Exploring Spiritual Care Services in Hospital Settings: A Multiple-Perspective Interviews Qualitative Descriptive Study

Nuridah Nuridah[1,*], Yodang Yodang[1,2]

[1]*School of Nursing, Universitas Sembilan Belas November Kolaka, Kolaka, Indonesia*
[2]*Faculty of Nursing, Chiang Mai University, Chiang Mai, Thailand*
**corresponding author: nuridah.usnkolaka@gmail.com*

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Abstract

Aims: This study explored spiritual care services in a hospital setting from multiple perspectives.

Methods: We used a descriptive qualitative method based on a social-ecological model. Participants were selected using purposive sampling and classified into intrapersonal (five patients), interpersonal (five family members), community (five nurses in charge), institutional (three nurse leaders and managers), and regulation (protocol or spiritual care guidelines). Data were collected through semi-structured in-depth interviews. Data analysis was performed to identify themes using Colaizzi's method.

Results: Themes were extracted according to the socio-ecological model, which was classified into intrapersonal, interpersonal, community, institutional, and public policy-related themes. These themes are patients' spiritual care needs, spiritual care barriers, spiritual care facilities, spiritual care support, and spiritual care regulation.

Conclusion: Current study offers insights into spiritual care services, particularly in hospitals located in rural areas. We suggest that providing spiritual care among patients and family members is crucial as part of the patients' needs while they are in the hospital. Thus, spiritual care should be considered as a priority in healthcare services by providing spiritual care facilities, support, and policies. However, many challenges in providing spiritual care must be addressed.

Keywords: barriers and challenges, health services, regulation, spiritual care, spiritual knowledge.

Introduction

Religion and spirituality are concepts that typically refer to a human's search for meaning and purpose in life and death. Spiritual care is an essential element of caring for patients. However, despite the nursing paradigm that spirituality is a fundamental part of the whole human being, it has largely been ignored in practice compared to other care dimensions (Moosavi et al., 2019). This condition affects the implementation of spiritual care services in hospitals; consequently, patients' spiritual needs are not met (Rushton, 2014).

In recent years, there has been growing evidence to support the benefits of spiritual care among patients to help them recover from and cope with life-limiting illnesses and improve their quality of life (Memaryan et al., 2020). Therefore, the provision of spiritual care in healthcare facilities should be prioritized as part of patient-centered care (Kincheloe et al., 2018). Failure to provide spiritual care that could be affected the physical, mental and spiritual of patients to have existential and spiritual distress, depression, grief, fear of future, death anxiety, and low of quality of life (Asadzandi et al., 2022; Hvidt et al., 2020). Furthermore, spiritual care can also increase patient and family satisfaction with care and health outcomes (Taylor et al., 2015).

A prior study in Turkiye reported that nearly 87% of patients believed that spiritual care is fundamental and related to religion and worship (Kırca et al., 2024). Even patients declared that spiritual care is essential; however, another study reported that nurses provide spiritual care only at an average frequency (Dündar & Aslan, 2022). A study conducted among nurses in Iran showed that 74% of nurses had unfavorable competence in spiritual care (Adib-Hajbaghery et al., 2017). In contrast, a study from Indonesia among muslim nurses found that they have high spiritual awareness and positive attitudes toward spirituality and the provision of spiritual care (Herlianita et al., 2018). In order to support spiritual care services in healthcare facilities, hospitals can create policies to implement interventions geared towards creating a spiritually friendly environment, encouraging the creation of safe places where patients, families, and healthcare professionals can freely express their spirituality regardless of preference or religious denomination (Cruz et al., 2018).

Numerous studies have been conducted on nurses, patients, and families for patient care purposes (Nuridah et al., 2022; Nuridah & Yodang, 2020). However, these studies focus on a singular perspective, and no research exists in detailing spiritual care needs from various perspectives such as patients, families, nurses, and hospital managers. To fully understand the provision of spiritual care in hospital settings, we need to identify that issue through the whole picture from different perspectives. This study used the social-ecological model to examine the interdependencies between intrapersonal, interpersonal, community, institutional, and public policies (McLeroy et al., 1988). The model allows for the exploration of multiple contributing factors to complex situations and for the identification of potential strategies for improvement in that setting (Komalasari et al., 2021). Thus, this study aimed to explore and investigate spiritual care services in a district hospital from the perspectives of patients, families, nurses, and hospital managers.

Methods

This study used a descriptive qualitative method (Braun & Clarke, 2023). This method is frequently used to describe experiences or perceptions in a straightforward manner,

particularly in areas where little is known about the topic under investigation (Sandelowski, 2010). This study was conducted in a teaching hospital in a semi-urban area of Southeast Sulawesi Province, Indonesia. Predominantly, patients who were treated in the hospital were Muslim. Meanwhile, research inquiries focus on spirituality and spiritual care from an Islamic perspective.

Participants were selected using purposive sampling methods from different backgrounds. The participants in this study were classified into five layers: intrapersonal (patients), interpersonal (family members), community (nurses in charge), institutional (nurse leaders and managers), and public policy (hospital regulation, protocol, or spiritual care guideline services).

Data collection was carried out through in-depth and semi-structured in-person interviews to answer the research questions. The duration of the individual interviews ranged from 30 to 45 minutes (mean 39.5 minutes). Interviews were conducted in a private room or a convenient place for the participants. Two topic guides were developed based on the study theme for each group, to allow comparisons across group participants. The interviews also included several questions covering sociodemographic data, including age, gender, marital status, educational background, occupation, and employment status.

The tools used during the interviews included voice recorders, field observation sheets, and interview guides. Respondents were recruited until the data were saturated. No new information or suggestions for new dimensions of theoretical categories can be obtained from interviews with additional participants (Polit & Beck, 2017).

Collected data were analyzed using Colaizzi's method (Colaizzi, 1978). It involves a systematic process of familiarizing oneself with the data, identifying significant statements, formulating meaning, clustering themes, developing exhaustive descriptions, producing a fundamental structure, and validating the findings (Wirihana et al., 2018). The method is considered rigorous and robust, enhancing the credibility and reliability of the study findings. All participants were invited to recheck and validate the data. After that, the transcript of the data was carefully read to identify and find the meaning of the significant data and to code the important statements. The last step involves defining categories, subthemes, and themes.

The rigor of the study was established through meticulous attention paid to credibility, transferability, dependability, and confirmability (Ann Cutler et al., 2021). Credibility was achieved by rigorously analyzing the data of the research team. Transferability was ensured by providing a comprehensive description of the study setting and detailed narratives of participants' experiences. Accordingly, dependability and confirmability were sustained through a meticulous audit of the methodological decisions made by the research team throughout the study.

This study followed the Helsinki Declaration as a set of ethical principles when involving humans as research participants and as a guide for researchers to prioritize the well-being and rights of participants (World Medical Association, 2025). Institutional permission and ethics committee approval (62/KEPK-IAKMI/VI/2022) were obtained to conduct this study. Participants were informed of the purpose and procedure of the

study before participation, and informed consent was obtained from those who agreed to participate.

Results

In total 18 participants evolved in this study, which classified into an intrapersonal group (five patients), interpersonal group (five family members), institutional group (three nurse leaders and managers), community group (five nurses in-charge), and public policy document. There were equal numbers in terms of gender among all participants (male=9, female=9), the age ranged from 32 to 56 with a mean score 42.2 (SD=5.56), and all patients and family members were married, while 50% of the professionals were unmarried. Nine of patients and families work in private sectors, such as farmers, self-business owners, and housewives. Eight out ten of patients and family members had low educational levels (primary and secondary schools). The majority of the professionals were female, accounting for 75%. Their ages ranged from 32 to 56 years, with a mean score 40.3 (SD=62.7), and more than 60% had a diploma educational level and permanent employment status (Table 1). All documents related to policies, guidelines, and standard operational procedures for spiritual care services were assessed. All data transcripts were analyzed using the Colaizzi method. Themes were extracted according to the socio-ecological model and then classified into intrapersonal, interpersonal, community, institutional, and public policy-related themes.

Table 1. Participants' characteristics

Participants' characteristic	Frequency	Percentage (%)
Patients and families (n=10)		
Gender		
Female	3	30
Male	7	70
Age (Mean±SD)	32-56 (44.2 ± 4.85)	
Marital status		
Married	10	100
Widowed	-	-
Level of education		
Primary school	1	10
Secondary school	7	70
Tertiary school	2	20
Employment		
Civil servant	1	10
Farmers	3	30
Self-business owner	3	30
Housewife	3	30
Professionals (n=8)		
Gender		
Female	6	75
Male	2	25
Age (Mean±SD)	32-56 (40.3 ± 6.27)	
Marital status		
Married	4	50
Not married	4	50
Level of education		

Diploma	5	62.5
Bachelor	3	37.5
Master	-	-
Employment status		
Permanent	5	62.5
Semi-permanent	3	37.5

Intrapersonal (patients)

From the patient's perspective, we identify that they have perceived spiritual care needs as important, and they are willing to implement their spirituality into religious practices, such as salating as a compulsory prayer in Islamic beliefs. As the patients argued, their statements were as follows:

“I don't pray. Yes, it would be great if the nurses helped us do our prayers.” (P1),
“I am aware that regular prayer is compulsory, and I need to offer the prayer as I wish.” (P4).

However, there is a barrier faced by patients, particularly the knowledge of how to perform compulsory prayer in a certain condition, such as being treated in a hospital. The patients’ statements are as follows:

"I don't understand praying in this condition, ma'am... it's still hard to go to the bathroom" (P1).
"I don't know... it's hard for me to pray, I can only lie down" (P2).
"I can't pray because I'm sick and dirty..., it's hard to go to the bathroom, I can only lie down like this..,”(P3).
“I don't understand how to pray when I'm sick, I still can't go to the bathroom” (P4).

Moreover, patients also reported that they faced a lack of support from nurses, particularly when they needed guidance to pray at bed. Lack of facilities, such as prayer tools. The patients reported the following:

“No nurse has ever come to guide me, ma'am..” (P1)
“Not yet, just asked to pray a lot” (P2)
“There are no nurses to guide me, only remind” (P3)
“There is no prayer equipment, the nurse just reminded me”(P4).

According to the patient's perspective, spiritual care is essential for patients since the salat is an obligatory prayer among Muslims in Islamic beliefs. However, the patients faced obstacles in implementing the prayer, such as a lack of knowledge on salat practice for ill persons and limited prayer tools, including prayer guidance. Support from nurses also needs to be improved.

Interpersonal (family members)

From the family members’ perspective, we identified challenges faced by patients in performing regular prayers while in the hospital. Family members' perceptions were as follows:

“He prays at home, but he is not doing regular pray since he admitting in the hospital, he cannot do pray” (F3).

“His condition was still weak, I also thought he wasn't clean enough to pray while he was sick, so he didn't pray” (F3).

Furthermore, family members also identified a lack of support from healthcare professionals, prayer tools, and salat guidance. Their opinions were as follows:

"If we just pray in this room..., no one will tell us where the Qibla direction is, there should be" (F4).
“There are no nurses who specifically guide prayers, only remind them. We usually have to go down from the 3rd floor to find a prayer room when we want to pray” (F3).
“There is no prayer equipment, the nurse just reminded me. We usually go down from the 4th floor to look for a mosque or prayer place that we can use” (F4).
“I have never seen nurses taking priests or Islamic scholars to patients, we invite them ourselves” (F5).

Finally, family members also have experience getting support from nurses, and their perceptions are as follows:

“Appreciative, we were allowed to be able to bring the priest into the ICU, even the nurses always reminded us to keep praying” (F5).

From the family members’ perspective, we identified themes such as internal barriers from the patients due to the lack of knowledge and external barriers from healthcare professionals due to the lack of support and facilities. However, family members feel that they receive support from nurses, even just for reminding them to do salats.

Community (nurses in charge)
From the nurses-in-charge’s perspective, we explored the ICU nurses’ perception and identified some fundamental aspects of care, including spiritual care needs for patients, the following statements mentioned as follows:

“Satisfying the spiritual needs of the patients is quite important in my opinion, sir... especially in the environment of ICU care, where the patients have already arrived at the time, the family can also strengthen their mind with the provision of this care, sir.” (N1).

There are some barriers faced by nurses, such as lack of time, lack of knowledge, working overload, and lack of competence to offer services. Nurses’ perceptions were as follows:

"At the moment it's not working, sir, because the nurses are quite busy..., we are just waiting for the patient's family to come to us if they want to be called by a chaplain, we can only facilitate them to get that opportunity." (N1),
"We don't really understand how spiritual care is implemented, sir..., so we as nurses only facilitate and advise families to pray a lot." (N3),
"At the moment, there is no specific spirituality provided by the hospital, and the competence of nurses in the implementation of spiritual care to patients is still not maximum."(N4).

The nurses in charge identified the challenges in implementing spiritual care services within the hospital, such as a lack of support and a lack of control and monitoring from nurse leaders. The statements are as follows:

"Actually, there is a spiritual care form provided, but we haven't implemented the application because we don't fully understand how it is implemented." (N2).
"I don't think there is yet if what is meant is worship equipment, because we only provide the assessment form, but the application is not yet running" (N5).

The nurses in charge identified the challenges in implementing spiritual care services within the hospital, such as a lack of support from hospital management. Support for spiritual care services was identified as promising and facilitating clergy or religious scholars to attend prayers based on family requests. The statements are as follows:

"Actually, we are also confused, because there must be support from the management regarding guidelines for implementing worship, but we don't have it yet, sir." (N1).
"So far this has only been limited to that, sir..., we just advise the patient to call a clergyman from outside, or if the patient is dying, we suggest that the family talk to him, there are no specific treatment guidelines for this yet." (N2).

Institutional (nurse leaders and managers)
From the nurse leaders' and managers' perspectives, we identified some points of view, such as spiritual care needs, the statement is mentioned as follows:

"Spiritual care is very important, because the patient must be motivated by that spiritual, because the nurse must actually motivate the patient". (NL3).

Nurse leaders and managers also perceived a lack of training for nurses, facilities, and resources such as guidelines or books for spiritual care services. The statements are as follows:

"Only with us... there are no special guidelines regarding spiritual care, there is no special training for nurses, we are still working on improvements for future accreditation" (NL1).
"Here... the obstacles may not be maximum because of the different levels of awareness and understanding of nurses, let alone there is no special training related to it." (NL2).
"At the hospital it is not yet running, individual patients are not being cared for, our nurses don't have anyone who specifically motivates us for spiritual care," we are also constrained by time due to other activities." (NL3).
"As for facilities... we only have what we have, even in this room itself, such as guides, prayer books, and worship equipment such as women's prayer garments, but they are still very lacking." (NL2).

The nurse leaders' and managers' perspectives were perceived as limited support they could offer to nurses; they only encouraged nurses to provide such care to patients. The statements are as follows:

"The support that can be provided is limited to motivating nurses in providing maximum service to patients, including fulfilling their spiritual care needs." (NL1).
"Support from management is only limited to a support system by improving services to patients; there is nothing specific about spiritual care." (NL2).

“There has been no training, just motivation. The nurse only advised the family to bring it from outside" (NL3).

Nurse leaders and managers identify some hopes for improvement. They pointed out, such as training for nurses and policies related to spiritual care services.

"In the future, hospital management should provide training for spiritual care among nurses as they are needed to improve their capabilities in spiritual care services” (NL1).
"Waiting for a training call from above if there is training to be followed, but until now there hasn't been any" (NL2).
"The management policy is already in place for accreditation, but it's just not optimal" (NL3).

Discussion

In this study, we identified that there is no regulation for spiritual care implementation in hospitals. Even in this study, we found a spiritual form as part of the patient assessment form; however, spiritual assessment seems likely to be ignored. There is a lack of support for spiritual care regulation. The study identified that regulation is still in progress and only a part of the accreditation assessment. From the above findings, we elaborate and group into five themes: patients’ spiritual care needs, spiritual care barriers, spiritual care facilities, spiritual care support, and spiritual care regulation.

To the best of our knowledge, this is the first study conducted in Indonesia to focus on spiritual care issues from multiple perspectives. The study involved patients, families, nurses in charge, nurse leaders, and managers to explore spiritual care services in a hospital setting. There are some thematic points of view found in this study, such as spiritual care needs, spiritual care barriers, spiritual care facilities, spiritual care support, and spiritual care regulation. This study may stem from an Islamic viewpoint since all the informants and participants were Muslim.

Spiritual care is not limited to terminal or end-of-life care and is an essential component of basic patient rights. Therefore, it is crucial to explore and identify the spiritual care needs of patients, families, and health care professionals points of view (Willemse et al. 2018). Furthermore, the study reported that patients and their relatives shared their philosophy of life regarding spirituality, including the role of spirituality in coping with illnesses. This study also agrees that spiritual care needs are patients' rights and consent, as with the majority of informants. Another scholar also points out that spiritual care is an essential element in human healing, and spiritual needs increase during crises of human life; thus, spiritual care will help individuals encounter the transcendent meaning of their crises (Rhyu et al., 2023). A prior study conducted in Iran reported that spiritual care needs are important among patients, and that they regularly perform religious rituals, meaning, hope, care, and respect (Özveren et al., 2022). This study was conducted in a region where the majority of the population and participants were Muslims. According to Islam, an illness is a trial and divine hardship that can abolish one’s sins and purify one’s soul, with God being the only source of cure for impairments.

The barriers in the provision of spiritual care that we found and identified in this study among the nurses in charge were lack of knowledge, lower confidence, and unfamiliarity with the services. Another study reported that there are some barriers to providing spiritual care services in a clinical setting among nurses, such as insufficient

confidence, knowledge, and skills (Rhyu et al., 2023). In this study, we found that nurses, nurse in-charges, and nurse leaders and managers had a diploma educational background. This educational background affects the students' knowledge, skills, and competence in spiritual care. A prior study in Turkiye found that nurses with a bachelor's degree had a higher perception of spiritual care than nurses with an associate's degree and vocational school background (Bakir et al., 2017).

Further, scholars have also identified that poor working conditions, such as high job demands, lead to lower quality spiritual care in practice. This finding is also in line with our study's result that nurses claim they are too busy with their regular tasks; consequently, they tend to ignore offering spiritual care services to patients. Moreover, most nurses claimed that they had insufficient knowledge and skills to provide spiritual care services due to a lack of training. A study conducted in Ethiopia reported that training is substantially associated with spiritual care competencies among nurses. Training in spiritual care increased spiritual care competencies by 0.3 times compared with those who did not receive any training in spiritual care (Seid & Abdo, 2022). Nurses who are knowledgeable about spirituality and spiritual care tend to have good perceptions of spirituality and spiritual care (Bakir et al., 2017). However, even though nurses were trained in spiritual care, they were unable to meet their patients' spiritual care needs because of the intensive work environment and personal insufficiency (Toker & Çınar, 2018). This means that the working workload also affects the ability of nurses to provide such services to patients.

All informants and participants claimed that spiritual care facilities in hospitals were lacking and insufficient. As patients reported that there is no direction for the qibla, this makes the patient feel unconfident about praying. In addition, equipment was also limited, such as prayer mats, women's prayer garments, the Quran, and prayer guide books. Providing spiritual care support enhances and boosts patients' hopes and quality of life. Spiritual care support not only has a positive effect on psychological problems but also spiritual distress (Khezri et al., 2022). Interestingly, the need for nurses to arrange for a chaplain or religious scholar to visit patients and family members was the preferred practice in the current study. This finding is also in line with a study that reported that families are encouraged to choose a person or a chaplain to provide spiritual support, as it is probably the spiritual care skills of the person that inform their choice, rather than the profession of the person (Zambezi et al., 2022). Similar to a previous study from Turkiye, it was found that the most frequently provided type of spiritual care remained with a patient after completing a task to show caring, offer to pray with a patient, and listen to the patient's spiritual concern (Dündar & Aslan, 2022).

A more contemporary view is that spiritual care is part of the human psyche and consequently forms part of human care, as well as society, families, patients, and healthcare professionals. Furthermore, patients' reliance on spiritual care increases during life-altering conditions such as a serious illness (Mahilall & Swartz, 2021). However, while many healthcare professionals recognize the value of spiritual care interventions for their patients, many feel inadequate in providing that care themselves. This study found that the majority of nurses, even nurse leaders and managers, poorly recognized spiritual care because of the lack of support and regulation of spiritual care services. The nurse leaders reported that spiritual care is just embedded in regular assessment for patients without providing sufficient and proper facilities for patients and family members and guidance for all healthcare professionals, including nurses.

The findings of this study indicate that even though most informants and participants were aware of spiritual care, some issues should be addressed to provide spiritual care services among patients and family members. The hospital lacks formal regulations or procedures for spiritual care, making the implementation inconsistent. Most nurses do not receive spiritual care training during their work, which affects their confidence and competence. Indonesia, as a pluralistic society, requires sensitive and inclusive approaches to spiritual care in order to respect various beliefs. To solve these issues, there are some strategies that may benefit, such as establishing guidelines and integrating spiritual care into regular standard operational procedures, incorporating the spiritual care module into nursing education, offering ongoing workshops to improve competence, collaborating with religious leaders and local organizations to ensure culturally appropriate care, and raising awareness among patients. Then, using tools like the Nurse Spiritual Care Therapeutics Scale to assess the frequency and quality of spiritual care provided

Limitations

This study focused only on spiritual care from an Islamic perspective, as almost all nurses and patients admitted to the hospital were Muslim. Identifying spiritual care from other religious backgrounds is needed to provide spiritual care services for all patients who are treated in hospitals, as the Indonesian government has approved that there are six official religions within the country.

Contribution to global nursing practice

The findings of this study offer new insights into the provision of spiritual care in a hospital setting from various perspectives, particularly from the Islamic religion. Indonesian nurses often incorporate Islamic principles into care, such as facilitating prayer, which demonstrates how religious sensitivity can be harmonized with clinical protocols and offers blueprints for faith-based care worldwide. The hospital in Indonesia serves patients from various ethnic and religious backgrounds who require nurses to be culturally and spiritually agile. This could lead to the development of multi-faith care frameworks, which can be adapted to other pluralistic societies. Finally, the findings support the global movement toward measuring and improving spiritual care outcomes in nursing.

Conclusion

The spiritual care issues in a hospital setting, from multiple perspectives, we identified five important themes related to spiritual care in a hospital setting, such as spiritual care needs, spiritual care barriers, spiritual care facilities, spiritual care support, and spiritual care regulation. This study offers insights related to spiritual care services, especially in hospitals located in rural areas. We suggest that providing spiritual care to patients and family members is crucial as part of the patient's needs while they are in the hospital.

Author Contribution

All authors contributed equally to this study.

Conflict of interest

We declare that there is no conflict of interest in this study

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