Original Article

Interventions by Hospital Nurses for the Spiritual Needs of Patients in the Eastern Black Sea Region of Turkey

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ABSTRACT

Aim: The aim of this study is to evaluate the spiritual care interventions of the nurses in hospitals. **Subjects and Methods:** Nurses employed in the 5 hospitals of Eastern Black Sea Region constitute the universe of the research that was planned to be descriptive. 1254 out of 1765 nurses were reached out between 1-30 May 2015 without a sample selection. The data were collected by the researchers is based on face-to-face survey techniques in which sociodemographic attributes built on literature and opinions on spiritual care were evaluated. Permission of the hospitals and nurses were obtained for the study. Number and percentage distributions and Chi-square test were used for statistical analysis. **Results:** As the nurses' sociodemographic attributes were examined, 29.3% of them belonged to 30–35 age group, 26% of them worked as a nurse manager for 82–161 months, and 56.7% of them worked for 162–300 months. Ninety-one percent of them stated that they never practiced spiritual care-related nursing, 97.5% of them stated that they never received support from hospital clergymen, 93.2% of them stated that they did not talk about spiritual need with the patient since they did not find it necessary. **Conclusions:** This study showed that there is very little or no interventions directed at the spiritual dimension during the patient's caring process.

KEYWORDS: *Evaluation of intervention, nurse, patient, spiritual care, Turkey*

Date of Acceptance:
10-Oct-2017

INTRODUCTION

A fundamental of good nursing care is helping individuals protect, maintain, or obtain physical, psychological, social, and spiritual well-being.[1] In the past, human spirituality was explained only in religious terms, but since the advent of holistic health care, it has gained importance equal to the physical, psychological, and social dimensions of health. Although the term holistic care was introduced in the literature by Rogers, Parse, and Newman, nurses have provided care in a holistic way traditionally.[2]

Spiritual care exerts a strong influence on health-related dynamics, attitudes, and behaviors and should not be considered separate to normal nursing care.[3,4] Unexpected changes in a patient's health can lead to patients and families questioning the meaning of life, with spiritual beliefs used to provide individuals with hope and as a coping mechanism when they endure suffering.[5] In particular, when individuals become ill or are hospitalized, they may want to consider hospitals as their homes and to bring their religious beliefs and practices, just as they want to bring other needs with them.[6] Therefore, spiritual care may be considered a basic component of the holistic care philosophy.[3] In this way, spiritual care can be defined as providing individuals with religion and faith support, helping them find new meaning in their lives, and accompanying them to religious services during times of distress, fear, or crisis. Spiritual care enhances the spiritual dimension of a patient's health and raises the possibility of improving recovery by promoting hope and treatment participation.[7-9] Nurses should be aware of

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Access this article online

Quick Response Code:

Website: www.njcponline.com

DOI: 10.4103/njcp.njcp_62_17

How to cite this article: Demirbag BC, Ozkan CG. Interventions by hospital nurses for the spiritual needs of patients in the eastern black sea region of Turkey. Niger J Clin Pract 2018;21:624-31.

the beliefs, faiths, and spiritual practices of their patients, and they should be prepared to offer them customized spiritual care.[10]

Spiritual needs are those that, when targeted, can reduce spiritual deprivation or strengthen spiritual power.[11-14] In other words, spiritual needs can be defined as factors that are necessary for individuals to maintain their dynamics. Spirituality can simply be how someone finds meaning with their life, how they feel connected, and the rules by which they live.[11-15] These definitions clearly explain what objectives nurses should have and what nurses should do to provide spiritual care. To support this provision, the need to provide spiritual care is enshrined in various laws and codes of practice. Although spiritual care and support are recognized as important needs for patients and their families, the current health-care system in our country does not meet this need.[1,10] Recognition and allowance for spiritual care practice are obligatory in many accredited hospitals around the world, but in Turkey, these practices are only officially permitted in hospitals accredited by the Joint Commission International, and only on request.[16]

In Turkey, spiritual care is often not offered effectively in routine nursing practice because of heavy workloads, insufficient knowledge, inadequate training about spiritual care services, and families' fears of wasting staff time.[17-20] Moreover, the studies on spirituality and spiritual care by nurses in Turkey are lacking, and it is notable that few studies have targeted and measured the knowledge of hospital-based nurses have about spiritual practice.[10,18-22]

Governments are responsible not only for making policy but also for implementing that policy.[16] There is a need to improve awareness of provision among health-care personnel, to improve the awareness of service regulations that will improve health care, and to improve hospital policies. Spiritual care, in particular, may be neglected in the holistic care approaches provided by nurses working in hospitals because of nursing workloads, not having sufficient knowledge level, not receiving training on spiritual care services, and families not wanting to waste the time of staff that provides spiritual health-care services.[17-20] It is also necessary to assess whether there are differences by geographic region or city if we are to identify where health-care services are lacking. This study was designed to fill the gap left by the lack of research assessing interventions by nurses for spiritual needs, focusing on hospital settings in the Eastern Black Sea Region of Turkey. It is hoped that reporting such results nationally and internationally will help mobilize the government to solve the identified problems. In the current study, we aimed to identify the interventions made by hospital-based nurses to address the spiritual needs of patients.

Subjects and Methods

Study group and sample size

The current study was designed to produce descriptive data for a population of nurses (n = 1765) who worked at five hospitals in the Eastern Black Sea Region of Turkey. The five hospitals provided nurses in total. No sampling was intended, and all nurses working at these five city center hospitals (university and public) were targeted between May 1st and 30th 2015. Problems related to voluntary participation, annual leave, and sick leave meant that the final population comprised 1,254 nurses, of which 343 nurses (n = 550) were from the first hospital, 400 (n = 447) were from the second hospital, 191 (n = 223) were from the third hospital, 159 (n = 228) were from the fourth hospital, and 161 (n = 317) were from the fifth hospital.

Data collection

Data were gathered by questionnaire, which was designed after a literature review, and implemented using face-to-face interviews lasting 10–15 min. The questionnaire included six questions about sociodemographic characteristics and seven questions about interventions for spiritual care. The participants were informed about the study and signed voluntary participation forms. They were reassured that the confidentiality and anonymity of their responses was guaranteed.

Data analyses

SPSS, Version 15 (SPSS Inc., Chicago, USA), was used for all statistical assessments, with number, percentage, standard deviation (SD), minimum and maximum values, frequency analyses, and Chi-square tests and Pearson's correlation used as appropriate. Statistical significance was set at $P < 0.05$.

Ethical aspects of the study

Before the study, the ethical suitability of the research was approved by the Ethical Council of the relevant medical facilities, and all participants provided informed consent verbally. This study was conducted in accordance with the Declaration of Helsinki guidelines and written informed consent for enrollment in the study was obtained from all participants.

Results

Sociodemographic characteristics

All participating nurses who responded were women and Muslim, and their mean age was 32.5 years (SD = 7.5, range = 24–47). Most nurses were married (79.6%), had one child on average (SD = 0.31, range = 0–4), and were educated to undergraduate degree level (83.6%). Although most worked as

nurses in internal medicine clinics (62.5%), some were employed as nurse managers (4.2%). Overall, 56.7% had been working in the same hospital for 19 years (SD = 4.02, range = 2–300 months). Similar proportions of nurses rated their working conditions as good or bad, at 43.2% and 56.8%, respectively. Most of them had not received any specific training on spiritual care (98.1%) [Table 1].

Distribution of variables by provision of spiritual care interventions

When spiritual care interventions were considered, it was found that nurses devoted 11.2% of daily work time to these tasks. However, most nurses did not ask about the spiritual needs of their patients (91%) and did not provide any spiritual interventions (88.8%). When asked to explain the reason for this, 7.9% of the nurses responded that they did not have the time, 46.9% said that they did not know what kind of intervention to provide, and 45.2% said that they did not need to provide spiritual care because it was not part of their role [Table 2]. Moreover, 92% of nurses felt that they did not need to talk to patients about their spiritual

Table 1: Sociodemographic characteristics

	n (%)
Age	
24-31	661 (52.6)
32-39	342 (27.2)
40-47	251 (20.2)
Marital status	
Married	999 (79.6)
Single	255 (20.4)
Number of child	
1-2	953 (75.9)
3-4	301 (24.1)
Education status	
High school	200 (15.9)
Undergraduate degree	1048 (83.6)
Postgraduate degree	6 (0.5)
Religious	
Muslim	1254 (100)
Work satisfaction	
Good	541 (43.2)
Bad	713 (56.8)
Working-length at the current department (months)	
2-81	218 (17.3)
82-161	324 (26.0)
162-300	712 (56.7)
Department where nurses worked	
Managerial position	53 (4.2)
Internal services	785 (62.5)
Surgical services	416 (33.3)
Whether or not nurses received courses on spirituality during education	
Yes	25 (1.9)
No	1229 (98.1)
Total	1254 (100)

Table 2: Spiritual care interventions provided by nurses

	n (%)
Time nurses spent for spiritual care	
Yes (10-30 min)	141 (11.2)
No (Not taking the time)	1113 (88.8)
Why is not he/she taking the time for spiritual care?	
She does not know what to do	589 (46.9)
Not taking the time for hardworking and feared	97 (7.9)
Does not need it (not included in care of patients)	568 (45.2)
Did you ever talk to patients about their spiritual emotions? (beliefs about sickness, death, sin, life after death, and responsibility toward others about faith)	
Yes	29 (2.3)
No	71 (5.7)
No need	1154 (92.0)
How do you question your patient's spiritual needs?	
I ask them to patients	23 (1.8)
I observe them and then decide	59 (4.8)
I ask them to their relatives	30 (2.4)
I do not ask	1142 (91.0)
What are your nursing interventions for spiritual needs?	
I arranged a place of worship in patient room and hospital	34 (2.7)
I introduced them prayer room of the hospital	79 (6.3)
I arranged times of religious rituals and planned nursing care	41 (3.2)
I did not do any intervention	1100 (87.8)
Did you ever support patients relatives so that their spiritual needs could be answered?	
Yes	101 (12.3)
No	1531 (87.7)
Did you ever get help from religious official of hospital?	
Yes	32 (2.5)
No	1222 (97.5)
Developed hospital protocol for spirituality?	
Yes	101 (12.3)
No	1531 (87.7)
Allow religious ceremonies	
Yes	983 (78.3)
No	271 (21.7)
To keep religious books at bedside	
Yes	1142 (91.0)
No	112 (9.0)
Private place for individual praying	
Yes	24 (2.0)
No	1230 (98.0)
How would you help patients about their troublesome situations if they had no expectations about religious beliefs?	
I would let them sing	33 (2.6)
I would call the one they most trust	350 (27.9)
I would let them alone	292 (23.2)
I would wait until they asked me for something	579 (46.3)

Table 3: Comparison of sociodemographic characteristics with interventions for patients' spiritual needs

Sociodemographic characteristics	Situation nursing intervention and time for spiritual care		Why is not she/he taking the time for spiritual care?			How do you question your patient's spiritual needs?				Did you ever talk to patient's about their spiritual emotions?			What are your nursing interventions for spiritual needs?			
	10-30 minute (yes), *n* (%)	Not taking the time (no), *n* (%)	She does not know what to do, *n* (%)	to taking the time for hard work, *n* (%)	Does not need it, *n* (%)	I ask them to patient's, *n* (%)	I observe them and then decide, *n* (%)	I ask them to their relatives, *n* (%)	I do not ask, *n* (%)	Yes, *n* (%)	No, *n* (%)	No need, *n* (%)	I arranged a place of worship in patient room and hospital, *n* (%)	I introduced them prayer room of the hospital, *n* (%)	I arranged times of religious rituals and planned nursing care, *n* (%)	I did not do any intervention, *n* (%)
Age																
24-31	65 (24.6)	596 (60.3)	257 (43.6)	32 (32.9)	231 (40.6)	7 (30.4)	15 (25.4)	9 (30.0)	630 (55.1)	7 (24.1)	26 (36.6)	628 (54.4)	9 (26.4)	21 (26.5)	9 (21.9)	622 (56.5)
32-39	37 (14.0)	305 (30.8)	200 (33.9)	40 (41.2)	237 (41.7)	7 (30.4)	25 (42.3)	9 (30.0)	301 (26.5)	9 (31.0)	12 (16.9)	321 (27.8)	11 (32.3)	10 (12.6)	9 (21.9)	312 (28.3)
40-47	162 (61.4)	89 (8.9)	132 (22.5)	25 (25.9)	100 (17.7)	9 (39.2)	19 (32.3)	12 (40.0)	211 (18.4)	13 (44.9)	33 (46.5)	205 (17.8)	14 (41.3)	48 (60.9)	23 (56.2)	166 (15.2)
Total	264 (100)	990 (100)	589 (100)	97 (100)	568 (100)	23 (100)	59 (100)	30 (100)	1142 (100)	29 (100)	71 (100)	1154 (100)	34 (100)	79 (100)	41 (100)	1100 (100)
χ^2, *P*	χ^2=19.24, *P*=0.12		χ^2=37.7, *P*=0.03			χ^2=9.87, *P*=0.02				χ^2=18.67, *P*=0.00			χ^2=16.54, *P*=0.04			
Working-length at the current department (months)																
2-81	24 (9.09)	194 (19.5)	99 (16.8)	35 (36.0)	84 (14.7)	5 (21.7)	9 (15.2)	5 (16.6)	199 (17.4)	7 (24.1)	16 (22.5)	195 (16.8)	8 (23.5)	11 (13.9)	7 (17.0)	192 (17.4)
82-161	89 (33.7)	235 (23.8)	74 (12.6)	50 (51.5)	200 (35.2)	7 (30.4)	16 (27.1)	7 (23.3)	294 (25.7)	7 (24.1)	14 (19.7)	303 (26.2)	8 (23.5)	20 (25.3)	6 (14.6)	290 (26.3)
162-300	151 (57.2)	561 (56.7)	416 (70.6)	12 (12.5)	284 (50.1)	11 (47.9)	34 (57.7)	18 (60.1)	649 (56.9)	15 (51.8)	41 (57.8)	656 (57.0)	18 (53.0)	48 (60.8)	28 (68.4)	618 (56.3)
Total	264 (100)	990 (100)	589 (100)	97 (100)	568 (100)	23 (100)	59 (100)	30 (100)	1142 (100)	29 (100)	71 (100)	1154 (100)	34 (100)	79 (100)	41 (100)	1100 (100)
χ^2, *P*	χ^2=12.07, *P*=0.02		χ^2=28.91, *P*=0.00			χ^2=16.14, *P*=0.04				χ^2=36.9, *P*=0.03			χ^2=23.4 5, *P*=0.02			
Work satisfaction																
Good	211 (79.9)	116 (11.7)	317 (53.8)	23 (23.7)	201 (35.3)	17 (73.9)	31 (52.5)	13 (43.3)	480 (42.0)	22 (75.8)	15 (21.1)	504 (43.6)	24 (70.5)	54 (68.3)	29 (70.7)	434 (39.4)
Bad	53 (20.0)	874 (88.3)	272 (46.2)	74 (76.3)	367 (64.7)	6 (26.1)	28 (47.5)	17 (56.7)	662 (58.0)	7 (24.2)	56 (78.9)	650 (56.4)	10 (29.5)	25 (31.7)	12 (29.3)	666 (60.6)
Total	264 (100)	990 (100)	589 (100)	97 (100)	568 (100)	23 (100)	59 (100)	30 (100)	1142 (100)	29 (100)	71 (100)	1154 (100)	34 (100)	79 (100)	41 (100)	1100 (100)
χ^2, *P*	χ^2=22.78, *P*=0.04		χ^2=18.09, *P*=0.01			χ^2=24.01, *P*=0.00				χ^2=24.01, *P*=0.02			χ^2=22.11, *P*=0.00			
Whether taking course or not																
Yes	18 (6.8)	7 (0.70)	5 (0.8)	6 (6.1)	7 (1.3)	5 (21.7)	6 (10.1)	8 (26.6)	6 (0.5)	7 (24.1)	6 (8.4)	12 (1.1)	7 (20.5)	6 (7.5)	5 (12.1)	7 (0.6)
No	246 (93.2)	983 (99.3)	584 (99.2)	91 (93.9)	561 (98.7)	18 (78.3)	53 (89.9)	22 (73.4)	1136 (99.5)	22 (75.9)	65 (91.6)	1142 (98.9)	27 (79.5)	73 (92.5)	36 (87.9)	1093 (99.4)
Total	264 (100)	990 (100)	589 (100)	97 (100)	568 (100)	23 (100)	59 (100)	30 (100)	1142 (100)	29 (100)	71 (100)	1154 (100)	34 (100)	79 (100)	41 (100)	1100 (100)
χ^2, *P*	χ^2=28.8, *P*=0.01		χ^2=19.19, *P*=0.03			χ^2=19.96, *P*=0.00				χ^2=12.53, *P*=0.03			χ^2=17.61, *P*=0.04			

P<0.05, yates' correction

emotions (beliefs about sickness, death, sin, life after death, and responsibility toward others about faith). Most nurses also reported that there was no hospital protocol for asking religious officials to help manage the spiritual needs of their patients (87.7%), which prevented them from obtaining help from appropriate religious officials (97.5%) [Table 2].

Most of the nurses responded that they would allow religious ceremonies if patients and their significant others wished (78.3%), and that they would allow patients to keep religious books at their bedside or to hang these books on the wall (on condition that they would inform hospital management (91%). However, 46.3% of nurses stated that they would wait until the patients asked for help or raised concerns about their troubles (if the patients had no expectations about spirituality), and most (98%) reported that no private places were provided for individual praying [Table 2].

Association between sociodemographic characteristics and spiritual care intervention

The associations between interventions made for patients' spiritual needs and nurses sociodemographic characteristics are shown in Table 3. No significant correlations were seen between supporting spiritual needs and educational level (χ^2 = 11.32, P = 0.08), marital status χ^2 = 9.11, P = 0.31), work department (χ^2 = 10.05, P = 0.07), or ages (χ^2 = 14.69, P = 0.12). However, significant correlations existed between the following: the nursing intervention situation and experience (χ^2 = 12.09, P = 0.02), work satisfaction (χ^2 = 22.78, P = 0.04), receiving training (χ^2 = 19.19, P = 0.03); not providing spiritual care and age (χ^2 = 37.7, P = 0.03), experience (χ^2 = 28.91, P = 0.00), work satisfaction (χ^2 = 18.09, P = 0.01), and receiving training (χ^2 = 19.19, P = 0.03); determining patients' spiritual needs and age (χ^2 = 9.87, P = 0.02), working length (χ^2 = 16.14, P = 0.04), work satisfaction (χ^2 = 24.01, P = 0.01), and receiving training (χ^2 = 19.96, P = 0.00); talking to patients' about emotions and age (χ^2 = 18.67, P = 0.00), working length (χ^2 = 36.9, P = 0.03), work satisfaction (χ^2 = 24.01, P = 0.02), and receiving training (χ^2 = 12.53, P = 0.03); how interventions were provided by nurses and age (χ^2 = 16.54, P = 0.04), working length (χ^2 = 23.45, P = 0.02), work satisfaction (χ^2 = 22.11 P = 0.04), and receiving training (χ^2 = 17.61, P = 0.04) [Table 3].

Discussion

Our main aim was to determine whether nurses provided interventions to meet the spiritual needs of their patients. Certainly, we found that most respondents did not perform any interventions to determine or meet the spiritual needs of their patients, and that they did not include any assessment of spiritual needs in their care plans. Many studies have mentioned that spirituality is based on lifelong experiences that are meaningful to individuals and that constitute life goals.[1,3-8,10,16,23] Spirituality protects against hopelessness and feelings of despair and facilitates coping in the face of negative situations. Therefore, assessing spiritual needs and providing appropriate intervention should be considered an important nursing role. Such care requires that nurses accurately diagnose and ask individuals about spiritual needs, ensuring that nurses understand the nature of spirituality, its role in different individuals, how they should evaluate it, and how they can use spiritual coping strategies.[1,24-26]

Strengthening the emotional health of patients, through spirituality, will increase their hopes and likelihood of compliance with treatment, potentially improving recovery rates.[18] International studies worldwide report that nursing approaches that cover spiritual care are effective in enhancing the quality of care.[27-32] Although it is clear that spiritual care improves the success of nursing interventions, domestic studies indicate that the current interventions are inadequate.[1,17,22,33-37] The findings of this study are consistent with those results, with most nurses not questioning patients about their spiritual needs. Discussing spiritual needs with significant others is an important diagnostic stage in nursing practice[1,38] and our finding that nurses did not talk to family about spiritual needs is worrying.

This study also aimed to assess the reasons why nurses did not offer interventions for patients' spiritual needs. Primarily, nurses feared to offer spiritual interventions because they either lacked any knowledge about spirituality or because they were too busy to provide care for spiritual needs. In Turkey, spiritual care is not discussed or taught sufficiently during nursing education, which was reflected in the poor competence in the study group. Other studies have shown that nurses who were insufficiently trained about the spiritual needs of patients during their academic training lacked the basic knowledge to establish appropriate care plans.[37,39] In addition, the current study showed that none of the hospitals had any protocols in place for the provision of spiritual care and that none of the clinics provided a dedicated space for individual praying or reflection. The basic scope of the caregiving process of the nursing schools and hospitals should include a holistic approach that covers unitary human concept because this approach should include not only people's religious/spiritual practices but also their earthly concepts. However, in countries where the majority of the nurses were Muslim, many studies stated

that this holistic concept is perceived only as a religious service. Therefore, the importance of spiritual care is not well understood by nurses, which results in failures in practice. In Turkey where most of the people are Muslim, there are studies that emphasize these failures of nursing.[17,19,22] Consistent with other research, even nurses who had university degrees did not provide spiritual care interventions.[17,19,22] There are numerous international studies reporting that nurses develop positive opinions about spirituality if they receive specific undergraduate and postgraduate education.[27,40-46] The authors also stress that the concept of spirituality is not discussed enough during nursing education or practice; unfortunately, the abstract nature of spiritual needs makes them difficult to notice, emphasizing the crucial role of education in providing the skills, and empathy to assess and provide appropriate care for those spiritual needs.[7,45,47-49]

This study aimed to clarify the types of interventions nurses provided for spiritual needs and to assess whether there was any correlation with the sociodemographic characteristics of nurses. However, it was evident that most nurses did nothing to meet the spiritual needs of their patients. Those who did conduct interventions reported giving patients information about where they could pray or attend services and did not talk about spirituality in terms such as disease, death, sin, life after death, and responsibilities toward others. This finding indicated that nurses perceived spirituality as providing the necessary assistance to only fulfill religious duties.

According to the available literature, it is evident that spiritual care should be integrated into holistic care,[1,3-8,10,16,17-23] and that patients whose spiritual needs are met not only show positive adaptation to disease and hospitalization but that they also have a better recovery.[24-26-28-31] However, spiritual care here refers to not only allocating patients special rooms for fulfilling religious duties but also talking to them about some concepts in relation with their religious beliefs and realizing nursing approaches accordingly. In addition, nursing interventions into patient spirituality can provide a basis for perceiving one's control over a behavior. In our study, it was identified that nurses understood spirituality insufficiently.

Interestingly, we showed that most of the nurses' spiritual care interventions were not affected by marital status, education, or place of work (medical department), but that they were affected by age and experience (years). Because nursing education emphasizes assessing individuals holistically (including spiritual care), nurses with a university education could reasonably be expected to be more professional and assertive in providing spiritual care. However, we found no statistically significant difference in spiritual care provision between nurses based on their educational level. This may be consequent on the fact that spiritual care interventions are not discussed or taught sufficiently during nurse training in our country. Indeed, the results of other relevant studies in Turkey are comparable to ours.[17,19,22] Numerous international studies, by contrast, report that nurses who receive spiritual care education as undergraduates, and who continue to get this education after graduation, develop positive opinions and practices.[27,40-46] Certainly, it is evident that the concept of spirituality is not discussed enough during nurse education or practice, and that this may only be remedied by focused education because of the abstract nature of spiritual needs.[7,45,47-49]

The studies have reported on the correlation between nurse experience (years) and their use of spiritual care interventions. Three or more years' experience can be considered important to patient care because the clinical experience is critical to the development of necessary psychomotor and technical skills used to understand patients and manage their problems.[50,51] This development is necessary for nursing professionals to establish and manage their own holistic nursing care practice, to understand patients' needs, to guide patients so that their needs are answered, to educate patients about their health-care needs, and to help patients adapt to healthy lifestyles. In other words, sufficient clinical experience is a prerequisite to being able to determine patients' spiritual needs, plan holistic care, and reduce spiritual distress. Although some studies do indicate that length of clinical experience positively affected nurses' spiritual care interventions, others do not.[17,19,22,35,45,52]

In the current study, most nurses responded that they did not talk to patients about their spiritual needs, but that they would attend to them if requested. For example, they would call a religious official if a patient asked, they would not prevent worship, and they would permit a religious ceremony if requested. However, they also stated that they would not make any interventions until patients asked them to do so, even if they saw the patient was in distress. In the literature, the authors report that talking to and listening to patients, providing patients with a comfortable setting, asking for help from religious officials, being friendly, and facilitating patients coming together with their relatives, are among the key interventions used to address the spiritual needs of patients.[18,53,54]

Florence Nightingale, who laid the foundations of holistic nursing, opined that nursing was about more than providing physical care. Indeed, she emphasized the importance of spirituality, stating "The needs of the spirit

are as critical to health as individual organs that make up the body."[12] Spiritual support is necessary because it reduces the spiritual gap and strengthens spiritual power in an individual.[47] Certainly, we conclude that the spiritual care interventions provided by nurses were insufficient to meet the spiritual needs of patients in most instances. Spiritual care is not only a basic need but also an important coping mechanism for patients and their families during health-related crises. Given that effective spiritual care can produce positive effects on recovery, it is an undeniable fact that nurses should have sufficient knowledge and experience to care for the spirituality of their patients and relatives.[1,3-8,10,16-25]

Conclusions

Our results indicate that there are, at best, very few nursing interventions directed at a patient's spiritual health during hospital care in the Eastern Black Sea Region of Turkey. Notably, nurses responded that they either did not know enough about spirituality or they were too busy to prioritize spiritual needs in care plans.

Limitations of the study

The study has several limitations. The convenience sample is not representative of Trabzon's entire nursing population, limiting the generalizability of the results.

Acknowledgments

We thank the nurses who participated in this study.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

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