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Research Article

The Relationship between Spiritual Health and Spiritual Care Competencies in Nurses: A Cross-Sectional Study

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Abstract

The aim of this study is to explore the relationship between spiritual health and spiritual care competencies among nurses. A cross-sectional study was conducted with nurses employed at a hospital in 2022 (n=205). Data were collected using the "Socio-demographic Information Form," "Spiritual Health Scale-Short Form," and "Spiritual Care Competence Scale-Turkish." The study found that nurses exhibited a moderate level of spiritual health and spiritual care competence. Nurses with higher levels of education and those who had undergone courses or training in spiritual care demonstrated higher levels of spiritual health and spiritual care competencies. A significant correlation was observed between spiritual health and spiritual care competence. Factors such as increased spiritual health, age, level of education, years of professional experience, and participation in religious activities were identified as predictors of enhanced spiritual care competence among nurses. These findings suggest that nurses' spiritual care competence is influenced by their levels of spiritual health. Based on the study results, it is recommended to incorporate educational and consultancy services aimed at enhancing and developing spiritual health (including assessing and supporting spiritual needs) into the curriculum for nursing students, as well as organizing educational seminars for practicing nurses.

Keywords:
Spiritual health • Spiritual care competence • Nursing education • Nurses

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Introduction

Spiritual health is acknowledged as a fundamental dimension of overall health. It positively influences not only individuals' mental health and emotional well-being but also their physical, mental, and social dimensions (Cone & Giske, 2022; Jaberi et al., 2019; Sadat Hoseini et al., 2019). The theoretical framework of the concept of spirituality is generally defined as the sum of beliefs, cultural systems, and world views, and includes the concept of religion. The concept of religion is an organized system of belief and worship defined as the individual's desire to find meaning and value in life (Sadat Hoseini et al., 2019). Spirituality is a broader concept than religion and encompasses all existential aspects of an individual's life (Ghorbani et al., 2020; Sadat Hoseini et al., 2019). Spiritual health concept includes a purposeful life, transcendence and actualization of different dimensions and capacities of human beings. Spiritual health creates a balance between physical, psychological, and social aspects of human life (Jaberi et al., 2019). Studies have found that spiritually healthy individuals have higher levels of hope, self-esteem, happiness, mental well-being and well-being, cope with stress better, and have a higher quality of life. The concept of spirituality, which is so important, has taken its place in the health system as spiritual care. Spiritual care is defined as nurses taking interventions to meet the spiritual needs of their patients and evaluating this process (Ghorbani et al., 2021; Willemse et al., 2020). Although spiritual care had been overlooked in nursing care in the past (Alshehry, 2018), more attention has been given to the spiritual care needs of patients in recent years (Jaberi et al., 2019). Both national and international nursing organizations (American Nurses Association, 2022; ICN, 2012) emphasize that nurses are responsible for providing spiritual care (Hu et al., 2019). Spiritual care in nursing is defined as activities and procedures that improve patients' spiritual quality of life and spiritual well-being (Adib-Hajbaghery et al., 2017).

Addressing these needs and applying interventions to address them can contribute to patients' recovery processes and coping skills (Wu et al., 2015; Ghorbani et al., 2021). Spiritual care interventions applied to the patients by the nurses can be categorized in different ways such as providing religious materials to the patients, supporting patients' religious activities (i.e. prayer), referring patients to spiritual counsellors, or helping patients communicate with people valuable to them (Willemse et al., 2020; Ghorbani et al., 2021). Spiritual care may be necessary for all patient groups during hospitalization. Addressing these needs through appropriate interventions can significantly contribute to patients' recovery processes, enhance their coping skills, and improve their health-related quality of life. Research indicates that spiritual care positively impacts patients' recovery (AdibHajbaghery et al., 2017). Because it is required for nurses to have spiritual care competence for them to provide good spiritual care (Heidari et al., 2022). Spiritual care competence is the ability to have a

high awareness of the patient's values, show an empathetic approach to worldviews and develop individual interventions specific to each patient (van Leeuwen et al., 2009). While spiritual care competence includes a set of knowledge, skills and attitudes that enable nurses to practice holistic care in their care behaviours, spiritual care behaviours are closely related to their spiritual health (Heidari et al., 2022).

Spiritual health is associated with the meaning and purpose of life, transcendence, faithfulness, and interconnectedness, and constitutes an essential dimension of holistic being (Jaberi et al., 2019). Spiritually healthy nurses can better help patients by providing spiritual care (Chiang et al., 2021). Spiritual health serves as an empowering factor for nurses in delivering spiritual care. Beyond enhancing their ability to provide effective spiritual support, spiritual health contributes to personal and professional outcomes, including happiness, resilience, improved quality of life, enhanced job performance, and reduced burnout (Chiang et al., 2021; Akbari et al., 2018). Studies noted that nurses' own spiritual health might influence their awareness of the spiritual needs of their patients and their ability to provide spiritual care to them (Heidari et al., 2022; Jafari et al., 2021). The spiritual health of nurses plays a crucial role in the effectiveness of spiritual care interventions within care settings. Nevertheless, there remains a scarcity of literature examining how the spiritual health of nurses impacts the delivery of spiritual care (Atashzadeh-Shoorideh et al., 2017; Chiang et al., 2016; Chung et al., 2007; Hu et al., 2019; Yari et al., 2018). In the studies conducted in Iran and China, significant positive relationships were found between nurses' spiritual well-being and their spiritual care competencies (Jafari et al., 2021; Heidari et al., 2022; Hu et al., 2019; Wang et al., 2022). It is very important for nurses to have spiritual care competencies in terms of quality of care. Strategies to increase spiritual care competencies in health professionals have recently continued with increasing interest (Han et al., 2023; Kurtgöz et al., 2023; Manookian et al., 2023). This study is based on the idea that spiritual health is a potential factor in increasing spiritual care competence among nurses and may therefore aid interventions to increase spiritual care competence. From this perspective, the spiritual well-being of nurses can make significant contributions to the development of new strategies to increase the spiritual care competence of nurses, especially by making critical care environments such as intensive care, palliative, and oncology less stressful and less challenging. Therefore, to increase awareness of spiritual health for nurses and develop care competence, it is important to identify different individual and/or external potential factors associated with nurses' ability to provide spiritual care. However, in our country, no relationship has been found between nurses' spiritual health and spiritual care competence. The purpose of this study, it was aimed to examine the relationship between the spiritual health and spiritual care competence of nurses.

Method

Study Design, Setting and Sample

The study design is quantitative, correlational survey. A correlational research design investigates relationships between two variables (or more) without the researcher controlling or manipulating any of them. The study population consisted of nurses from a hospital (public hospital) located in western Turkey. The sample consisted of nurses who met the inclusion criteria which were as follows: (1) practicing the nursing profession for more than 6 months, (2) working full-time in the clinic, and (3) agreeing to participate in the study. The exclusion criteria from the study were (1) working in units such as an outpatient clinic or operating room. For the research, a two-tailed hypothesis was formulated, and the sample size was calculated using G*Power 3.1.9.7. In the calculation, the correlation value of 0.264 obtained from the study conducted by Jafari et al. in 2021 was used as a basis, and for a correlation analysis with a 5% error margin (α=0.05), a correlation value of 0 for h0, and a power of 89.5%, the required sample size was calculated to be at least 150 individuals. The convenience sampling method was used in this study. The study was completed with a total of 205 nurses who met the inclusion criteria.

Data Collection Tools

Socio-demographic information form, Spiritual Health Scale-Short Form and Spiritual Care Competence Scale were used as data collection tools in the study.

Socio-demographic information form: The form was prepared by the researchers by screening the literature. This form consists of 8 questions including the age, gender, marital status, income level, education level, attending religious activities, and the status of having training or taking training courses about spiritual care (Jafari et al., 2021; Heidari et al., 2022; Wang et al., 2022).

Spiritual Health Scale-Short Form (SHS-SF): The SHS-SF, which was developed by Hsiao et al. (2013), is used to measure spiritual health among nursing students. The scale consists of a total of 24 items and five sub-dimensions. Turkish validity and reliability studies of the scale were performed by Kartal et al. (2022). The sub-dimensions were the connection to others, meaning derived from living, transcendence, religious attachment, and self-understanding. All the items included in the scale were positive statements. Individuals were asked to answer each item by selecting from a range of completely disagree (1) to completely agree (5) on a 5-point Likert-type. The scores of the Turkish SHS-SF ranged from 24 to 120, with a higher score indicating better spiritual health. The Cronbach's alpha value of the total scale was 0.91, and it was 0.83, 0.86, 0.86, 0.92 and 0.77 for the sub-dimensions, respectively. The Goodness of fit indices of the scale were as follows: $x^2/(df)= 2.39$,

RMSEA= 0.067, CFI= 0.92, TLI= 0.91, IFI= 0.92. In our study, the Cronbach alpha value of the scale was found to be 0.91.

Spiritual Care Competence Scale (SSCS-T): This scale, which was developed by van Leeuwen et al. (2009) in the Netherlands, measures students' perceptions of their competence in providing spiritual care (Van Leeuwen et al., 2009). The validity and reliability studies of the Turkish version were conducted by Dağhan et al. (2019). It is a 5-point Likert-type scale ("strongly disagree=1, "strongly agree"=5). The scale consists of 27 items and three sub-dimensions which are the evaluation and implementation of spiritual care, professionalization in spiritual care and patient counselling, and attitudes towards the patient's spirituality and communication. The highest possible competence score that can be achieved is 135, and the lowest possible score is 27. A high score shows that perceived competence related to spiritual care is high. The Cronbach α coefficient was found to be 0.97 in the validity and reliability studies of the Turkish scale. Cronbach's alpha coefficients of the three-factor scale were .94 for the first factor, .96 for the second factor, and .97 for the third factor. While the Spearman-Brown coefficient was .88 for the whole SCCS-T, it was .93, .89, and .96 for the first, second, and third factors, respectively. The goodness of fit indices of the scale were $x^2/(df)$= 3.86, RMSEA= 0.099, GFI= 0.76, CFI= 0.98, NNFI= 0.98, and IFI= 0.98. In our study, the Cronbach alpha value of the scale was found to be 0.95.

Data Collection Process

First, information about the purpose and content of the study was given to the participants. Before they filled out the data collection tools, their informed consent was obtained. The data were collected through the face-to-face interview technique in the hospital between 20th October to 30th December 2022. Filling out the data collection tools took about 30 minutes.

Data Analysis

The data were analysed using the Statistical Package for the Social Sciences (SPSS) version 22.0. The normality of the data was examined using the Kurtosis and Skewness values. In this study, parametric tests were used because SHS-SF and SSCS-T fit normal distribution (Skewness/Kurtosis value for SHS-SF= -0.358/0.450; Skewness/Kurtosis value for SSCS-T= 0.256/0.842). According to this test, it was determined that the data were suitable for normal distribution (p>0.05). Therefore, parametric tests were used in the study. Descriptive statistics including mean data, standard deviations and percentages were used to present the demographic data and the spiritual health and spiritual care competence scores. Independent Sample t-test and the Bonferroni corrected One-way ANOVA tests were used to determine the relationship between

mean spiritual health and spiritual care competence scores and socio-demographic characteristics of nurses. Linear regression analysis was carried out to determine the predictors affecting spiritual health and spiritual care competencies.

Results

Participant characteristics

The mean age of the participants was 31.90±1.10 years. The mean year of clinical experience of the participants were 9.96±8.22 years. In the study, 23.40% of the nurses' work in surgical units, 22.00% in internal medicine, and 21.50% in intensive care units. Many of the nurses were women (89.3%), married (59.0%) and bachelor's degree (67.80%). Many of the participants 67.80% were engaging in religious activities (prayer, fasting, etc.), and 19.00% were taking courses/training on spiritual care (Table 1).

Table 1.
Demographic Characteristics of the Participants (n= 205)

Characteristics	*n (%)*	*Mean ± SD*
Age (year)		31.90±1.10
Year of occupation		9.96±8.22
Gender		
Female	183 (89.3)	
Male	22 (10.70)	
Clinic		
Surgical clinics	48 (23.40)	
Internal medicine clinics	45 (22.00)	
Intensive care unit	44 (21.50)	
Palliative clinic	16 (7.80)	
Neurology clinic	15 (7.30)	
Oncology clinic	14 (6.80)	
Obstetrics clinic	10 (4.90)	
Pediatric clinic	9 (4.40)	
Psychiatry clinic	4 (2.00)	
Marital status		
Married	121 (59.0)	
Single	84 (41.0)	
Education level		
High school degree	13 (6.30)	
Associate degree	17 (8.30)	
Bachelor degree	139 (67.80)	
Master/doctoral degree	36 (17.60)	
Income		
Income less than expense	34 (16.60)	
Income equals expense	131 (63.90)	
Income more than expense	40 (19.50)	
Engaging in religious activities (prayer, fasting, etc.)		
Yes	139 (67.80)	
No	66 (32.20)	
Taking courses/education on spiritual care		
Yes	39 (19.00)	
No	166 (81.00)	

SD= Standard Deviation

Spiritual health and spiritual competence levels of the nurses

In this study, the SHS-SF mean score was 93.81±12.19 while the SCCS-T mean score was 105.45±17.10. Nurses' SHS-SF and SCCS-T levels were found to be moderate (Table 2).

Table 2.
Spiritual Health and Spiritual Competence Levels

Scale and subscales	*Mean± SD*
SHS-SF	93.81±12.19
Connection to others	17.29±2.89
Meaning derived from living	25.01±4.03
Transcendence	22.02±3.22
Religious attachment	16.73±3.22
Self-understanding	16.96±2.75
SCCS-T	105.45±17.10
Evaluation and Practice of Spiritual Care	23.17±4.97
Professionalism and Patient Counseling in Spiritual Care	56.61±10.34
Attitude and Communication of the Patient towards Spirituality	25.66±4.24

SD= Standard Deviation
SHS-SF= Spiritual Health Scale-Short Form, SCCS-T= Spiritual Care Competence Scale-Turkish

Spiritual health and spiritual competence between relationship

In this study, there is a positive and moderately significant relationship between SHS-SF and SCCS-T (r=0.534; p=0.000). In addition, a significant relationship was found between the total scales and their subscales (Table 3).

Table 3.
Spiritual Health and Spiritual Competence between Relationship

	SSCS-T	EPSC	PPCSC	ACPTS
SHS-SF	0.534***	0.450***	0.484***	0.479 ***
Connection to others	0.464***	0.439***	0.337***	0.532***
Meaning derived from living	0.546***	0.465***	0.513***	0.406***
Transcendence	0.270***	0.171*	0.265***	0.243**
Religious attachment	0.271***	0.202**	0.251***	0.243**
Self-understanding	0.470***	0.429***	0.412***	0.387***

SHS-SF= Spiritual Health Scale-Short Form, SCCS-T= Spiritual Care Competence Scale-Turkish, EPSC= Evaluation and practice of spiritual care, PPCSC = Professionalism and patient counseling in spiritual care, ACPTS= Attitude and communication of the patient towards spirituality, * p < .05, ** p < .01, *** p < .001

Relationship between socio-demographic characteristics and spiritual health, spiritual care competence scores

The mean SCCS-T score of female nurses were found to be significantly higher than male nurses (106.56 vs 94.22±16.88). Nurses working in intensive care unit, pediatrics, and obstetrics clinics have been found to have higher scores on both SHS-SF and SCCS-T total scales (p<0.05). Undergraduate and master/doctoral graduates had a higher SHS-SF and SCCS-T mean. The SHS-SF mean score of the nurses who

participated in religious activities was found to be higher. The SCCS-T score of the nurses who received a course/training about spiritual care was higher (p<0.05). There was no difference between the groups in terms of other variables (p>0.05) (Table 4).

Table 4.
Investigation of Spiritual Health and Spiritual Care Competence Scores in terms of Socio-demographic Characteristics

Characteristics	*SHS-SF*	*SCCS-T*
Gender		
Female	94.29±12.09	106.56±16.88
Male	89.86±12.59	94.22±16.44
t- test	1.616 p=0.108	2.720 p=0.007
Clinic		
(1) Surgical clinics	99.22±10.83	105.52±15.50
(2) Internal medicine clinics	92.24±16.46	97.06±18.88
(3) Intensive care unit	101.81±10.49	111.522±15.22
(4) Palliative clinic	97.18±10.22	108.81±15.47
(5) Neurology clinic	92.60±13.22	95.00±14.90
(6) Oncology	99.78±10.02	105.28±15.11
(7) Obstetrics clinic	103.00±6.87	112.50±10.87
(8) Pediatric clinic	104.77±13.82	118.55±17.81
(9) Psychiatry clinic	97.50±12.36	111.50±14.70
Anova	2.753 p=0.007 2 vs 3<0.05 3 vs 5<0.05	4.235 p=0.000 2 vs 3<0.05 3 vs 5<0.05 5 vs 8<0.05
Marital status		
Married	93.32±12.31	106.79±16.22
Single	94.53±12.06	103.52±18.21
t- test	-0.699 p=0.485	1.349 p=0.179
Education level		
(1) High school degree	94.30±9.56	108.46±13.44
(2) Associate degree	87.35±20.54	102.47±23.38
(3) Bachelor degree	92.75±11.03	102.37±15.12
(4) Master/doctoral degree	100.80±9.38	117.66±17.08
Anova	6.350 p=0.000 1 vs 3<0.05 2 vs 4<0.05 3 vs 4<0.05	8.843 p=0.000 2 vs 4<0.05 3 vs 4<0.05
Income		
(1) Income less than expense	95.85±10.42	102.64±14.48
(2) Income equals expense	93.09±12.99	105.55±17.35
(3) Income more than expense	9.45±10.84	107.50±18.35
Anova	0.752 p=0.473	0.745 p=0.476
Engaging in religious activities		
Yes	95.33±12.28	105.25±17.02
No	90.62±11.46	105.86±17.38
t- test	2.624 p=0.009	-0.236 p=0.814
Taking courses/trainings on spiritual care		
Yes	96.48±7.82	110.74±16.51
No	93.19±12.95	104.21±17.04
t- test	1.522 p=0.043	2.166 p=0.031

Note. F= One-way ANOVA, Bonferroni, SHS-SF= Spiritual Health Scale-Short Form, SCCS-T= Spiritual Care Competence Scale-Turkish, t= Independent sample t-test <0.05

Predictors affecting spiritual health and spiritual care competence levels in nurses

According to the results of Table 4, multiple linear regression analysis was performed to determine the common effects of the variables that were found to cause differences in the spiritual health and spiritual care competence levels of nurses. The predictors affecting the spiritual health and spiritual care competence level of nurses are shown in Table 5.

Table 5.
Predictors Affecting Spiritual Health and Spiritual Care Competence Levels in Nurses

	Independent Variables	*B*	*SE*	*Beta (β)*	*t*	*p*	*F*	*Model (p)*	R^2	*Durbin Watson*
SCCS-T	Constant	67.952	13.71	-	4.956	0.000***	18.008	0.000***	00.390	2.243
	SHS-SF	0.671	0.083	0.478	8.080	0.000***				
	Age	1.326	0.438	0.583	2.896	0.004**				
	Gender (female)	3.748	3.194	0.068	1.173	0.242				
	Education level (Master/doctoral degree)	9.148	2.655	0.204	3.445	0.001**				
	Year of occupation	1.402	0.420	0.674	3.334	0.001**				
	Engaging in religious activities (yes)	4.184	2.078	0.115	2.013	0.045*				
	Taking courses/ training on spiritual care (yes)	4.181	2.474	0.096	1.690	0.093				
SHS-SF	Constant	92.547	9.721	-	9.520	0.000***	4.390	0.000***	0.117	1.777
	Gender (female)	3.136	2.725	0.080	1.151	0.251				
	Age	0.276	0.392	0.170	0.705	0.482				
	Education level (Master/doctoral degree)	8.081	2.199	0.253	3.674	0.000***				
	Year of occupation	0.228	0.360	0.154	0.635	0.526				
	Engaging in religious activities (yes)	4.709	1.747	0.181	2.695	0.008**				
	Taking courses/ training on spiritual care (yes)	2.069	2.113	0.067	0.979	0.329				

Note. SE= Standard error of coefficient, β= standardized regression coefficient, R^2= proportion of variation in dependent variable explained by regression model, p= the level of statistical significance, * p < .05, ** p < .01, *** p < .001

The predictors that affect the spiritual health of nurses were found to be education level (β=0.253) and engaging in religious activities (β=0.181). The predictors that affect the spiritual care competence of nurses were found to be spiritual health level (β=0.478), age (β=0.583), education level (β=0.204), year of occupation (β=0.674) and engaging in religious activities (β=0.115).

Discussion

This study was conducted to reveal the relationship between nurses' spiritual health level and their spiritual care competencies. As a result of the study, a positive correlation was found between spiritual health level and spiritual care competencies. The spiritual health of the nurses in this study was determined to be at a moderate level. We could not come across any similar study that was conducted on nurses in Türkiye. Studies in which the same scale was used in different countries revealed that the spiritual health level of nurses was at a moderate level, similar to our findings (Chiang et al., 2021; Wang, et al, 2022; Zhao et al., 2022; Wang et al., 2021). These results reveal that spiritual health affects spiritual care competence. Since spiritually healthy nurses will increase their competency in providing spiritual care, the quality of care will also increase. Therefore, interventions that increase the spiritual health levels of nurses should be planned.

In our study, nurses' spiritual care competence levels were determined to be above a moderate level. Studies conducted in T**ürkiye** on the topic show that the spiritual care competence levels of nurses are generally moderate or above (Karaman, & Sagkal Midilli, 2022; Semerci et al., 2021; Irmak, & Midilli, 2021; **Özakar** Akça et al., 2022; Kalkim et al., 2018; Sezer, & Ozturk Eyimaya, 2022). Our findings and the literature indicate that especially nurses' spiritual care competence levels are not at the desired level and should be improved. In their study, Ross et al. (2018) revealed that students' perceptions of spiritual care competence increased with spiritual care training. Similarly, Hu et al. (2019) also noted that the spiritual care competence of nurses who received spiritual care training increased. The fact that nurses' spiritual care competencies are at a moderate level may be related to the fatigue and burnout caused by working in the profession for many years.

In our study, there was a positive significant relationship between spiritual health and spiritual care competence and spiritual health was determined to be an important predictor of spiritual care competence. In the study of Heidari et al. (2022) on the subject, a significant relationship was found between spiritual health and spiritual care competence. Also, the spiritual health-related performances of nurses have been determined to predict their spiritual care competence (Heidari et al., 2022). Furthermore, other studies have determined that there is a significant relationship between spiritual health and spiritual care competence (Jafari et al., 2021; Wang et al., 2022). Heidari et al. (2022) and Jafari et al. (2021) noted that nurses' own spiritual health might affect their awareness of the spiritual needs of their patients and their ability to provide spiritual care to them.

In this study, it is seen that female nurses have higher spiritual care competence levels than males. This result is largely similar to the findings in the literature (Jafari,

& Fallahi-Khoshknab, 2021; Melhem et al., 2016; Kaçmaz, & Çam, 2019). Kaçmaz and Çam (2019) states that female nurses practice skills such as establishing helpful relationships and expressing emotions more than male nurses. Similarly, in the study conducted by Heidari et al. (2022) and Melhem et al. (2016) the spiritual health and spiritual care competence of female nurses were found to be higher. The fact that the female gender has these characteristics can be associated with the fact that women's awareness levels are better than male nurses in the planning and implementation of spiritual care. It was emphasized in the literature that females are more successful in expressing their feelings, understanding the feelings of others, and are more compassionate and sensitive to the needs of others (Löffler, & Greitemeyer, 2021).

In the literature, increasing the education level of nurses and receiving courses/ training on spiritual care are important determinants of spiritual health and spiritual care adequacy (Green et al., 2020; Harrad et al., 2019; Ross et al., 2018). In a study conducted with nurses who care for psychiatric patients, it was determined that as the education level of nurses increased, nurses perceived themselves more competent in nursing care for dimensions such as hope, sensitivity, and spirituality and were able to apply care better (Kaçmaz, & Çam, 2019). In a study examining the spiritual care levels of Turkish nurses, it is stated that nurses with postgraduate education have a higher level of spiritual care than nurses with undergraduate education (Karaman et al., 2022). Many researchers state that there is a need for training in spiritual care to increase the spiritual care competence of nurses (Cooper, & Chang, 2016; Green et al., 2020; Ross et al., 2016). In one study, it was determined that nurses who received spiritual care education at the hospital had higher spiritual care competence than those who did not (Green et al., 2020). In addition, it was determined that nurses who received spiritual care education at the workplace and stated that they felt ready to provide spiritual care received higher scores in "evaluation of spiritual care, practice, professionalization and improving the quality of spiritual care. Wu et al. (2016) stated that nurses who attend spiritual care classes as a part of their nursing education are more willing to provide spiritual communication and spiritual care with their patients than those who do not attend such courses. In another similar study, it was determined that educating health professionals about spiritual care was effective in improving the competence of nurses to provide spiritual care to patients (Hu et al., 2019). These studies show the need for a structured and comprehensive education/course on spirituality and spiritual care both in the curriculum of nursing students and of nurses working in hospitals professionally. It is believed that incorporating nurses into spiritual care course programs could positively impact their capacity to deliver spiritual care.

Engaging in religious activities was one of the predictors affecting the spiritual health level of nurses in our study. Since religious commitment is one of the components of the concept of spiritual health, this might be an expected finding

(Jaberi et al., 2019). Similarly, in some studies, nurses participating in religious worship were found to have higher levels of spiritual well-being and spiritual care (Eskandari et al., 2019). In our study, the high level of spiritual health in nurses can be attributed to the fact that individuals in Turkish society are more inclined towards religious beliefs and spiritual values since believing in religious values and having religious beliefs are necessary characteristics for the formation of spiritual health in individuals (Eskandari et al., 2019). In the literature, it is stated that personal spirituality, religiosity, and religious activities lead to positive results on spiritual health and care (Akbari et al., 2022; Neathery et al. 2020). Neathery et al. (2020) in their study of psychiatric nurses stated that nurses who see themselves as "spiritual and religious" provide spiritual care more often than those who see themselves as "spiritual but non-religious" and have a higher level of spiritual perspective. In their study, Deluga et al. (2020) states that nurses' personal spirituality has an impact on spiritual nursing care and shows that there is a strong relationship between nurses' 'Spiritual Activities' and their religious commitment. In other studies, it is stated that the personal spirituality or religiosity of nurses is directly related to their attitudes towards providing spiritual care (Ross et al., 2016). Similarly, in our study, it is seen that nurses' religious activities are an important predictor of spiritual health and spiritual care competence. This situation can be interpreted as nurses engaged in religious activities may have a better spiritual sensitivity and awareness in meeting the spiritual needs of the patients and responding to the patient's faith-based concerns.

Conclusion and Implications for Practice

As a result, the spiritual health and spiritual care competence levels of nurses are moderate. A relationship was found between spiritual health and spiritual care competencies in nurses. In other words, the spiritual health of nurses is effective on the level of spiritual care competence. The spiritual care competence of female nurses and the spiritual health level of nurses participating in religious activities are higher. In addition, the spiritual health and spiritual care competencies of the nurses who have a high level of education and who take courses/educations on spiritual care are at a better level. The relationship between spiritual health and spiritual care competence shows that competence includes various knowledge, attitudes, skills, and behaviours. The spiritual health of nurses is an important predictor affecting their competence in spiritual care. Based on these results, it can be said that supporting spiritual health can increase the quality of spiritual care in nursing and positively affect the competence of nurses.

As nurses, it is important to develop strategies and plan initiatives to increase the level of spiritual health of nurses to increase the adequacy and quality of spiritual care practices. According to the results of this study, it is necessary to include education

and consultancy services to increase/develop spiritual health (such as increasing the ability to evaluate spiritual needs and support spiritual needs) in the curriculum of nursing students and education seminars for nurses.

Limitations

An important limitation is that this study was conducted on nurses in one hospital. The fact that the data in the study was collected by the self-report method is a limitation as it may affect the results of the study. Another limitation is that causal conclusions cannot be reached in this study because the data were not collected by experimental or longitudinal method.

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Ethical approval. This study was conducted in accordance with the principles of the Declaration of Helsinki. Ethics committee approval for the research was received from the Pamukkale University Non-Interventional Clinical Research Ethics Committee (Date: 18.10.2022, Number: E-60116787-020-279030), informed consent was obtained from all nurses, and permission for use was received via e-mail from the owner of the scales used.

Authors' contribution. Study conception and design: E.K.İ, E.A., Data collection: E.K.İ, E.A. Literature Search: E.K.İ. Data analysis and interpretation: E.K.İ. Writing Manuscript: E.K.İ, E.A. Critical revision of the article: E.K.İ, E.A.

Peer-review. The research was evaluated by two or more field experts and the research was developed in line with their opinions.

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