spirituality for pre- and post-registration nurses, ranked 3.5 in this present study).

Data on the table reveals that most of the nurse respondents lack the time to provide spiritual care for their patients. This can be related to the situations nowadays where many nurses are overloaded with tasks that they somehow compromise their delivery of holistic care for their patients. This finding is reinforced by the work of Cockell and McSherry (2012) and Wong and Yau (2010) which reported that insufficient management support, manpower and resources, cultural factors, increased workload, and nurses' consideration that their knowledge and skills are insufficient to administer spiritual healing; are the factors that hamper the practice of spiritual care. In terms of the second top item about nurses having anxiety about providing appropriate, non-discriminatory spiritual care, this happens because spiritual care was not given emphasis during the undergraduate years of training as nurses. Merely, the focus of the undergraduate program is on theory and procedures or skills on how to be a nurse, and just recently spiritual care nursing had been included in the curricula. This finding is supported by the works of O'Shea et al (2011) who noted that nursing education has provided few opportunities for the inclusion of spirituality and spiritual care, which leaves the nurse unprepared to meet the challenges of providing therapeutic spiritual care for patients and their families.

As to the third and fourth items chosen by the nurse participants as the top challenges in rendering spiritual care, about nurses lacking clear guidelines for their role in providing spiritual care; and lacking training and education on spirituality for pre- and post-registration nurses, respectively, can be traced to the fact that there are some hospitals that really do not have specific guidelines and trainings on spiritual care. Usually, they relied on the services of the hospital chaplains/clergy or spiritual mentors and advisers for this type of care. This has made nurse unable to be trained and render spiritual care to their patients. Affirming this finding is the study by

Balboni et al (2013), which reported that nurses perceived that lack of skill in spiritual care and of under preparation and a lack of confidence that contributed to hindrance in rendering spiritual care. Balboni et al (2013) also recommended that additional training provision in this area is needed for nurses.

4. Conclusion

The researcher concluded that the nurse respondents have a very high level of awareness towards spiritual well-being as to religious well-being (RWB) and existential well-being (EWB); they have a moderate extent of practice in terms of spiritual care; that the null hypothesis was rejected, there is a significant moderate relationship between the nurses' level of awareness towards spiritual well-being in terms of religious well-being (RWB), existential well-being (EWB), overall spiritual well-being and their extent of practice of spiritual care. This implied that there is a relationship between the two variables accordingly but not to the highest degree; that is, the very high level of awareness towards spiritual well-being (sense of well-being from spiritual attitudes and strivings) of nurses just moderately affected the extent of the practice of spiritual care; especially if there are barriers or hindrances (time constraints, anxiety, and lack of clear guidelines in providing spiritual care). It is therefore important for nurses to always take time to prepare, practice, and provide spiritual care whenever it is needed. It is a vital part of the nurse's role for their patients.

5. Recommendation

Based on the results of this study the following recommendations are given:

1. Nurses to enhance their spiritual well-being and manage their practice of spiritual care to their patients by engaging/participating in the implementation of the Spiritual Care Program that was developed based on the results of this study.
2. Hospital Administration to spearhead the development and implementation of the Spiritual Care Program (in their institution) that was developed based on the result of this study. This is to help increase the awareness of their nurses and make them spiritually well and more capable of rendering spiritual care to their patients holistically.
3. Patients and their significant others to continue giving importance and support to their nurses as they enhance their spiritual well-being and holistically render spiritual care to their patients.

4. Nurse Education / Nursing School to become a bridge in further developing the nursing curriculum in terms of enhancing the spiritual well-being of nurses and how they would render spiritual care for patients.

5. Future researchers to use the results of this study as reference material for future researchers having the same topic.

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